The Pathway Partnership Programme
Annual Report: 2022-23

Breaking the Cycle: Improving Hospital Care and Discharge for Patients Experiencing Homelessness

Edited by Dr Peter Buchman and Alex Bax

Pathway
Homeless & Inclusion Health

“It’s the most anyone has done for me in a long time.”

Pathway Team patient

Pathway
Homeless & Inclusion Health

Crisis
Together we will end homelessness

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Acknowledgements

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About Us

Pathway is the UK’s leading homeless and inclusion health charity. We work with and alongside the NHS to improve care quality and outcomes for people experiencing homelessness and other inclusion health groups. In 2021 Pathway joined the Crisis group to create a strategic alliance to maximise our joint impact.

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If you would like to talk to someone about joining the Pathway Partnership Programme or commissioning an initial Pathway Needs Assessment, please contact **paul.hamlin@pathway.org.uk**

If you would like information about our wider work on homeless and inclusion health, please visit our website at **www.pathway.org.uk**

You can join the Faculty for Homeless and Inclusion Health and receive regular email updates about our work and about inclusion health in the NHS by signing up at **www.pathway.org.uk/the-faculty/support-the-faculty/**

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Executive Summary

Introduction

Ahead of Michael Marmot's insight, the first Pathway Team in the UK began working with homeless patients at UCLH in 2008, changing what happened for homeless patients in hospital, and trying to change what happened to them afterwards.

Ten years of work later, as part of a national programme funded by The Health Foundation, we launched our formal Partnership Programme to offer to the NHS a structured, managed approach to share the wisdom, knowledge and experience we had gathered from a decade of incredible colleagues building on the model to improve health and housing outcomes for homeless patients in hospital.

During 2022-23 we had an average of eight Teams signed up to our Partnership Programme: five in London hospitals and three in Hull, Leeds and Plymouth. In this report, we for the first time publish consolidated performance data from these Teams. Alongside this data the report includes a selection of individual case studies showing the startling complexity of the work Pathway Teams get involved in and the severity of the need that they respond to.

The randomised controlled trial conducted on the Pathway Team approach between 2011 and 2013 showed that clinically led enhanced care co-ordination Teams working with homeless patients in hospital markedly reduced returns to rough sleeping and generated significant health gains for their patients six months post-discharge. Other reviews of the Pathway Team approach have shown significant efficiency gains for the health system in terms of avoided future care costs.

During the twelve-month period covered in this report, the Teams affiliated to the Partnership Programme worked with 2,640 patients - an average of about 300 patients per Team. Alongside the serious physical health problems that had brought people to hospital, Teams reported that 55% of patients had mental health needs, 55% had substance misuse problems and 42% needed to be considered for referral to adult safeguarding. The data shows the Teams reduced returns to rough sleeping among their discharged patients by 50% and reduced returns to sofa surfing by 35%.

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"What good does it do to treat people and send them back to the conditions that made them sick?"

Prof. Sir Michael Marmot,
The Health Gap, 2015

Learning from the Pathway Partnership Programme

Multi-disciplinary Teams of committed compassionate professionals can work with homeless patients in hospital to transform outcomes for their patients. Pathway Teams can stop people returning to the street and, particularly where they have access to specialist step-down accommodation, massively increase vulnerable patients' engagement with community services to support their longer-term needs and stop them needing to come back to hospital.

Different reviews of the work of the first generation of Teams across our wider network ('legacy Teams' created before the launch of our Partnership Programme) showed that a Pathway Team reduces returns to hospital care and increases engagement with planned and managed care. Several studies also showed a significant drop in total bed days relating to homeless admissions. A series of significant research papers over the last couple of years, examining the impact of the Pathway Team working with psychiatric in-patients at South London and Maudsley NHS Trust, have further confirmed this effect.

At the same time, feedback from front-line staff across the Teams tells us that:

Levels of complexity among homeless patients seem to be rising;

- The housing crisis, cost of living crisis and crisis in local government finance are making it ever harder to make the case for our patients with other parts of the system;
- This is reflected in high levels of stress and vicarious trauma among staff in these Teams, with Team members talking of the 'moral injury' they experience when they can get nothing for their sick, vulnerable patients;
- Numbers of patients with no recourse to public funds are rising, and all the Teams report that helping these patients is particularly challenging;
- Teams value being part of our national support network, the connections we make for them with each other, and the professional support of Pathway's core Team of inclusion health experts.

For health service commissioners and leaders our programme shows that:

A Pathway Team is a straightforward, direct intervention that improves outcomes among one of the sickest and most vulnerable of patient groups.
Doing nothing for homeless patients means they continue to use emergency and crisis services and are left cycling round and round the system in vicious circles of despair.

Uncertainty in funding undermines the potential for good care. These Teams, unsurprisingly, are best able to focus on improving patient care when commissioning decisions are made in good time and peoples' jobs are not continuously at risk.

As Pathway, a small charity dedicated to improving care for the most excluded, we have shown we can support NHS partners to adopt and adapt the Pathway Team model of care, help to recruit and then support Teams of staff and help them keep going in the face of adversity. The case studies in this report show the dramatic efficiency gains to the NHS and improved outcomes for patients that the Teams can achieve, but overall, both financial and other system pressures mean that both Pathway and the frontline Teams who are our partners in the programme often have to spend much of their time continuously proving their value and arguing for funding.

As well as observing how self-defeating it can be for health systems to ignore the circumstances in which their patients live, Michael Marmot has argued that to properly address health inequalities we need to base our actions on the principle of 'proportionate universalism'. Within our universal health service, we should seek to slant additional resources towards those with the highest needs. When it comes to Pathway Teams (especially where a Team also has access to their own step-down provision) there is good evidence that having a Team is cheaper for a system than not having one in terms of long-term avoided costs of care. The arguments in favour of investing in these services are financial as well as moral.

We thank all our amazing Partnership Programme Partners in each one of the places that have been courageous enough to join this programme for their commitment to this principle.

Chapter 1. Introduction

Welcome to the Pathway Partnership Programme's first annual report. In this report, we describe how we work with NHS organisations through our partnership programme and how working together we help them to improve care and outcomes for people experiencing homelessness.

We present a summary of data across the nine Teams in the programme and highlight the specific successes of each of these Teams. Drawing on the data and the Teams' collective experience, we also highlight some of the extreme challenges facing homeless patients and Pathway Teams around the country, and share the parallel challenges we have faced, as a small national charity, of trying to work in a new way, in collaborative, reciprocal partnership with large NHS institutions and ever-changing commissioning structures.

Pathway is a unique national homeless and inclusion health charity. Our mission is to transform health and care outcomes for people experiencing homelessness and other excluded groups. We believe in the NHS, so our task is to make positive change happen within the health service. Pathway's small multi-disciplinary staff Team works with and alongside NHS staff and organisations to test, develop and share best practice, and to use the evidence we can gather from our work to argue for wider policy and system change at the national level. A core priority for the charity, based on over ten years of work and experience, is to help the NHS replicate, spread (and continuously improve) our first innovation: a simple model of a specialist homeless Team in a hospital – a Pathway Team.

Beyond the Pathway Teams, our other strategic priorities include:

- Making the case for the provision of specialist intermediate care for inclusion health groups
- Exploring how primary care might do more to prevent homelessness and multiple exclusion
- Working with our partners in Crisis (the national homelessness charity) to support wider system change 'at place'. That is, in specific localities, with a focus on Integrated Care Systems
- Continuing to raise the profile of inclusion health as a priority across the health service, through developing and hosting the Faculty for Homeless and Inclusion Health and a range of specialist clinical and support networks

We dedicate this report to all the staff working in Pathway Teams. The work they do every day can be exceptionally challenging. On behalf of their patients Pathway Teams members must often query the decisions or assessments of other services - particularly when the Teams are just establishing themselves - and this doesn't always make them popular. We hope our own support helps them to keep going but we also want to thank them for their fortitude, dogged determination and solidarity with their patients.

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Chapter 2. The Pathway Partnership Programme and Pathway Teams

The Pathway Partnership Programme and Pathway Teams

The first clinically led, specialist homeless Team in a hospital (later christened a Pathway Team) was launched at University College London Hospitals NHS Trust in 2008. We conducted a two-site randomised controlled trial of the intervention between 2011 and 2013, with National Institute for Health and Care Research funding and a Health Foundation development grant supporting the establishment of two further Pathway Teams at the Royal London Hospital in East London and at Brighton and Sussex University Hospital. The trial showed clear benefits to patients and to hospital efficiency.

In 2013 Guys and St Thomas' Hospital charity funded Pathway to carry out a needs assessment in South London, which led to the funding of large Pathway Teams covering Guy's and St Thomas' Hospital and King's College Hospital. A year later, funding was secured to pilot the model with South London and Maudsley NHS Trust (a series of significant research papers have followed showing the value of a Pathway Team for homeless patients on psychiatric wards). At the same time, we secured a Department of Health innovation grant to fund a Team in Bradford for 18 months. Bevan Healthcare adopted and adapted the model to their local circumstances and have gone on to create a whole series of integrated, specialist services for people experiencing homelessness and extreme exclusion. Again, adopting and adapting the model, in 2014 colleagues from the Urban Village practice in Manchester invited us to visit their new 'MPATH' service, working to support homeless patients in Manchester Royal Infirmary. We now call all these early adopters of the model our 'legacy Teams'.

During this period Pathway brought in a range of charitable grants and research funds to cover our own costs and often to forward fund the first months or years of operation of a new local Team. We also developed a structured approach to help local systems assess the need for a specialist hospital Team and regularly brought the front-line Pathway Teams together to capture and share the rich learning the programme was generating and support new colleagues as their services launched.

In 2018 we were selected to join a three-year national programme, led by the Health Foundation, to explore how well-evidenced improvements to care quality and patient outcomes could be replicated and spread more quickly across the NHS, and whether subscription-based funding models might work within the NHS to meet the costs of the 'originator' of an intervention. That funding allowed us to design and launch the Pathway Partnership Programme.

Pathway Teams are clinically-led, multi-disciplinary Teams that provide holistic support for patients experiencing homelessness and other vulnerable groups within acute and mental health hospital settings.

Teams are typically comprised of some combination of GPs, Nurses, Housing Workers, Social Workers, Occupational Therapists and Care Navigators.

The overall goals of a Pathway Team are to maximise the benefits of a hospital admission and ultimately improve health outcomes for people experiencing homelessness and multiple exclusion.

Teams achieve this through a wide range of activities including:

- Building relationships of trust with patients and meeting immediate practical needs – for fresh clothes, shoes, making contact with friends and family;
- conducting holistic, patient-centred assessments;
- clinically-supported housing advocacy and discharge planning;
- convening and attending multi-disciplinary meetings involving key hospital and community services;
- ensuring patients are registered with a GP they can access on hospital discharge; making appropriate referrals to Safeguarding, Social Care and other key services such as substance misuse;
- establishing patients' legal entitlements to benefits, and housing support and to regularising their immigration status;
- training and educating local colleagues to promote culture change.

Pathway Teams are NHS employed staff who work with their patients to bridge the boundaries between health, housing and social care.

A note on language:
For ease of reference in this report we describe all the Teams we support through our Partnership Programme as Pathway Teams. Many of them are called different things locally, for example the 'inclusion health Team', or the 'homeless Team'.

A Brief Summary of the Pathway Partnership Programme

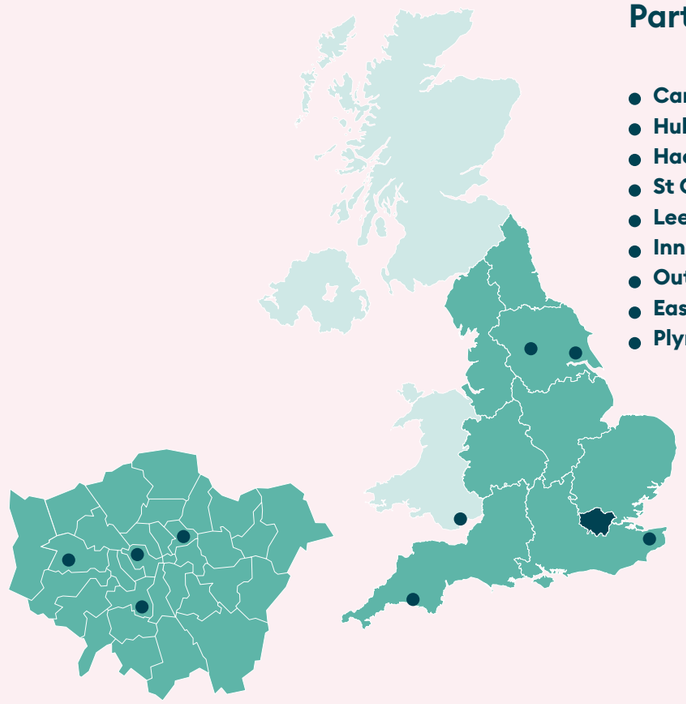
In return for an annual subscription fee, the Pathway Partnership Programme offers hospitals and their partners a practical way to help people experiencing homelessness. Organisations that join the Programme get access to 12 years of distilled experience and best practice in costing, designing, recruiting, training and launching a Pathway Team.

We work with local commissioners to assess local need and build business cases, and once Teams have gone live, we give Team members access to a range of practical support, an online support manual, training and peer networks. In return we ask our NHS partners to share service data with us, work to meet our minimum quality standards, and commit to our collaborative network. Together we work to keep learning and improving, and to use our shared experiences, knowledge, skills and clinical and patient voice to campaign for wider changes in the NHS and beyond, to change the system and end homelessness for good.

The top map shows the nine places where we currently support a Pathway Team. In each of these places we have a formal agreement with local NHS organisations, usually based on our 'Partnership Agreement' which commits Pathway and our partners to work together to improve care. In some places our partner is the acute hospital or other NHS trust, in others the Team is commissioned from a community provider and the Team 'in-reaches' to the hospital. Our local partner pays an annual subscription or fee towards the costs of our programme. As a charity, we further subsidise the costs of the programme as much as we can (currently we match fund the partnership fee) and bring in additional funds to add enhancements to the programme, or develop research in specific areas of interest to the Teams. For example, with a grant from the Frontline Foundation we currently fund access to specialist legal advice for most of the Teams across the network. We are delighted to support our growing national network of services and the passionate and dedicated homeless and inclusion health professionals that work in these hospitals across the UK. When places join Pathway's network, they are also joining a national movement for change and making a visible commitment to tackle the worst health inequalities.

The second map shows our wider network of 'legacy Teams'. These are sites where there is a Pathway Team, or similar, and where we have been involved to a greater or lesser extent in developing or supporting the service. We invite legacy Team staff to our wider network meetings, but they do not have access to the support described in this report, nor do they provide us with monitoring or outcome data. This map also shows places where we have carried out commissioned needs assessments or other engagement work but where a Pathway Team service has not (yet) been established.

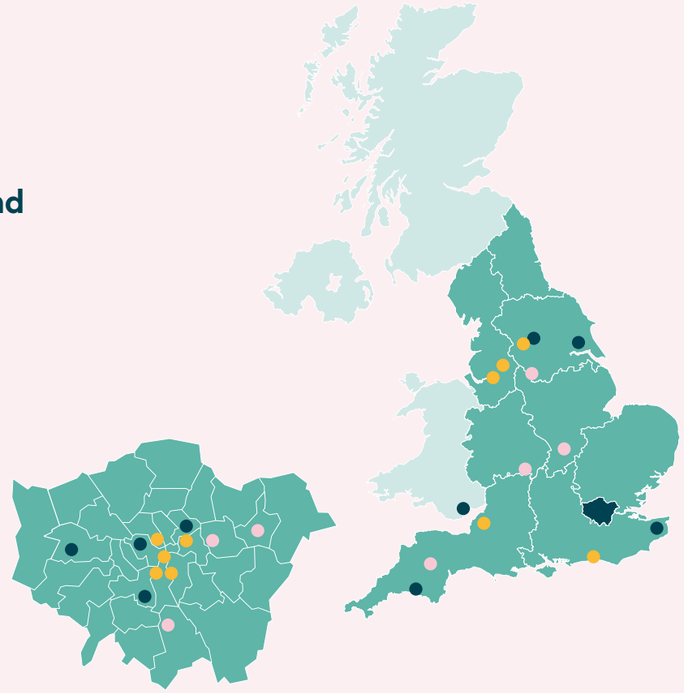
Nine Pathway Partnership Teams



- Cardiff & The Vale
- Hull
- Hackney
- St Georges
- Leeds
- Inner NWL - Imperial
- Outer NWL - Ealing & Northwick Park
- East Kent
- Plymouth

Pathway Teams Around the Country

- 9 Partnership Teams
- 10 Legacy Teams
- Possible future Teams



Phases of Support within the Partnership Programme

The Partnership Programme helps places to set up a specialist homeless hospital Team through four distinct phases. Through these phases we provide a range of support to commissioners, service managers and service staff. Before a Team is created, we offer Pre-Service Design support, working with local champions of inclusion health to assess the local level of need and encourage relevant stakeholders to act.

We often work to support a local champion for some time before a local system or Trust decides it wants to work with us in a more formal relationship. A first step has frequently been for the local system to commission us to carry out a detailed homeless and inclusion health Needs Assessment, based on our standard method. If the needs assessment finds more than 250 homeless admissions per annum, we are likely to recommend that the local system commissions a Pathway Team. (Alongside thinking about hospital care, a Pathway needs assessment will also make recommendations about other local services and how to improve care for homeless patients in a locality more generally). We then support commissioners and local champions with development of a business case, detailed Service Design and specification, and help commissioners to identify an appropriate local provider organisation to deliver the service.

Our support during the Implementation Phase includes advice on the project management of local procurement and contracting, and service start up, including helping the local provider recruit and train the new Team. Following the launch of a new service, we move into the Ongoing Support phase. Detailed advice and guidance, document templates and training materials for each of these phases are all available to partners via our online support manual.

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Overview of the Direct Support we Provide

Phase	Objective	Activities	Funding for phase
Pre-Service Design	Build a case for a Team and start conversations with an interested commissioner	• A local champion is identified/ recruited • Early stakeholder engagement • Funding and support for a needs assessment is negotiated • Needs Assessment carried out, if needed • Business case for a Team created	One off fee for Needs Assessment
Service Design	Commissioner agrees to fund a Team and sign up to the Partnership Programme	• Service Specification created • Local Pathway Team designed • Potential Provider identified • Hospital and other stakeholders engaged • Partnership Agreement signed	Either included in fee for Needs Assessment, or Partnership Fee paid at start of Phase
Implementation	Commissioner, Provider and Hospital Trust progress towards the launch of a new Pathway Team	• Provider appointment/procurement • Appointment of a 'Nominated Hospital Lead' • New Team Staff Recruitment • Comms strategy implemented, including Launch event • Practical needs of Team addressed (office space, systems access, honorary contracts, reflective practice, etc) • Initial data pull, and ongoing data collection process agreed • Training of the Team • Staff Induction	Partnership Fee
Ongoing Support	Pathway Team operational	• Team Operational • Ongoing support package from Pathway begins	Partnership Fee

Feedback from Commissioners

In 2023 we sought feedback about the Partnership Programme from some of the commissioners we have worked with recently:

> **"In my thirty plus years of working, the most inspiring and proud thing I have been involved in is the set-up of this Team. We wouldn't have done it without your help. We would not have been successful. Every day together we're saving lives and that's what it comes down to."**
>
> *Steve Cox, Commissioner*

> **"The Pathway Team make us feel reassured really quickly... you guys led us through [how to set up a homeless health Team], and that was so valued...Everyone on the Pathway Team has different strengths and represented different parts of the system."**
>
> *Lewis Irani, Commissioner*

By signing up to our formal Partnership Agreement, local NHS commissioners and providers agree to meet our Minimum Service Standards for a Team. Beyond these core Service Standards, local partners have freedom to innovate and develop their service in the best way to meet local needs and fit in with other services. The Partnership Agreement also commits our partners to share back with us and the wider network any service innovations or improvements that will help others. Our support package aims to empower partner organisations to deliver a good quality and evidence-based service for patients experiencing homelessness and multiple exclusion. As more places join the programme, we have grown a collaborative network of Pathway Teams, sharing best practice and improving and developing the service model over time, in line with Pathway's core values and mission. As our network grows it then becomes more valuable for each new place that joins.

Pathway's Funding Challenge

Later in this report we describe how front-line staff value being part of our Partnership Programme, how managers find our support with commissioning and service monitoring invaluable, and how our focus on quality improvement continues to improve care for patients. However, we have also found that local NHS budget holders often struggle to justify our annual support fee of £22,500. Pathway has reviewed our management of the programme this year. Currently, the fee income generated from subscriptions covers just over half of the costs of providing the support programme. Pathway makes up this gap with charitable funding. Outside of the Partnership Programme, Pathway funds extra help for Teams wherever we can, like our national legal advice network, or 'dignity funds' for clothes, shoes, phones and other basics for patients. Pathway's board will be reviewing in the next 12 months how long we can continue to subsidise the programme to the NHS.

Possible Costs and Benefits of a Pathway Team

Over the years we have been involved in many studies to estimate the costs and financial benefits of Pathway Teams. Here we present a crude calculation of what value the Teams may be delivering. It is based on a number of broad assumptions and we present it here to give an order of magnitude suggestion of what the relative costs and benefits of this work may be to the health system.

In March 2023 Will Quince, Minister of State, told Parliament that the average cost per day of a non-elective hospital stay was £901.[Ref 1]

If we take the 2,640 patients accepted by the Pathway Teams in the year covered by this report and use the current average length of stay figure for an un-planned hospital admission of 8.3 days, we can estimate that these patients might have occupied 21,912 bed days. At £901 per bed day this equates to a cost for all these admissions of some £19.7 million.

We have a range of studies about the impacts of Pathway Teams, but several have reported that before and after the introduction of a Pathway Team in-patient bed-days in relation to homeless patients in a trust can fall by around 30%. If that reduction was achieved by the patients seen by Pathway Partnership Teams in 2022-23 that would equate to avoided health service costs of £5.9M in the year. An estimate for the annual revenue cost of an average Pathway Team could be around £350,000, or for eight Teams £2.8M. So, the eight current Teams may be saving the NHS £3M in avoided costs and/or making £5.9M worth of hospital beds available for other patients.

Across England we think there are probably at least 40 hospitals who would benefit from the intervention. Based on these estimates, un-scheduled hospital care for homeless patients in 40 hospitals could cost the NHS close to £100 million per annum. Pathway Teams in all those locations might reduce that figure by £15 million while delivering better health and housing outcomes for the 13,000 plus homeless patients we might expect to find. (Between our Partnership Programme, the Pathway legacy Teams we are aware of and others with services in place at least 20 of these already have some kind of specialist homeless response in place.)

A 2010 Department of Health study reported homeless patients are two to three times sicker than the average hospital patient at the point of admission, so their actual costs and length of stay could well be higher than an average hospital patient.

Chapter 3. Lived Experience and Understanding Patients

For Pathway, lived experience as a concept is about understanding people's interactions with health and care services from their own perspectives and the meanings they derive from those experiences and interactions.

People with lived experience bring a crucial perspective to health and care policy, service design and delivery. As a charity, Pathway has sought to involve lived experience in all our work since our foundation in 2009 and this involvement is one of the charity's core values. We have an active Experts by Experience Programme running alongside all that we do, and this includes involvement in the Partnership Programme. Pathway's Experts by Experience meet regularly online and in-person. Through their lived experience of homelessness and exclusion they offer their expertise and insights to help shape Pathway's work in nearly every area. The group have been pivotal in decisions made not just by Pathway but across our wider networks, and in influencing positive changes.

Lived Experience has told us we need to think harder about how we suggest Teams collect feedback from their patients. The group have been part of designing and implementing training for our Pathway Teams. Who better to design training than those who truly know how it feels to be excluded from healthcare for the simple fact of being without a home? Lived experience opens our eyes to areas we may not think are as important, making sure the whole programme remains grounded in reality.

In the first Pathway Team at UCLH and at the Royal London Hospital, we created paid roles for Care Navigators with lived experience. Having staff with lived experience of homelessness in the Team (supported by a training programme and progression to care qualifications) directly challenges stigmatising attitudes among other staff and made it much easier for Teams to win the trust of their patients. The value of bringing lived experience into the Team was recognised by staff and by the patients. Someone who has been there themselves has a much better understanding of how a patient experiencing homelessness might feel, helping to build trust and embodying hope for people who have experienced so much exclusion from society. They also serve as great role models.

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> ***"The Pathway Teams are centred around the needs of patients experiencing homelessness; a Team of experts to guide the person to where they need to be, holistically. This then brings us to our main belief that the real expert in homelessness is the one who has walked the path. From a life on the streets to a life helping others, the progression we bear witness to makes us believe that change is possible. It's our responsibility to instil this belief in another."***
>
> ***Mandy Pattinson, Lived Experience Programme Manager***

While many of our newer Teams do not have specific lived experience roles, there are staff with lived experience amongst our Teams and we continue to value all that this brings.

We now intend to explore new opportunities to bring more lived experience into the Teams, whether through paid roles, volunteering, or work experience. We contributed to the development of a best practice toolkit on employing people with histories of homelessness with NHS Employers in late 2023.

As part of our quality improvement work, we would like to see more structured service-user feedback and Team reflection on what it highlights and would like to involve people with lived experience in learning and quality improvement processes as best practice.

We are also exploring the creation of a lived experience advisory group for the programme, where ideas, questions and challenges from the front-line Teams can be discussed.

Chapter 4. Meet the Current Teams

In this section we present short pen-portraits of each of the Teams supported through our Partnership Programme in 2022-23.

Each Team is similar, and they are also all different! The Teams are all based on the core Pathway Team model. On average, during 2022-23 each Team supported around 260 homeless patients during and after a hospital admission.

Alongside the Team portraits most of the Teams have shared a patient case study. The case studies vividly illustrate the extreme complexity and multi-layered challenges that Pathway Teams face every day, as they try to get the best outcomes that they can for their patients.

The Team descriptions also summarise how each Team is funded. Some of the Teams have posts funded by local government budgets alongside NHS funding. Most Team staff are NHS employees but, in some Teams, different staff members are employed by different local organisations. Multi-disciplinary working is central to the Pathway approach and in the larger Teams, alongside GPs, nurses and occupational therapists, there are social workers, peer support workers and in one Team part-time clinical psychology input.

It is observable that the Teams work best when they have stable funding. The more mature Teams have had time to build their local networks and relationships with community services, and this knowledge and these relationships help them get more for their patients. Teams also need clear and confirmed line management and clinical supervision arrangements around them. Our experience through this programme is that Pathway Teams, particularly in their first year or two of operation, must continuously prove their benefit to colleagues and commissioners. Also, as Pathway Teams are set up to build bridges between services, routine structures of NHS hospital management often struggle to put the right kind of support around them. Affiliation with our Partnership Programme gives Teams access to a lot of external support and we are sometimes in a good position to raise these kinds of management and structural issues with local managers, on behalf of a local Team.

Over the last year only a couple of the Teams described here have not faced serious funding challenges, and in several instances funding for the current financial year was only agreed at the very end of the preceding year. In some cases, this meant experienced staff left and Teams have had to rapidly recruit new staff to keep going.

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St George's Homelessness Inclusion Team (HIT)

The Team at St George's NHS Trust in Tooting, Southwest London, launched in November 2021. The Department of Health and Social Care's 'out of hospital care fund' paid for the pilot year. Since then, it has been funded by South West London Integrated Care Board. The Team currently consists of GP /Clinical Lead Dr Danielle Williams, two Specialist Nurses: Gugu Khumalo and Oliver James, two Housing Officers: Georgina Earthy and Jamie Robinson. The Team has recruited a Care Navigator who is due to start later this year. The Team are managed within the Emergency Department in St George's and take referrals from across the hospital including both A&E and inpatient wards. Their inclusion criteria are people over 18 experiencing or at risk of homelessness and within inclusion health groups.

The Team works with inpatients and where it can, continues to support patients in the community for up to six weeks after discharge from hospital. They have one dedicated step-down bed in a local hotel. They have strong links with Wandsworth Council, particularly with the rough sleeper Team, and with the St George's Hospital Charity. As a regional trauma centre the hospital admits emergency patients from a wide geographical area, so the Team find themselves working with many different London boroughs. The Team puts particular emphasis on inclusion health education, delivering training sessions across the hospital and in the local community. They have put together a booklet of local services and support that has been distributed in the local area. They are also part of the Southwest London Homeless Health Steering Group.

The Team is friendly, committed and passionate about their work. Their monitoring data shows they helped to reduce rough sleeping in their patient group by 77% since launching, in addition to a 66% reduction in A&E attendances for frequent attenders. They aim to give holistic, health-focused care with a strong multi-disciplinary approach.

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Case Study:

Mr A was a young man who presented to the St George's Homelessness Inclusion Team (HIT) shortly after the service went live. He had previously been living with his family in a metal storage container unit in an industrial park, but he and his family had all been evicted prior to his hospital admission.

Mr A had a long-term stoma in situ following several surgical interventions after a gunshot wound two years previously. He required parenteral (intravenous) nutrition via a Hickman line (a central venous line directly into his bloodstream). He also suffered with Post Traumatic Stress Disorder (PTSD) secondary to the gunshot injury, which caused him to have low mood and anxiety.

Mr A had had 33 inpatient admissions from 6 A&E presentations and 30 outpatient appointments in the two years prior to being referred to the HIT Team. These recurrent admissions were due to infections in his Hickman line, and issues managing his parenteral nutrition probably exacerbated by his living conditions and his low mood. During this time, he had missed other outpatient appointments. On the admission when he met the Team, he was septic secondary to a severe infection in his Hickman line and had an Acute Kidney Injury secondary to severe dehydration.

While he was an inpatient the HIT Team was able to support him to engage fully with and understand his medical care. This involved the whole Team liaising with a variety of hospital Teams including medicine, gastroenterology, microbiology, dietetics, and the stoma care Team. It also included providing direct emotional support to Mr A, as he often struggled with social interaction and engagement due to his PTSD. During this time the Team liaised with his family and his GP.

The Team Housing Worker supported him with a housing application and liaised with the Local Authority. This included helping him to reject the first temporary accommodation offer that was made (it was on the top floor of a 4-storey building with no lift, no private bathroom, no room for medical equipment and no space to manoeuvre with a drip stand). The Team GP provided a detailed medical letter outlining the various requirements that would be needed to house him safely. He was then offered alternative temporary accommodation in another borough which was suitable. On discharge, the Team used its personalisation fund to help him to buy new bedding and other basic items to ensure his new accommodation was liveable.

The Team continued to support Mr A after discharge, helping him to complete his housing benefit application. They also helped him to re-register with a local GP and understand the local support services available in his new area. Finally, the Team referred him to a counselling service that deals specially with PTSD and encouraged him to engage with Red Thread (an organisation supporting gang violence victims). The Team worked with Mr A for a total of six weeks until he was settled and well supported.

They continue to have occasional updates on him and are glad to say that he is now doing well in new long term social housing. He is engaging with all the support and health care offered, including attending all his scheduled outpatient appointments. He has not had any further ED attendances, inpatient admissions or outpatient DNAs in the six months following discharge from hospital.

Hackney Pathway Homeless Team (The Homerton Hospital Inclusion Health Team)

Hackney Clinical Commissioning Group and Local Authority commissioned Pathway to carry out a detailed homeless health needs assessment in 2020. Using this evidence and with Pathway's support, local commissioners developed a business case, and the Homerton Hospital Inclusion Health Team launched in January 2022. The Team was brought together through a partnership with Homerton University Hospital NHS Foundation Trust, the City and Hackney Centre for Mental Health (operated by East London NHS Foundation Trust - ELFT), Northeast London Integrated Care Board, Hackney Council and the Peabody Trust.

The Team also have access to a specially commissioned six-bedded step-down facility, Lowrie House, managed by Peabody Trust, to which they can discharge patients who need extra support while waiting for their final move-on destination to be ready.

The Team is made up of a GP, nurse, occupational therapist, social worker, peer link workers and a housing worker. Based in the hospital, the Homerton Inclusion Health Team support and advocate for homeless patients, improve patient care, enable safe discharge and follow-up in the community. They also help to train hospital staff to identify homelessness, and host regular multi-disciplinary Team meetings to ensure the ongoing progression of complex cases. Referrals to the service are accepted from within the hospital, GPs, supported housing providers, local authorities or from people experiencing homelessness themselves.

In January 2023 the Team's Lead Nurse, Hannah Green, won the Daisy Award for Nursing Excellence. On top of this, Housing Worker Melissa Moench won the Bumble Bee Award for Celebrating Excellence Every Day that same month!

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Case Study:

Ms X is a woman in her 40s with HIV, paranoid schizophrenia, a history of injecting drug use (requiring Methadone), cognitive impairment issues, unclear immigration status and a significant history of rough sleeping.

After a prior mental health admission to another hospital (where she had been discharged to her 'Aunt's house', a place where she had said she was going but which did not exist), she was admitted to the Homerton with sepsis and poor HIV markers due to a lack of concordance with treatment. Initially she absconded, but then returned. She was very unwell. She was referred to safeguarding, assessed to lack mental capacity in several areas, and placed on a Deprivation of Liberty Safeguarding Plan (DOLS) to ensure that she could be treated.

The Team Nurse liaised with the patient's Mental Health Care Coordinator, St Mungo's Rough Sleeping Care Navigator, GP and others, initiated two case conferences and started to work on an appropriate discharge destination and health plan. This included liaising directly with a health commissioner about funding for the potential options. The Head of Adult Safeguarding was also involved.

Unfortunately, after about four weeks, Ms X was allowed to self-discharge in the middle of the night, despite being on a DOLS. Although this was generally viewed as a mistake (in that the person undertaking the mental capacity assessment, and allowing her to go, had not fully understood the context), it underlines how tricky some of these decisions are. However, the Team put alerts out to community partners, and she was found and persuaded to return. The DOLS was reinstated.

During both admissions the Team saw her every day. Over time there was an improvement in her trust and engagement. She was referred to Praxis for immigration support, and to Social Care for a package of care, focused primarily on medication concordance and monitoring self-neglect. She was also referred to the Home Treatment Team for mental health support on discharge. She then had a planned discharge to a Bed and Breakfast placement funded by St Mungo's with a package of care twice a day, and daily health support, the funding of which was then taken over by ELFT. All her physical health follow up was arranged by the Team, including follow up treatment for a pulmonary embolus she had suffered whilst an inpatient.

She has been taken to panel, and various options are being considered in the wider context of her immigration status. She has been monitored in her current accommodation by the Team, and since discharge she has not returned to the hospital or rough sleeping and remains engaged with all support services.

Homeless Health Team - Northwest London (Inner)

The Inner Northwest London Team at Imperial College Healthcare NHS Trust went live at the beginning of December 2021 based at St Mary's Hospital, Paddington. After a period of significantly reduced service the Team now has stable funding and a newly established staff Team. As of January 2024, the Team comprises a Team Lead (social worker), two Band 7 Nurses and two Housing Coordinators. The Team will be completed this year by a third Housing Coordinator and a part-time GP. Community nurses are also being recruited to follow up patients after discharge when required.

The Team provides homeless health cover to three hospital sites (St Mary's, Charing Cross and Hammersmith) and has a wide group of statutory and voluntary sector stakeholders across five boroughs who contribute to weekly Multi-Disciplinary Team meetings.

It is a busy Team with almost 100 referrals over the final quarter of 2023, of which two thirds were inpatients and over a third were verified rough sleepers. They provide a remote advice and signposting service for most A&E referrals and more substantial face-to-face support to inpatients or high intensity users of A&E.

They work with health (Dr Hickey Surgery, Great Chapel Street, Community Nurses), housing and social services (Hammersmith & Fulham, Westminster, Brent, Kensington & Chelsea), and the wider homelessness sector (St Mungos, Marylebone project, West London Women's Service, the Passage, Crisis, CSTM) to ensure that hospital inpatients get the best possible health impact from admission and are linked into appropriate housing and health services on discharge. By working collaboratively with patients and homeless/health partners to identify their needs and goals and accessing health and homelessness information systems, the Team ensures its assessments are holistic, wide-ranging and collaborative. They liaise with clinicians within the hospital to maximise referrals and increase knowledge and confidence in dealing with some of the complex needs of patients experiencing homelessness. They also advocate with housing departments to try and ensure that clients' specific circumstances are considered, and accommodation is provided where possible. When patients are not eligible for statutory housing, they reach out to other organisations (charitable and commercial) to try and find satisfactory solutions.

They can also provide practical support to promote engagement such as mobile phones, and warm clothing.

In the future, the Team is looking to develop further areas of expertise, for example around No Recourse to Public Funds, and promote a stronger health focus in their interventions. They are also considering expanding their offer to A&E departments and will continue to develop their networks to foster a greater variety of resources in the community.

Their case study demonstrates engagement, persistence, information gathering, advocacy, anti-discriminatory practice, networking and legal nous, all qualities that help patients achieve positive outcomes while they are engaged with the service (and core to the values of all Pathway Teams).

Case Study:

A white British man in his 60s was referred from the emergency department. He had told staff he was rough sleeping in Soho, and they were keen to discharge him just with housing advice. However, the Team's initial checks on NHS & rough sleeper databases suggested he had an address and was not an entrenched rough sleeper. When assessed by the Team he insisted he was rough sleeping yet struggled to provide a cogent history but did manage to give a phone number of his friend. The friend explained that the patient had previously worked as a caretaker at the venue he was sleeping rough outside, and felt very lonely at the accommodation he had been living in. By highlighting some inconsistencies in his presentation (sleeping rough but having an address, incoherent history) the Team advocated for an admission to further assess his cognition.

On further assessment, he described the poor state of his flat and conceded that he was unable to live independently. This was confirmed by more formal cognitive assessments, which resulted in a referral to adult social care and placement in a dementia care home. Without the intervention of the homeless health Team, it is likely he would have been discharged from A&E with the belief that his presentation was 'normal' for a rough sleeper, and his underlying cognitive impairment would have been missed.

East Kent Homeless Pathway Team

The hope for a strategy to support East Kent patients experiencing homelessness began when a man with both his lower limbs amputated was discharged from a local hospital to the council housing department. Fortunately, both the local NHS and the local authority realised that this was unsafe and inequitable, and decided to act to prevent further such events. Heather Walker, a programme manager from the local CCG, joined forces with the trust safeguarding lead for homelessness, Kendal Beasley, to make an approach to Pathway to request a needs assessment. The results showed that East Kent warranted a specialist Team to work with patients experiencing homelessness. Finance was initially secured for a 6-month pilot in 2022 and has now been extended and augmented to allow the Team to grow.

From the very start the Team has been a joint initiative between the NHS, Pathway and other organisations. It has an NHS GP and nurse, Dr Helen Burnett and Millie Waters, who are the clinical members of the Team. Care Connector Lorraine Seago has been seconded from the charity Porchlight, supporting patients within the hospital and then working with them after discharge to help prevent them losing their new homes. An administrator, Karen Richardson, provides organisational support, and is soon to be joined by a housing officer from Canterbury Housing Options who will personally manage the cases of patients who have approached Canterbury for housing support, as well as liaising with the 11 other District Councils of East Kent.

The success of this partnership model resulted in the service receiving a Highly Commended award at the Kent Housing Group Excellence Awards 2023. A short film showcasing the great work of the award-winning model was also produced.

Case Study:

Mr C was a man in his 50s. There was no available historical medical record for him as he had been living in Spain for at least a decade. The Team believe he was cared for there by his parents and when they died, he inherited the house. Because he had never worked in Spain, he could not access a bank account or benefits, so after using up the money he could access, he returned to the UK. The family had previously lived in Ashford, so he came to Kent. His first encounter with health services was when he was found wandering on train lines by the police. They took him to Maidstone ED from where he was taken to the emergency mental health signposting service. They assessed him and suspected he possibly had an autism spectrum disorder. He was fed and washed and then in the morning transported to Ashford Borough Council for housing support. As he was not ordinarily resident, he was judged not to be eligible for help.

Having arrived in Ashford he went on to present to ED seven times over the next three weeks. The Team were involved from the second presentation onwards. Some of these attendances were again the result of interaction with the police when he was found wandering on train lines or in heavy traffic. When the Team first met Mr C we were struck by his cognitive issues. He struggled with various processing skills. A Mini Mental State Examination (MMSE) scored 21/30 despite him having no memory problems. We raised this with the admitting Team who repeated the MMSE twice and got normal scores. They dismissed our concerns and discharged him to the street.

He presented repeatedly with minor ailments such as sore feet or hands and frequently these presentations were out of hours. Despite the Team raising a safeguarding alert he was repeatedly discharged to the street. The Team GP called the doctor in charge of ED on one occasion to ask if they could hold him next time he presented. This was refused.

Over the course of his attendances, we supplied him with three phones. He lost them all so we could rarely contact him. However, we were liaising with the outreach Team who were keeping an eye on him and knew he was going to the local soup kitchens and drop ins. The outreach Team were very supportive but could only watch out for him; the council knew of his vulnerabilities but were not prepared to offer him accommodation that he was not yet eligible to access.

A safeguarding alert was raised with Kent County Council, and we accused the hospital of neglect. Finally, he attended ED in daylight hours and our safeguarding colleagues informed the department that he must be held until he could have a complex capacity assessment. Two safeguarding colleagues performed this and found him to be childlike, unable to understand basic concepts and completely unable to keep himself safe. He was admitted under a DoLS and referred to social care. He is now being assessed for his future needs whilst placed in a care home bed. Sadly, it took over three weeks of him sleeping rough to get this result.

Leeds Homeless and Health Inclusion Team

The Homeless and Health Inclusion Team in Leeds delivers a hospital in-reach service to assess those that are experiencing homelessness or are vulnerably housed and works with partners to provide step up and step-down intermediate care for this cohort. They have access to 12 beds they lead and coordinate care for. The Team also provides an outreach service in the community to Gypsy and Traveller communities.

The Team was launched in September 2013 and includes a clinical lead, specialist nurses and care navigators, a peer navigator, and GPs from Bevan healthcare who contribute to the MDT and provide expert medical assessments and expertise. The Team also includes a homeless integration lead who leads out-of-hospital care and has a wider role within the city to consider how health and housing systems meet the needs of those we serve. The Team provides individual support to vulnerable adults experiencing homelessness, offering medical and psycho-social support and timely, open discussions to help patients make their own decisions.

Delivering a citywide service, the Team assesses patients in Leeds's hospitals and at hostels or temporary accommodation. They support and help facilitate good discharge planning and ongoing care.

As part of its work, the Team also provides a Gypsy and Traveller outreach nursing service and visit Gypsy and Traveller sites and roadside encampments. With this, they provide support and facilitation to services that often struggle to engage with people who may not have a permanent address and help those who may be transient to engage with health services.

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Case Study:

Ms L is a woman in her late 20s who was referred to the HHIT Team in 2022. She was raised by her grandparents after the death of her mother when Ms L was two weeks old, and she has had very limited contact with her father. Her childhood was often chaotic, without boundaries, and sometimes her basic needs were unmet. Her grandparents often struggled to meet their own health needs and were described as frail. There was further evidence of vulnerability, particularly in relation to peers and relationships. There were safeguarding concerns raised in relation to her grandfather and another individual grooming/exploiting young women in the area. Following the deaths of her grandparents, Ms L said that she has no other family members, and was not able to give a next-of-kin.

Professionals have documented that she did not appear to have appropriate stranger discernment as a child and teenager, and would engage easily with strangers in public. This appears to have continued as a pattern of behaviour in adulthood. She has 'sofa surfed' with people she has described as friends, without being able to give an account of how she knows them or to understand any potential risks involved in these relationships.

In addition to this social history, she has a significant past medical history including mild learning disabilities, Type 1 Diabetes (with multiple admissions for hypo/hyper-glycaemia and diabetic ketoacidosis [DKA]), asthma, colectomy causing chronic diarrhoea, photocoagulation of the left eye, and history of suicidal thoughts. She had 76 previous hospital admissions, primarily relating to diabetes. Due to her history of homelessness and 'sofa surfing', Ms L was referred to the HHIT Team following a hospital admission for DKA and an infected right foot ulcer. The Team's activity strongly focused on bringing together the appropriate and responsible agencies and Teams within the local Leeds system. This included raising concerns around her understanding of diet and diabetes management, with referral to a GP practice nurse to offer education and support. She was also referred to and was accepted for a HHIB (homelessness specialist intermediate care) flat. The Team facilitated diabetes education and reviews by a Leeds Teaching Hospitals Trust (LTHT) diabetes Team nurse and the LTHT Learning Disability/Autism Team.

Following another hospital admission for a below knee amputation that resulted in a self-discharge prior to procedure, the Team also raised further concerns about poor glycemic control, high HbA1c, poor diet control and understanding of diabetes management.

HHIT discussed with her GP and the Nursing Team who advised to use a self-management facilitator to help the patient. She was also referred to the Community Learning Disabilities Team (CLDT) for community support and education to help her understand diabetes and to complete Mental Capacity Act (MCA) assessment, however this was declined as Ms L did not have a confirmed learning disability diagnosis in childhood.

She was referred to the MCA Lead for Leeds Community Healthcare Trust (LCH) for advice around capacity issues and diabetes, and HHIT discussed with the GP, Learning Disability Lead for LCH, and social worker, reasonable adjustments regarding her learning disability. A multidisciplinary Team meeting with the HHIT, Nursing Team, GP, LTHT Diabetes Team, LTHT Learning Disability Team and the Learning Disability Lead for LCH was convened. The HHIT raised safeguarding and risk concerns whilst on the ward regarding diet, diabetes management, leaving the ward for extended periods, missing treatments/investigations and medications, and financial exploitation by others. Several multidisciplinary Team meetings were arranged by HHIT with referrals to the MCA Lead LCH and MCA Lead for LTHT. Positive outcomes included the Nursing Team making learning disability reasonable adjustments by giving the patient specific hour time slots, telephoning prior to visiting, and providing the input of a self-management facilitator.

An MCA assessment was completed by doctors regarding diet and diabetes management, and Ms L was assessed as not having capacity. As a result, a Deprivation of Liberty Safeguards (DoLS) procedure was put into place, with restrictions on diet, staff management of insulin, the patient being accompanied when off ward, and monitoring/supervision of relationships on the ward with other patients. Ms L's bilateral above knee amputation was successfully completed. Following this, care management was passed on to the CLDT to ensure she was placed in the most appropriate care environment.

The HHIT Team presented the case at both a Patient Safety Summit and an Exceptional Risk Forum. As a result, the case was accepted as a city-wide risk, effectively engaged with by relevant services, and all reasonable steps were taken across different services to effectively provide care.

Hull Homeless Health Team

The Modality Homeless Health Team is a nurse led Team employed by a large GP Partnership organisation and aims to bridge the gap between primary and secondary care for people experiencing homelessness in Hull. Hull was the first place in the country to sign up to the Pathway Partnership Programme and the Team was initially launched in 2019. Modality Partnership took over the contract for the service in October 2021.

The service has made real progress in providing collaborative health care for its clients, having managed to secure a fixed dental contract with two sessions per week, whilst a hospital liver specialist nurse is working with the Team to provide liver scans in hostels and out in the community. There is also now a drop-in tissue viability service once a week and a drop-in podiatry service monthly.

The Current Team Composition is:

Nurse Manager: Responsible for overseeing Team members and operations.

Lead Nurse: Plays a leadership role in nursing and patient care.

LD Full-Time Hospital Nurse: A nurse working full-time in the hospital setting, with a background specialising in learning disability.

Community Nurse: A nurse who provides care and support in the community setting, following up hospital discharge and outreaching to rough sleepers.

General Practitioners: Two general practitioners collectively provide four sessions per week working in the hospital and community settings.

Care Coordinator: Responsible for coordinating care services, ensuring efficient and effective patient care plus data management.

Care Navigator: Assists patients in navigating the healthcare system, guiding them through various services and resources.

As part of the judging process for the Nursing Times Award, the Team produced a short film with the help of one of their clients.

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Case Study:

Ms S is a 40-year-old woman who was referred to the Team from the Intensive Care Unit (ICU). There was limited information with the referral, only that she was experiencing homelessness and was two days 'post-operation'. When the Team first saw her in hospital, her room was untidy, and her catheter bag was lying on the bed. The food and drinks she had been given were out of reach so she could not reach them. She said that she was in pain, worried that she wouldn't get her Methadone, was concerned about her younger sister and was felt that she was seen as a "problem homeless druggie" and not a 'real' patient. The nurse looking after her was under considerable pressure at the time due to staff shortages and stress, and this had contributed to the poor state of her hospital room.

The Team started to build a relationship with Ms S, taking her toiletries, underwear and magazines, and interacting with her as a human (rather than just a patient) first and foremost. Gradually building up trust allowed the Team to understand more about Ms S's situation. She and her sister were living in their GP's doorway in a nearby town, opposite a church-run hostel that they were trying to get a room in. Both had experienced a very traumatic childhood – their mother had been a sex worker, and both had spent time in care growing up. She expressed worries that her sister was "sex working and being paid in drugs and being pimped out by an older man".

She had been hospitalised due to an injury sustained to her lower back falling off her bike. Since she was sleeping rough, she had no access to washing facilities and her wound had become infected. She had previously attempted to attend A&E, but due to the combination of long waiting times and her addictions, she was not seen. A thorough health assessment revealed that she had sepsis, pyelonephritis, anaemia, and an infected leg ulcer. An MRI showed that she had an epidural haematoma, which required surgery, leading to her stay in the ICU.

The Team liaised with the hostel workers near to where she was rough sleeping and built up a strong working relationship. The hostel workers were able to temporarily provide a room for her sister, which helped remove some of her stress and worry. A rota was set up between the hostel workers and the homeless health Team, to facilitate communication between the two sisters whilst Ms S was in the ICU. The Team then liaised with all the services she was currently engaged with (probation services, drug and alcohol Team, a local hostel, and local authority housing). A 'Duty to Refer' was completed, to ensure housing support once she was medically fit for discharge. The Team worked with Harbour Place workers to ensure she would have housing options and support following her discharge from hospital, even though this was outside the Hull City area.

As a result of the Team's support, and the work of other services, Ms S is now drug-free and is feeling very positive about not going back onto drugs. She described her hospitalisation and the Team's intervention and an 'epiphany'. She told the Team that that they had really helped her; she felt heard, seen as a human and not as a problem. She thanked the Team for defending her and their visible care had helped her to start addressing her problems.

Homeless Pathway Team Ealing and Northwick Park Hospitals – Northwest London (Outer)

This Pathway Team went live at the beginning of June 2022 in Outer Northwest London covering Ealing and Northwick Park Hospitals. It is the sister Team for Inner Northwest London. Since the summer of 2022 Doctors Rula and Amisha, and nurses Archana and Grace have been leading the way within homelessness in London Northwest Hospitals. The following year, OT Nina was appointed service lead, and housing link workers Dami and Joe joined the Team. Amisha recently spoke about the Team's work at a meeting of the All-Party Parliamentary Group on Homelessness.

Health Inclusion Pathway, Plymouth

The Health Inclusion Pathway, Plymouth (HIPP) is a ground-breaking collaboration between Adelaide Street and St Levan Surgery, University Hospitals Plymouth, Plymouth City Council, community health provider Livewell Southwest, and the voluntary sector Plymouth Alliance.

Following a year's work on a detailed business case (with Pathway's support) the Team was established in 2022, with funding from NHS Devon, to meet the needs of people with homelessness or complex lives who are not able to access standard services. It works across the hospital and community, alongside housing colleagues from the Plymouth Alliance. It consists of a GP, nurse, health care assistant, social worker, occupational therapist, mental health nurse, clinical psychologist, health support worker and administrator, and has links with established primary care outreach and drug and alcohol services.

A fantastic short film showcasing the work of the Health Inclusion Pathway Plymouth was also produced.

Cardiff and Vale University Health Board (NHS Wales)

Following a series of discussions and information exchanges, and a fact-finding visit to inclusion health services in Brighton, Cardiff and Vale have committed to joining the Pathway Partnership Programme in 2024. This will be Pathway's first formal relationship with an NHS partner outside England and we look forward to working with our new Welsh colleagues over the next 12 months.

Core Values of Pathway Teams

The case studies presented in this section show the incredible complexity and variety of challenges faced by the Teams. Pathway Team members must be remarkable people to achieve such positive outcomes. We can summarise what Pathway Teams do: multi-disciplinary Teams providing advocacy and enhanced care co-ordination, based on building a trusting relationship with someone who cares. We are convinced it is the core values of Team members that persuades patients to trust them. In our training and support we therefore frequently talk about the values that we think are core to the work of a Pathway Team.

We copy below the values we talk about in our induction programme for Teams:

Compassionate, integrity, helpful, resilience, efficient, kind, practical, caring, tenacious, respectful, model the change we want to see, patient, honesty, curious, collaborative, creative persistence, listen to lived experience.

Chapter 5. Performance and Quality Improvement in 2022-2023

This section presents monitoring data collected by Pathway Teams during 2022/23 and shared with Pathway's data analyst. Sharing performance and benchmarking data and collaborating on quality improvement is a fundamental component of the Pathway Partnership Programme.

The Teams monitoring data allows us to:

- Report basic demographic characteristics of patients seen by Pathway Teams
- Monitor Teams' activities against Pathway's defined set of quality indicators
- Identify future priorities for quality improvement that emerge from the data,
- Share successful examples of quality improvement actions across the Teams

Over the four years of the Pathway Partnership Programme, we have worked closely with our hospital Teams and local commissioners to develop a set of indicators that are both practical for the Teams to collect but also connect well to things that we know are important to improve outcomes for patients experiencing homelessness. As with all indicator sets, they are probably somewhat skewed towards things that are more measurable.

The indicators should be read in conjunction with the case studies presented in the previous section to get a fuller picture of the multiple ways Pathway Teams respond to the complexities and challenges they face every day in trying to improve their patients' chances.

Pathway Teams' commitment to quality improvement is underpinned by:

- Collecting regular monitoring data to report against quality indicators specified in Pathway's Quality Framework.
- Conducting Pathway's recommended quality audits on care planning and assessment, discharges to rough sleeping and delayed discharges.
- Collecting regular patient feedback.
- Monthly support calls with Pathway's core Team of specialists.
- Support from Pathway's data analyst.

Routine Monitoring Data

Given the limited capacity of hospital patient data systems to identify and track patients experiencing homelessness, Pathway Teams collect their own dataset based on Pathway's recommended approach, covering patient demographics, high-level patient needs, discharge outcomes and performance against our recommended quality indicators. This data is used individually with Pathway Teams to identify Quality Improvement opportunities and to report on a Team's performance and impact to local managers and commissioners.

As part of the Partnership Programme, we support Teams to analyse and publish their own local data. Here we aggregate the data from all the Teams in the programme to provide programme-level analysis of our collective impact, and to inform Pathway's policy, research and lobbying work.

Data is collected through either specifically designed 'homeless health templates' within existing clinical systems (CERNER, SystmOne, EMIS) or manually recorded using Excel spreadsheet templates provided by Pathway.

There are several limitations to the data presented in this section. Firstly, for Teams manually recording in Excel spreadsheets, recording errors are possible and the time burden of manual recording often leads to incomplete datasets being returned to Pathway. For Teams using templates, technical errors and/or wider updates to hospital data systems can cause inaccurate or incomplete datasets to be returned.

Despite these issues, there is a reasonably large degree of consistency in the data returns, for both individual Teams over time and across different Teams. The data presented here covers the period 01/04/2022 - 31/03/2023.

During the year, Pathway has engaged in various activities to improve Pathway Teams' capacity to collect data, including holding consultations with Teams to adapt Excel spreadsheets to be as concise and easy to use as possible, and working with local Information Technology or Business Intelligence Teams to resolve technical issues with templates and data extraction.

The data presented in this section were provided by nine Pathway Teams, although not every Team was able to return data during all quarters of 2022/23.

- Q1: 8 Teams returned data
- Q2: 9 Teams returned data
- Q3: 8 Teams returned data
- Q4: 7 Teams returned data

Key Points from the Data

During the year, Pathway Teams accepted 2640 individual patient referrals, an acceptance rate of 88%.

Mental health (55.2% of accepted referrals with this need), substance misuse (55.1%) and safeguarding needs (42%) were common among all patients seen by Pathway Teams.

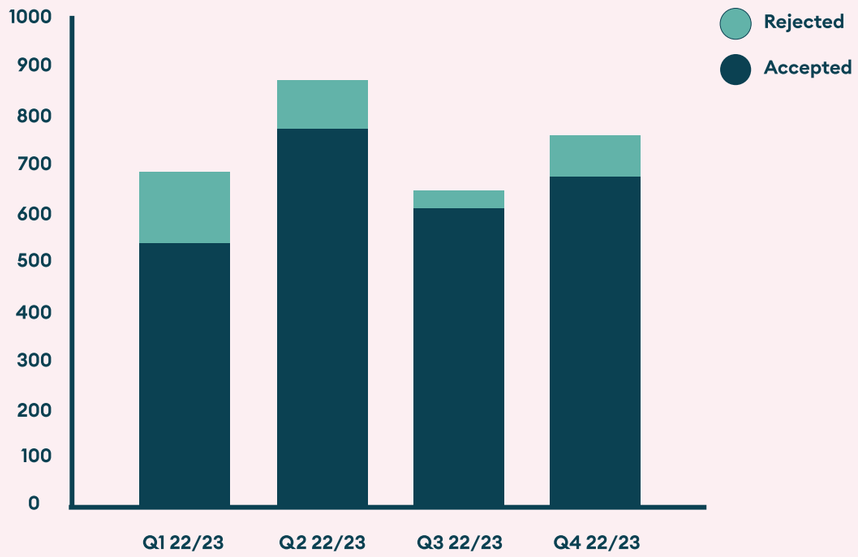
For London Pathway Teams, the proportion of patients found to have No Recourse to Public Funds (NRPF) rose from 15.1% in Q1 to 18.4% in Q4 (it was just above 2% for non-London Teams).

Comparing housing status at admission and discharge, Pathway Teams achieved a 50% reduction in rough sleeping and a 35% reduction in sofa surfing.

Referrals, Patient Demographics and Patient Needs

Over the year a total of 3016 referrals were made to Pathway Teams, of which 2640 (88%) were accepted. Referral numbers peaked in Q2, as data was returned by all 9 Teams. Despite only 7 Teams returning data during Q4, the total number of referrals and accepted referrals were higher than in both Q1 and Q3. This may be reflective of increasing demand for services and/or services becoming more visible within their local systems and receiving more referrals as a result.

Referrals to PPP Teams

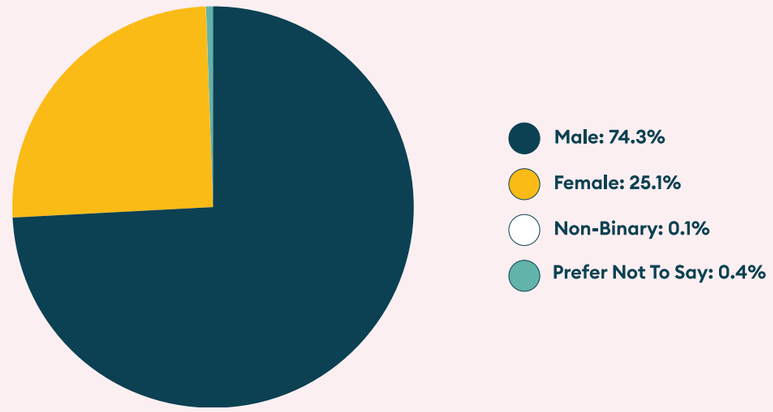


Patient Demographics

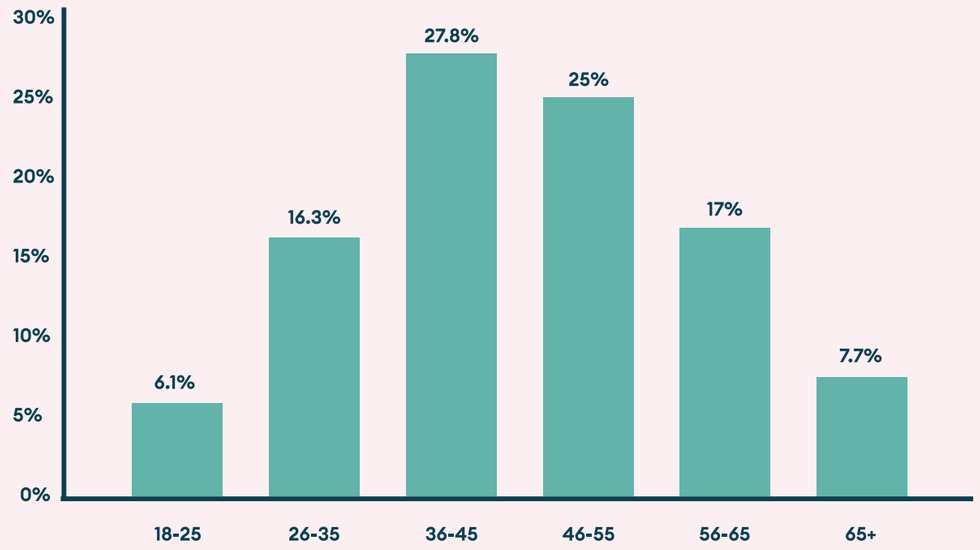
Gender and age group data were generally consistent over the course of the year and between different Teams. Pathway Teams see a roughly 3 to 1 ratio of male to female patients, and around half are aged between 36 and 55.

There was significantly more variation between Teams in relation to ethnicity. Teams outside London typically see a much larger proportion of White-British patients than those in London, and the main non-White-British ethnic groups seen vary between the London Teams, depending on the demographic makeup of the areas in which Teams are based.

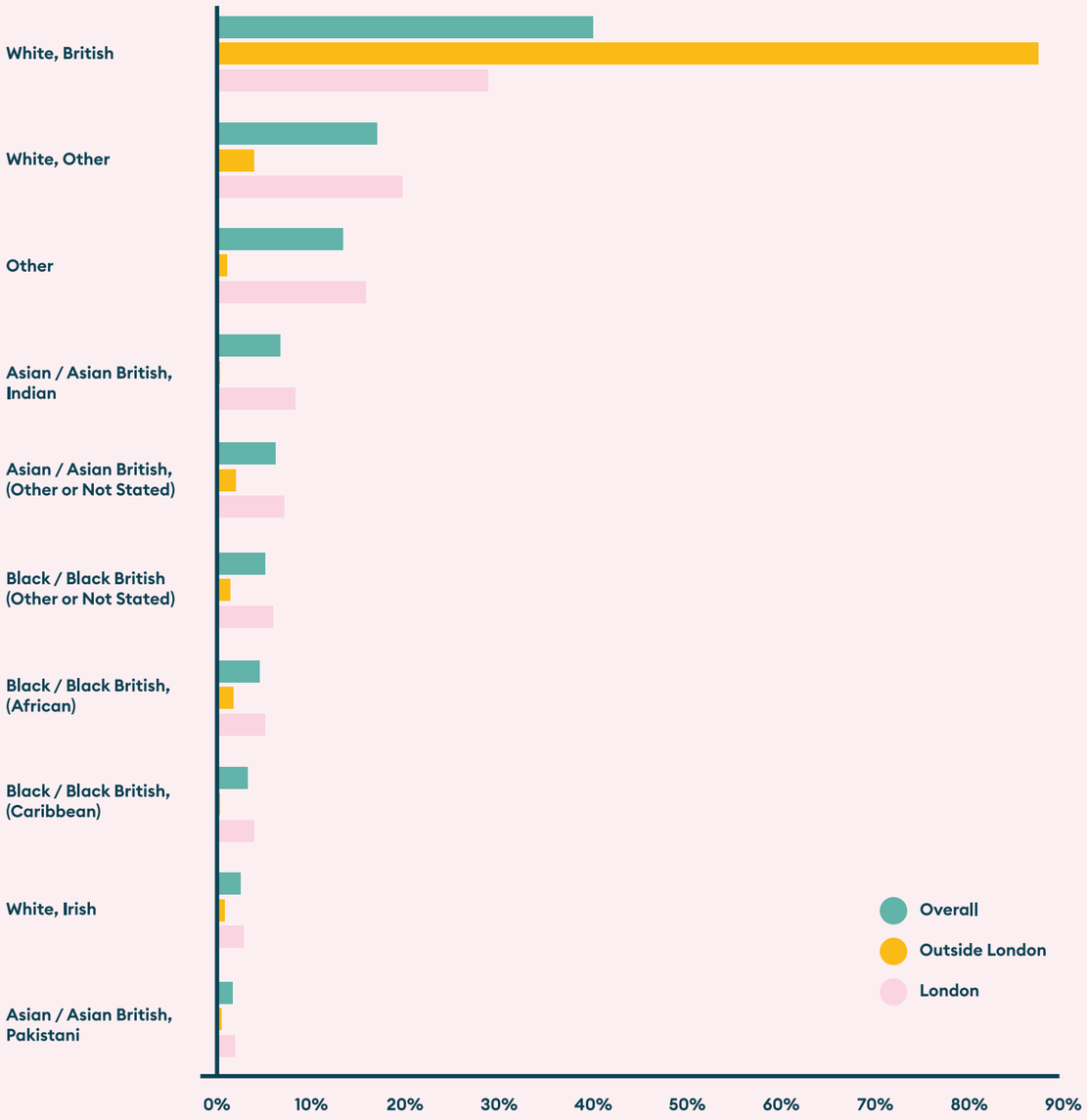
Gender, Accepted Referrals



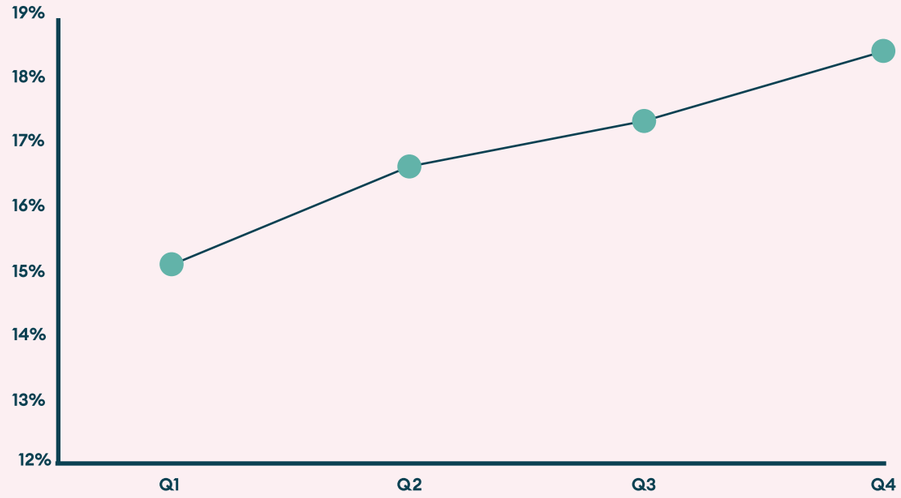
Age group, Accepted Referrals



Ethnicity, Accepted Referrals



NRPF, London Teams Only



London Teams also typically see a much higher number and proportion of patients with No Recourse to Public Funds (NRPF). For Teams in London, 17.1% of all accepted referrals had NRPF, compared to just 2.2% for Teams outside of London.

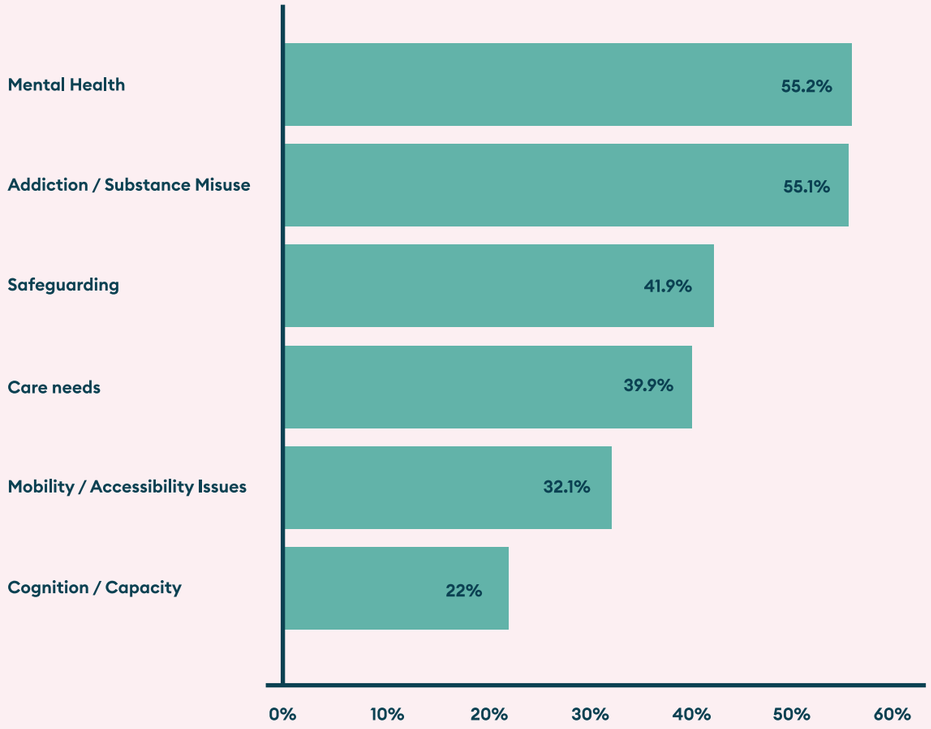
Across the year, the data suggest a possible rise in the proportion of NRPF patients being seen by Pathway Teams in London, although this may also be due to improved recording during the year.

Patient Needs

Reflecting the extreme burdens of disease and unmet need reported among people experiencing homelessness, the overall level of need among people seen by Pathway Teams is high, with patients often presenting with multiple overlapping needs. This is reflected in the high-level patient needs data we ask Teams to collect. It should also be noted that levels of data reporting under each of these broad categories of needs varies across the Teams. Substance Misuse and Mental Health fields were completed for 80% and 78% of all accepted referrals, Safeguarding for 61%, and Cognition, Care Needs and Mobility/Accessibility all for less than 50%. Despite this, the data we do have has shown high levels of needs across these domains. The case studies in the previous section starkly illustrate how often these needs overlap and compound each other. In addition to the needs identified in the chart below, every patient seen by a Pathway Team also has at least one, but very often several serious physical health problems.

Overall, patients seen by Pathway Teams reflect the general demographics and kinds of needs we might expect to see, based on other national profiles of the homeless population. [Ref 2]

Patient Needs, Accepted Referrals



Quality Framework Outcomes

Pathway Teams aim to work within Pathway's 'Quality Framework'. The framework contains a set of targets and indicators, each of which relate to different components of care quality and wider inclusion health outcomes. By collecting routine data to monitor their activity against these quality indicators, Pathway Teams (with support from Pathway) can identify specific areas for improvement and monitor their progress. Our quality framework was developed by Pathway, with input from Pathway Teams, and we keep it under review. As mentioned previously, a single indicator is often representative of a huge amount of work conducted by the Teams.

Quality Indicator 1: GP Registration

Coverage 78.4% (2064/2640 recorded)

Working to ensure that patients can access primary care following discharge from hospital is a key activity of Pathway Teams. Ensuring a patient leaves hospital with a live registration to an appropriate GP increases the likelihood that their health needs will continue to be met after their hospital stay. Where possible, Pathway Teams also aim to send discharge summaries to relevant GPs.

Quality Target: 85% of patients who do not have a GP, or who have an inappropriate GP on initial assessment, are assisted to register with an appropriate GP that they can access on discharge.

Outcome: Over the year, 19.2% of accepted referrals had an inappropriate or no GP on assessment – of these 58% were assisted to register with a new GP.

Comments: The figure of 58% being assisted to register was relatively consistent across Teams, suggesting that registering patients with an appropriate GP can be challenging for Pathway Teams. This may be due to a combination of lack of time in the Pathway Team to carry out this work, limited capacity of local GP practices to take on new patients, and/or procedural and administrative barriers within the registration process itself.

Quality Indicator 2: Housing Advocacy

Coverage 52% (1371/2640)

A key component of the work of a Pathway Team is to support patients with intensive housing advocacy during the time they are in hospital. Housing advocacy is a key intervention to improve the health of patients, as poor quality, inappropriate housing or a complete lack of housing makes recovery difficult, if not impossible.

Quality Target: 100% of consenting homeless patients or patients at risk of homelessness seen and assessed by the Team are referred to a Local Authority under the Duty to Refer as appropriate or are given equivalent appropriate advocacy or support to access housing.

Outcome: over the year, 62% of recorded referrals were assessed as eligible for the 'Duty to Refer', and of those 81% were referred.

Comments: while the figure of 81% is below the target of 100%, it represents significant and impressive housing advocacy conducted by Pathway Teams. A key learning point during the year has been that the housing advocacy conducted by Teams extends beyond statutory referrals. For example, even where patients are eligible, Teams may conduct alternative advocacy or support pre-existing applications to make sure they have got the best option for their patient. Teams also support patients who are not eligible for any statutory housing support with housing advocacy where possible. Throughout the year we have updated our Excel and clinical system template to more accurately capture the array of housing advocacy carried out by the Teams. More accurate templates should improve data coverage during 23/24.

Quality Indicator 3: Housing Status

Accurately recording housing status helps Teams to demonstrate the impact of housing advocacy, and to show the local need for the service. As housing outcomes are largely beyond the control of Pathway Teams and significantly depend on what is available outside the hospital, we don't set an outcome-based target for housing advocacy work across the Teams. However, our monitoring data shows the Teams have a very substantial impact on rates of return to rough sleeping.

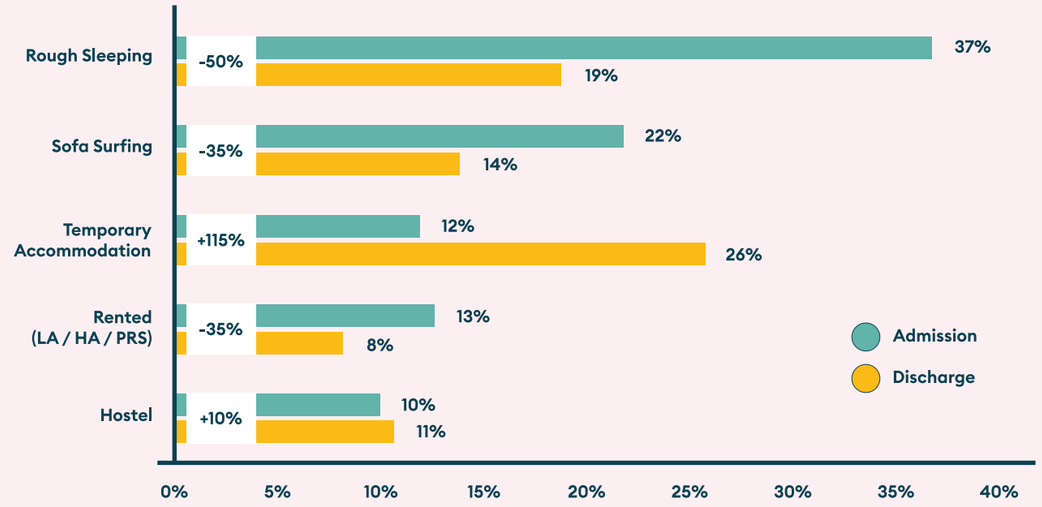
Quality Target: 80% of hospital patients have housing status recorded on both admission and discharge.

Outcome: over the year, 68% of accepted referrals had housing status recorded on both admission and discharge. 3 in 5 patients were either rough sleeping or sofa surfing on assessment, with 37% sleeping rough.

Comparing housing status at admission and discharge over the year showed that rough sleeping was reduced by 50% and sofa surfing by 35%. This reduction was substantially driven by increased temporary accommodation placements for patients, along with more appropriate discharges to care homes/nursing homes/intermediate care where available and needed.

Comments: Recording housing status proved to be challenging due to issues building the correct set of housing fields into templates on different systems and identifying the correct codes to be used in searches. With support from Pathway, Pathway Teams were able to work with local Information Technology/Business Intelligence colleagues to identify and implement solutions. Over the year, the percentage with housing status recorded for both admission and discharge rose from 54% in Q1 to 79% in Q4.

Housing Outcomes, All Accepted Referrals



Quality Indicator 4: Self-Discharges

Coverage (76% 1998/2640)

We view self-discharge (or discharge against medical advice) as a key indicator of patient experiences of health care and service quality across the healthcare system. Research has suggested that experiences of stigma and discrimination, long waiting time (especially difficult for those with addictions issues) and stressful A&E spaces are key reasons why patients may self-discharge. Patients who take their own discharge before their treatment is complete are also at high risk of serious adverse consequences.

Quality Target: self-discharges/abscondments are recorded and monitored, and interventions put in place to reduce self-discharge rates.
Outcome: over the year, 14.2% of recorded referrals self-discharged. Self-discharge rates ranged from 9.5% to 15.7% across the Teams. Over the year, self-discharge rates remained stable for four Teams, rose for four Teams and went down for one Team.

Comments: the self-discharge rate of 14.2% is comparable to other identified self-discharge rates for similar cohorts of patients, and significantly higher than the general population estimate of self-discharge rates of between 2% and 6%. Pathway Teams should continue monitoring self-discharge rates and aim to reduce self-discharges where possible. Many Pathway Teams report that service capacity (limited staff numbers covering multiple hospital sites) is a key challenge to reducing self-discharges, as patients may self-discharge during times that the Team is unable to physically see the patient. The quality review from the Leeds Team reported below emphasises that connecting with a patient from day one of an admission, particularly where addictions are present, is key to reducing self-discharge.

Quality Indicator 5: Delayed Discharges

Coverage 26.4% (697/2649)

Monitoring delayed discharges can highlight gaps in discharge processes and help Teams identify possible opportunities for improvement. Delayed discharges for Pathway Team patients are typically caused by housing/placement delays, straightforward lack of appropriate accommodation for people with multiple needs, and frequent delays in assessment by other services (for example Care Act assessments).

Quality Target: regular monitoring, aiming to reduce where possible.

Outcome: data coverage on delayed discharges was poor, with only 26% of accepted referrals showing activity recorded against this indictor. Of these, 24% were recorded as having a delayed discharge.

Comments: delayed hospital discharges amongst people experiencing homelessness are common. An audit of hospital inpatients on the caseload of specialist homeless health Teams across London showed that 44% had delayed discharges.

Quality Indicator 6: Time from Referral to Assessment

Assessing new referrals as quickly as possible ensures that patients have timely access to specialist care and allows more time for comprehensive care and discharge planning. It can start the process of building trust with the patient and means Teams can rapidly start to advocate for them while they are in hospital.

Quality Target: 80% of appropriate patients referred to the Team are seen and assessed within 2 working days of first referral.

Outcome: due to difficulties collecting accurate referral and then assessment dates for many Teams, we are not publishing aggregated data for this indicator across all Teams. Of the individual Teams for which this data was analysed for their own annual reports, the following outcomes were achieved:

- St George's:
  98.8% assessed within 2 working days
- Leeds:
  94% assessed within 2 working days
- Homerton:
  97% assessed within 2 working days

Comments: Where this has been recorded, Pathway Teams have been able to provide timely initial assessments for patients. At the same time, we are aware this can be particularly challenging for Teams working across multiple hospital sites and that accurately recording the lapsed times between a referral being made, accepted by the Team, and an initial patient assessment taking place, can be complicated.

Quality Indicator 7: Holistic Assessments and Care Planning

Holistic assessments and care planning are at the core of Pathway's person-centred and multi-disciplinary approach. Our online manual for Teams includes a model holistic assessment template. Assessments cover a range of health and social factors, and result in personalised care plans that aim to address the complex needs of referred patients.

Quality Target: 85% of accepted referrals receive a holistic assessment which covers physical health, mental health, substance misuse, housing and safeguarding and have a resulting care plan documented in their hospital notes.

Outcome: routine data was not available for assessment and care plan outcomes, due to recording and reporting errors. Audits conducted by Teams have shown varying outcomes, with one Team conducting assessments in 100% of audited cases, and another 55%.

Comments: we have updated our data templates for 23/24 to better capture assessments and care plan outcomes.

Quality Indicator 8: Patient Feedback

Understanding patients' experiences is key to improving quality and central to providing a compassionate, person-centred response. It is also essential to the co-production of services. Quality Target: feedback is collected from 10% of patients and/or dedicated focus groups/ interviews are undertaken with a smaller number of respondents.

Outcome: collecting patient feedback has been a challenge, with many Teams finding time constraints to be a key barrier. Pathway will this year be exploring how we might adjust our support for Teams to help them collect patient feedback more routinely.

Where feedback has been collected, it has been overwhelmingly positive. Below are some selected quotes from Pathway Team patients:

> **"Although it was dismal at the time, all the advice that the homeless Team gave me really worked – as a result I have now had 3 months of treatment and I am in a move-on house for 2 years. Things are going great. They really made a difference."**

> **"They saved my life."**

> **"You were the first person following the incident that didn't treat me like an animal that deserved the frostbite in my feet, they (hospital staff) made me feel less than human. I remember you getting me some crisps and sweets and I believed you would help me. It gave me some hope, and I will never forget you; you helped me stay alive, believing in me, visiting me telling me everything will be ok – I cannot thank you enough especially as I am now living in my forever home."**

> **"It's the most anyone has done for me in a long time."**

> **"If they hadn't helped me, I'd be on the streets. I had no chance to survive without them. They helped me a lot. I can't thank them enough. I've got immigration issues you see; I have to fight for everything."**

For all the Pathway Teams, routine collection and collation of this performance data is a challenge. Some Teams must record activity across several parallel systems at the same time. Where Teams have been understaffed, they have understandably prioritised their available resources on supporting their patients ahead of documenting their activity. Other Teams benefit from having their own administrative support to help with this work, relieving pressure on the professional staff. As previously stated, the preceding performance data should be read alongside the patient case studies in the previous section, which colour in so much of the detail that is the work of a Pathway Team.

Quality Improvement in Action

Leeds

Reducing self-discharge rates

During 2021/22, patients seen by the Leeds Pathway Team self-discharged 23% of the time. The Team identified this as a key problem and implemented the following interventions in response:

- Full holistic assessment on admission from the Team nurse which explored both health and housing needs.
- Daily visits from the Team to alleviate boredom and keep the patient informed of discharge planning.
- Introduction of weekly ward rounds with the GP and clinical lead nurse.
- Attending ward Team meetings to tell colleagues about what the Team offers and the needs of our patient cohort.
- Charitable funds from the trust financed a hospital pack which included activities (puzzle books, colouring) as well as toiletries and information about the service.
- Partnership working on this issue with other health, social and housing services.

During 2022/23, the Team audited self-discharge data provided by the Trust's Business Intelligence Team and their own monitoring data, using an audit template and materials provided by Pathway. Key findings from the audit were:

- Several patients had been incorrectly coded as self-discharging. The Team worked with local SystmOne Teams to ensure the correct coding was applied for self-discharge.
- 58% of self-discharges occurred before the Team had the opportunity to see the patient, within the first 1-2 days of admission.
- Of the remaining 42% who were assessed, 93% had addictions needs and 48% had been rough sleeping.
- Following the Team's interventions and more accurate recording of self-discharge, self-discharge rates were reduced from 23% in 2021/22 to 10% in 2022/23.

St George's Assessment and Care Plan Audit

Using Pathway's recommended template, the St George's Team conducted an audit of their assessment and care planning processes. The audit asks the Team to consider the quality of both holistic assessments and subsequent interventions, as well as reviewing the quality of care plans created for patients. The Team audited 20 randomly selected sets of patient notes.

Key findings from the audit were:

- Holistic assessments had been completed and recorded in only 55% of cases.
- Physical health needs were managed well during admission, but less thoroughly on discharge.
- Gaps in the Team's management of mental health needs and addictions needs especially following discharge.

Key opportunities and interventions following the audit:

- The Team worked to improve communication with addictions services, to ensure better management of addictions needs in hospital and post-discharge.
- The Team worked to improve collaborative working with Liaison Psychiatry within the Trust.
- A Community Nurse position within the Team was secured, to provide support for patients following discharge, and more effectively meet physical, mental health and addictions needs in the community.
- Ensuring that all completed assessments are accurately recorded, and care plans are clear within the Team's notes.

Hull Improving Nutrition and Collaborative Working

Access to proper nutrition is a key and often overlooked challenge for people experiencing homeless and other inclusion health groups. Led by the Team's GP, the Hull Pathway Team have improved the support offered around nutrition by ensuring that nutritional assessments are a key part of the Team's holistic assessment process. Effectively identifying patients who need additional nutritional support has improved the quality of the assessments and care provided by the Team.

The Team has also collaborated effectively with other local services and charities to provide care that meets previously unmet needs. This has included:

- Working alongside dental charity Dentaid to secure free dental support for their patients
- Collaborating with a local podiatry service to run a once-a-month drop in for their patients
- Working with local liver consultants to provide liver scans for patients, including a portable setup to in-reach into hostels and other locations

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Feedback:
Exit Interviews with Pathway Team members

Since December 2022, Pathway has offered structured exit interviews to any staff leaving post who want to feed back on their experience of working in a specialist hospital homeless Team. The challenging nature of the role and what Pathway Teams try to do, and the continued fragility of funding in many places, has meant staff turnover in some Teams has been high. The thirteen departing staff we have interviewed in the last year all consistently report feeling highly motivated by the opportunity to make a difference to homeless and inclusion health patients. They all also said how much they valued the support provided by Pathway through the Partnership Programme. However, many of them also spoke about the high levels of stress they felt and how the current context within and outside of the NHS poses significant challenges for Teams (See Section 7).

Exit interviewees flagged the importance of securing buy-in and support across hospital Trusts, and of having clear management and supervision structures and a shared understanding of the roles and responsibilities of all Team members. The absence of this, and in some places, other partners' lack of understanding, or excessive expectations on a Team, all added to the already stressful nature of the roles. Another common theme was the need for clarity around the criteria for patient referrals and doing more to manage hospital ward staff expectations regarding this; "we don't have a magic wand for housing".

Pathway has made several changes to our support programme based on this feedback. We have redesigned our two-day induction programme for new Teams to focus more on Team building, exploring the core values of Pathway Teams, and ensuring there is clarity about different roles and responsibilities within the Team. We are also recommending that all Teams should have access to regular, professionally facilitated Reflective Practice sessions to help them cope with the stress of the work. For our London Pathway Teams, Pathway is currently funding reflective practice with prize money from winning the 2022 London Homelessness Award.

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Feedback:
Interviews with Commissioners

Understanding the needs of commissioners is crucial for Pathway to develop a support package that is fit for purpose and complements the existing local infrastructure. In May 2023, we invited our local commissioners to an annual interview to provide feedback on our support and the Partnership Programme.

Commissioners told us that they benefit most from our specialist expertise and the responsive nature of Pathway support staff, which they recognise is highly valued by members of their hospital Teams. We heard about how difficult it is to make the case for our support under the current financial pressures facing the NHS. In response, we are working to strengthen our support on funding and evidence, which will help the development of local business cases and funding applications and will focus on how the Teams are a direct response to national health inequality duties. This annual report is one part of our efforts to raise the profile of this work and help our local partners see it in a wider national context.

Legal Advice: Improving Patient Outcomes through Changing their Status

Pathway has been raising charitable funds to pay for access to specialist legal advice for Pathway Teams in some shape or form since 2015, when a pilot programme for our legacy Team at UCLH showed the value of ready access to legal advice for patients. In 2022/23, nearly all of Pathway's legacy and current Pathway Teams had access to specialist legal advice for patients with legal issues relating to immigration or housing. Pathway procures a network of local legal specialists to answer legal enquiries from the Teams. In some instances, the legal advisors will take on active casework, particularly for the most complex referrals. The numbers of patients requiring legal support is on the increase, mirroring an increase in the number of people experiencing homelessness and using hospital services. The continuing hostile environment faced by migrants is a particular pressure for this work, alongside a drastic reduction in access to legal aid for most immigration cases. Our hospital Teams also see the impact of Section 21 evictions (no fault evictions), rising numbers of people fleeing domestic abuse, and an increase in cases of people with No Recourse to Public Funds. Challenges to local authority decisions on housing priority and eligibility have risen across the programme. Resolving a patient's immigration status can often be life changing as it will give them access to housing, benefits and social care. Timeframes for reaching resolution can be long in many cases, but the outcomes can be transformational for some patients.

Our legal advice is provided by a network of specialist immigration and housing advisers who Pathway contracts with to support local hospital Teams. Our current providers are:

- Praxis (for Migrants & Refugees) **www.praxis.org.uk**
- Hodge Jones & Allen (housing specialists) **www.hja.net**
- Bristol Law Centre **www.bristollawcentre.org.uk**
- Greater Manchester Law Centre **www.gmlaw.org.uk**
- Manuel Bravo Project **www.manuelbravo.org.uk**
- Voices in Exile **www.voicesinexile.org**
- CIAC Humber **www.ciacadvice.com**

The ability of the advisors to take on full cases is dependent on legal Teams having access to separate funding to support this. Changes in access to Legal Aid makes this more challenging for our providers. Despite this, 46 patients up and down the country have had their cases taken on over a 12-month timeframe, with 26 being resolved successfully during the year. The remaining caseload is still active so additional successful outcomes can be expected. Our legal advice network has also supported our hospital Teams with over 170 legal enquiries in 2022/23. Many enquiries can be resolved relatively quickly (with support from Pathway Teams) while others require signposting to other support organisations.

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Our legal experts respond to a wide range of immigration and housing enquiries/ cases, including: challenging local authority decisions on priority need for housing; securing access to suitable accommodation and care; regularising/securing immigration status, including applications under the EU Settlement Scheme. Legal providers also support our hospital Teams with general staff training about common legal issues and/or attendance at Multi-Disciplinary Team (MDT) meetings to discuss types of legal enquiries or potential cases coming through as well as current caseloads.

In Spring 2022, Pathway secured funding from the FrontLine Network to set up legal advice for Teams outside London for the first time. While this has improved coverage, the available funding has not allowed us to put the service in place for some of our newer Pathway Teams (East Kent and Plymouth). Finding longer term, sustainable sources of funding for this work is a constant challenge. Funding for two of our most established legal providers in London is due to end in the summer of 2024. We are actively seeking funds to extend our agreement with another. Our national grant supporting the rest of our providers will end in 2025. Pathway will continue to seek funding to support this work, although as in so many other areas the landscape for charity funding for legal advice has become noticeably more challenging.

Pathway Partnership Programme Support

In the year 2022-23 Pathway's core Team provided the following support

- 108 monthly support calls for Partnership Teams with Pathway's core multi-disciplinary support Team.
- Four two-day staff Induction Training programmes (for Plymouth, East Kent, North West London, St Georges).
- Nine all-Teams 'masterclasses' with expert speakers covering topics including: end of life care; trauma informed communications skills; immigration law and no recourse to public funds; reflective practice in action; abuse and gender-based violence; acquired brain injury.
- Regular support from Pathway's data management lead including preparation of Team annual data and quality reports.
- Two all-Teams national network meetings.
- Core Team support visits to Partnership Teams.
- Bespoke re-start support for the Inner North West London Team.

Pathway's expert core support Team responds to ad-hoc email and telephone inquiries from Team members throughout the year and Teams have access to our regularly updated online service and good practice manual (Our masterclasses and other training materials are all made available through the NHS Futures platform). Team members are encouraged to join the wider networks Pathway hosts for specialist inclusion health housing workers, nurses, OTs, mental health practitioners and GPs. As part of their Partnership Programme subscription, all Teams get four two-day tickets for Pathway's Annual International Homeless and Inclusion Health Symposium: 33 hospital Team staff joined over 400 other inclusion health professionals at the 2023 conference.

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Chapter 6. Key Challenges

Despite all the positive activity and improved outcomes for patients described, our Pathway Teams work day-to-day within profoundly challenging contexts and face many barriers to achieving better outcomes for patients.

Below we describe six of the biggest barriers to better patient outcomes currently confronting the teams. These challenges emerge from our review of the monitoring data, from our monthly support calls with teams, from the exit interviews with team members described in the previous section, through our regular online All-Teams meetings, and from our support visits to the teams.

Some of these challenges relate directly to Government policy at the national level and Pathway will raise them in our national policy and influencing work. Others are more amenable to action at local system level, and we will support Pathway Teams and inclusion health practitioners to raise them as appropriate with leaders in their local system.

No Recourse to Public Funds (NRPF)

As the data shows, Pathway Teams based in London work with many patients who are found to have No Recourse to Public Funds or uncertain immigration status when they end up in hospital. Given these patients explicit lack of legal entitlements to support, achieving positive outcomes for them can be extremely challenging. Their lack of eligibility for housing support and benefits is a significant barrier to safe hospital discharge and can often lead to discharge delays. Although Pathway Teams outside London work with a much smaller proportion of NRPF patients, they report the same challenges in helping patients in this position. Access to expert immigration legal advice and support and contesting a patient's NRPF status can change outcomes for many. However, funding for this legal input has to date has been through Pathway securing charitable funds and grants and is now vulnerable. More sustainable funding for legal support and advice would positively change outcomes for many patients by helping them become eligible for housing and benefits. This in turn will stop them becoming sick and needing emergency healthcare.

Hospital Discharges, Intermediate Care and the Housing Crisis

Our monitoring data shows that the Pathway Teams achieve impressive housing outcomes for their patients, however securing appropriate accommodation for patients on hospital discharge remains extremely challenging, and our Teams report this challenge is getting worse. Primarily, this is driven by the severe lack of accommodation that local authority housing departments have to offer. Even when it is available, the accommodation offered often is of low quality, inappropriate for patients' needs and detrimental to recovery. Alongside this, a lack of specialist NHS provided inclusion health intermediate care, and of other forms of long-term care and specialist accommodation placements, make securing safe and appropriate discharge locations for patients with complex needs a significant challenge.

"Securing appropriate long term support for patients can be very challenging "

High and rising levels of need and complexity

Patients seen by Pathway Teams typically have high levels of need, often presenting with complex combinations of physical health, mental health and substance misuse problems. Anecdotally, Pathway Teams report that levels of complexity in the patient group are rising. Because many key health services, such as mental health and substance misuse services, are unable or unwilling to work with patients who have multiple and complex needs, securing appropriate long-term support for these patients can be very challenging. People experiencing homelessness often become frail and develop chronic health conditions at a much younger age than the general population. Temporary accommodation provided by local authorities, particularly in London, can often only be found many miles outside the local borough, making linking patients to services and sustaining engagement very difficult.

Engaging Adult Safeguarding and Adult Social Care

Many patients seen by Pathway Teams have safeguarding and/or care needs. However, Pathway Teams the Teams report regular difficulties engaging Adult Safeguarding and Social Care, with delayed/inadequate assessments, services rejecting patients or declining to engage or offer support, and a low tolerance for missed appointments. Additionally, Care Act assessments conducted in hospitals are often seen to be inadequate, as they fail to consider the real needs of patients after discharge. Patients are assessed on the ward as having no care needs; however, a hospital ward environment bears little resemblance to where the homeless patient is going to have to live in the outside world. Evidence that someone was unable to self-care adequately prior to their hospital admission rarely seems to be considered. In addition, local authorities frequently reject referrals due to lack of evidence of local connection. And then there is a frequent incorrect assumption that because people experiencing homelessness are often younger, they do not (indeed cannot) have care needs. Finally, common problems found among homeless patients in relation to a lack of executive capacity due to brain injury are frequently overlooked or misunderstood.

Burnout, Stress and Staff Turnover

In our exit interviews with Pathway Teams members, staff regularly spoke about the stressful nature of the work and the impact this had on them in terms of burnout and poor physical and/or mental health. To further investigate this challenge, Pathway carried out a survey of Partnership hospital Team members which found concerning levels of burnout and secondary traumatic stress.

Both the survey and exit interviews highlighted key factors driving this. Firstly, stress was driven by inadequate resources and staffing levels within Pathway Teams, leading to unmanageable and overwhelming caseloads of very vulnerable and complex patients. Secondly, Pathway Teams are 'fighting against the system', battling to get support for their patients from other services, which are often either unable or unwilling to help, as noted above. Not only is this stressful in and of itself, but it severely limits the ability of Pathway Teams to generate good outcomes for their patients, and this in turn can lead to additional feelings of burnout and stress through 'moral distress' and 'moral injury' (the psychological impact of being unable to get even basic support for a patient with desperate needs).

One consequence of burnout is high staff turnover within Pathway Teams. Our exit interviews showed that staff turnover was driven in several Teams by the lack of job security that follows from the short-term, non-recurrent funding that was paying for the Team. Alongside significant numbers of staff leaving their positions during the year, our survey found that Partnership Team staff frequently thought about leaving their jobs, with one in four thinking about this on a weekly basis and half thinking about it at least monthly. Of course, problems with staff retention also leads to under-staffed services and increasing pressure on remaining staff members, leading to further stress and burnout.

At the same time, Team members regularly spoke about how being part of the Pathway Partnership Programme helped. They appreciated the practical and professional support they could get and the connection the programme gives them to a wide network of inclusion health practitioners. Team members took some comfort from the knowledge that they were not alone in facing these challenges.

Effective Professional Support and Management

Given the stressful nature of the work Pathway Teams carry out, good quality management and psychological support is central to ensuring staff wellbeing, retention and ultimately achieving positive patient outcomes. For some Teams a lack of clarity about local line management and supervision arrangements has been unhelpful. While Pathway has been able to use additional restricted charitable funds to pay for reflective practice sessions for several London-based Teams for the current year, there are gaps in the provision of ongoing psychological support for Pathway Teams. Additionally, Teams have faced challenges in terms of regular clinical and/or caseload supervision; our survey showed the less than half (49%) of Pathway Team staff had access to regular clinical/caseload supervision sessions.

Challenges for the Pathway Partnership Programme

Our interviews with commissioners and feedback from Teams themselves show that our Pathway Teams and commissioning colleagues highly value the direct support Pathway offers through our Partnership Programme and the wider benefits that come from being part of our network. Despite this, the programme faces several challenges:

Where funding for Pathway's support is not included in a Team's base operational budget, it is vulnerable every year to being seen as a luxury that the NHS can't afford.

Where our Teams have been critical of the actions of local partners or other services, this doesn't make them popular, threatening their own budgets and by extension threatening continued membership of our Partnership Programme. One of the ideas behind the external affiliation of our Partnership Programme is to help support Teams to raise local concerns where they need to.

As referred to in the next section of this report, despite strong duties in relation to health inequalities, other pressures on the NHS can simply crowd out concern for people experiencing homelessness and other inclusion health groups.

Pathway currently subsidises delivery of the programme with charitable resources. In 2022-23 subscriptions from our partners met just over half of Pathway's costs of providing our support programme – effectively our current partners get nearly twice as much support as they pay for. This is not a sustainable long-term funding option. We are reviewing the programme in the current year to see how our partners financial contributions can come closer to meeting the basic costs of providing support to the Teams and maintaining our national programme.

Chapter 7. The NHS Policy Landscape and Our Commissioning Challenges

Homeless and inclusion health has gained recognition as a movement within the UK's health system over the last decade, shifting the policy landscape in which Pathway Teams are commissioned and operate.

Most recently, the need to address the health and care needs of those experiencing homelessness, and those who are otherwise socially excluded, has been formally incorporated in NHS England's (NHSE) strategic priority to reduce health inequalities. The recent NHSE Inclusion Health Framework recommends that Integrated Care Systems (ICSs) develop and improve health services to meet the needs of people in inclusion health groups through five key principles: [Ref 3]

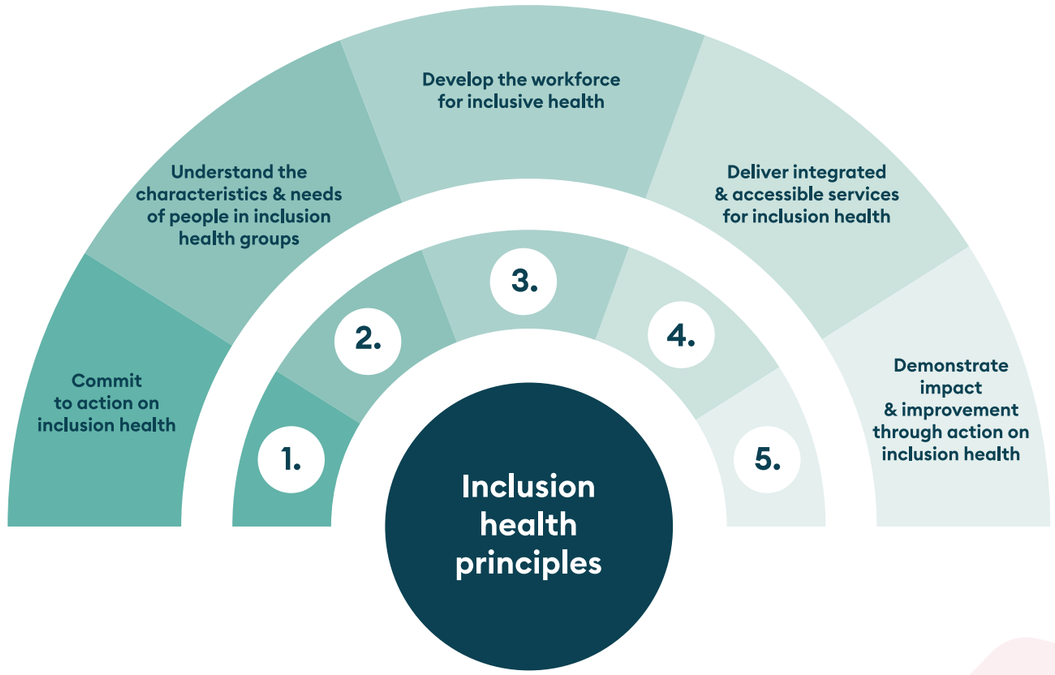

Figure 1: principles for action on inclusion health (NHSE 2023)

This framework sits within the wider Core20PLUS5 health inequalities initiative, NHSE's national approach to reducing health inequalities at both a systemic and local level[Ref 4] The 'Core20' is the most deprived 20% of the population while the PLUS designation refers to groups experiencing additional or intersecting barriers in access to, experience of and equitable outcomes from NHS services. The PLUS groups explicitly include the multiple complex needs homeless populations that Pathway Teams are designed to serve.

The National Institute for Health and Care Excellence (NICE) has published guidance on integrating health and social care for people experiencing homelessness which makes recommendations on how to improve access to and engagement with health and social care, and ensure care is coordinated between services.[Ref 5] The NICE guidance identifies hospital admissions as an opportunity to improve outcomes for these patient groups, referring to the randomised controlled trial of the intervention. The NICE guidance also recommends that inclusion health interventions (like Pathway Teams) should be seen as part of a wider, systematic response to the extreme needs of inclusion health groups. Pathway strongly supports this. In several places the establishment of a Pathway Team has helped to catalyse a wider response to homelessness and multiple exclusion across the health and social care sector.

The need to address health and social inequalities facing marginalised groups is now backed by a variety of legislation. Under the Health and Care Act 2022,[Ref 6] NHS bodies have a legal duty to consider the effects of their decisions on the health and wellbeing of people in England (including inequalities in health and wellbeing) and on the quality of services they provide (including inequalities in the benefits of these services). Integrated Care Boards have statutory duties to support partnership working where this would help to tackle inequalities and are encouraged to consider how their strategic plans will address disparities in health and wellbeing outcomes.

The Homelessness Reduction Act 2017 [Ref7] put prevention at the heart of tackling homelessness. It placed statutory duties on local authorities to intervene earlier to prevent homelessness and to provide help to all eligible applicants irrespective of 'priority need' or 'intentional homelessness'. It also introduced a duty on specified public authorities, including emergency departments, urgent treatment centres and hospital inpatient services, to refer service users who they think may be homeless or threatened with homelessness to a local housing authority. The aim of the Duty to Refer is to ensure closer collaboration and partnership working between public bodies, to effectively prevent homelessness by ensuring that people's housing needs are considered when they encounter public authorities.

Considering that the Pathway model is specifically designed to provide multi-disciplinary care and to transform outcomes for people experiencing homelessness, commissioning a Pathway Team would be a clear action for NHS bodies and ICSs to take towards meeting their legal obligations and statutory duties. For example, recent research suggests that compliance with the legal Duty to Refer tends to be better in areas that have pre-existing collaborative relationships between services, such as those with a Pathway Team.

While the NHS has developed a systematic, strategic approach to tackling health inequalities, and while Pathway Teams evidently help local systems meet these objectives in relation to some of the most excluded groups,

garnering support and funding for the Pathway model is a challenge. Our health and care systems are under immense pressure. Intense pressure on an overstretched emergency care system, the elective treatment backlog and ambulance waiting times are major political concerns and therefore top priorities for healthcare providers. The NHS delivery plan for urgent and emergency services recognises the need to respond to and reduce the number of patients experiencing delayed discharges in hospitals, a major priority for the government.[Ref 8] In a system under so much pressure, specialist provision for people experiencing homelessness is not seen as a political priority, so Pathway Teams and many other inclusion health services are often funded through short-term non-recurrent funding initiatives or special programmes. As discussed in previous parts of this report, the lack of long-term predictable funding threatens the stability of Pathway Teams, undermines staff retention and leaves Teams working with insufficient capacity. This financial insecurity also undermines staff's ability to build ongoing trusting relationships with patients and collaborative working relationships with colleagues in other agencies, ultimately impacting their ability to secure positive patient outcomes.

Despite the most extreme health inequalities faced by homeless and inclusion health groups, and the evidence that good quality healthcare can make a dramatic difference to health and wider life chances for people in these groups, the contribution of specialist homeless and inclusion health services can be seen by system leaders as of marginal interest, because the populations they help are relatively small.

Furthermore, some of the solutions the NHS brings in to address mainstream challenges inadvertently make progress towards improving healthcare access, outcomes and experience for the most marginalised groups more difficult. For example, virtual wards and other digital services are intended to provide care to patients where they live, in a care setting or at home. But this provision depends on someone having somewhere to go and without thought and adaptation can leave homeless patients without the follow-up support that they need.

"Specialist provision for people experiencing homelessness is not seen as a political priority"

Chapter 8. Conclusion

It has been a year of notable achievements and continuing challenges for the Pathway Partnership Programme and the dedicated Teams we support. Together, we stand united in our mission to improve the health of people experiencing homelessness and profound exclusion in face of an increasingly difficult landscape within the NHS, local government and other public services.

We know that more joined-up, patient-centred, integrated services, provided with care and compassion across service boundaries, can make a huge difference to the outcomes achieved by our patients, but shrinking resources and regular restructuring of systems makes this very hard to achieve.

NICE Guideline 214 on integrated health and social care for people experiencing homelessness (published in March 2022) sets out how the system should work for inclusion health groups. Together, Pathway's core Team and all our colleagues in our Pathway Teams described in this report work tirelessly with other hospital staff, NHS managers, commissioners and local authorities to advocate for equitable services. Pathway Teams try to model the change we want see in the system to achieve the very best outcomes possible for our most vulnerable patients.

This report includes impressive performance data from all of the Teams, showing consistently significant reductions in discharge from hospital to rough sleeping (down by around 50% on average) or sofa surfing, increases in numbers of patients leaving hospital registered with an appropriate GP, and most patients having a holistic assessment of their needs and a care plan agreed during their time in hospital. Pathway Teams have completed Quality Improvement audits in a range of areas including self-discharge, assessment, and care plans and nutrition. Following up their audit, the Leeds Team has reduced rates of self-discharge among their patients by nearly 50%. A sick, vulnerable patient leaving hospital before their medical Team thinks it is safe to do so is dangerous and should be a major cause for concern for any hospital in the country. We are immensely proud of what the Teams achieve for their patients despite all the challenges.

Commissioners have told us about the value to their system of being part of our Partnership Programme: helping them make the case for services; providing wider access to our inclusion health networks and expertise; helping to compile outcome data and service quality reports; in addition to supporting managers and the Teams themselves to build up their local resilience in navigating the challenges of battling for the needs of this patient group.

Some of the greatest challenges faced by Pathway Partnership Teams come from the multiple stresses placed on staff working at the interfaces between a series of deeply dysfunctional systems. Hospitals face huge pressure on beds and are often understaffed, which makes it difficult to meet all their patients' needs, but especially the often multiple complex needs of people experiencing

homelessness. Our data shows the 'Duty to Refer' (to housing) is routinely carried out by Pathway Teams for all patients who consent, but the extreme shortage of temporary housing or emergency accommodation available often results in response times from housing colleagues that are far slower than the expectations of hospital bed managers. Then, when accommodation is offered it can often be far from suitable, for example far out of area, or unmanageable for patients with mobility problems.

Pathway Teams also frequently struggle to get timely and effective responses from Safeguarding and Adult Social Care Teams. Referrals are sometimes declined due to lack of proof of local connection. There are parallel challenges when residential care is needed for people experiencing homelessness; patients who are under 55 and have coexisting addiction and mental health problems are routinely found not to meet the admission criteria of available facilities. Other patients are assessed as having no care and support needs despite their inability to cope in the community being the primary reason for their admission to hospital. Pathway Team staff often feel blamed for the delay to discharging a patient which follow from all of this, when in fact their work has either speeded up the process, or the extra time taken has achieved a much better destination for the patient, making it much less likely they will come back to hospital.

The pressure of achieving a safe and timely discharge for patients who need more specialist long-term care and support is frequently made even greater by an insufficient or non-existent supply of suitable rapid step-down options and intermediate care. Complex problems often require complex solutions, and these can take time to achieve. So many patients need a safe, supported place to go while a longer-term plan for them is developed. Patients experiencing homelessness are often excluded from various forms of rehabilitation. This means some are denied the opportunity to recover fully from physical trauma or addiction. Appropriately supported specialist step-down and intermediate care provision is not only a compassionate response but NICE guidance 214 says local systems should now provide specialist intermediate care for this population. There is strong evidence that it is cost effective and reduces re-admissions, and in some places it has been commissioned. However, this is clearly another commissioning challenge when resources are under such pressure.

Additional stress for staff in our Teams comes from lack of job security due to the short-term funding of the Team which is often agreed year to year and only at the last minute. NICE recommends inclusion health services should be commissioned for a minimum of five years. We face a clear commissioning challenge to secure longer-term, secure funding for Pathway Teams, although our colleagues in Hull and Plymouth are leading the way. This uncertainty has led to some Teams losing most of their staff as the financial year end looms, so even though funding was ultimately found, the Team has had to re-recruit and rebuild almost from scratch, losing experienced staff and the relationships with other services they have built up.

People with No Recourse to Public Funds (NRPF) are some of the most vulnerable patients that hospital Teams work with and are amongst the most challenging to help due to their ineligibility for housing or benefits. Lack of understanding of the complex immigration system in the UK often results in vulnerable migrants not regularising their status even when they have clear legal grounds to do so. Legal aid is no longer available for most of this population, so Pathway has for many years used charitable funds and grants to fund legal advice and support for patients with NRPF who are involved with a Pathway Team. This is difficult to sustain, and we have long lobbied for proper commissioning of legal support for NRPF patients. This would not only be cost effective in avoiding long hospital stays, but also compassionate and straightforwardly sensible as precious hospital beds are freed up when these patients become eligible for more support. The government published guidance in January 2024 for the NHS and local authorities on Discharging people at risk of or experiencing homelessness which states: "It is good practice for the NHS and local authority to establish referral pathways and consider commissioning services to help patients access immigration and welfare rights advice prior to discharge or while being accommodated." We are hopeful that this may signal a much-needed change.

Pathway is a small charity working with colleagues across the NHS and local government, and together with front-line clinicians and people with direct lived experience of homelessness and multiple exclusion. We work to bring about a permanent shift in the culture of care to improve the health of people experiencing homelessness. Despite a truly daunting array of social, economic and political challenges, the fact that our Pathway Teams continue to achieve so much for their patients is remarkable. Our Partnership Programme, developed with and alongside NHS colleagues, along with the wider changes that have often followed from shining a light on this extreme end of the system (emergency hospital care for homeless patients), are at the heart of our wider work to change the system for the better.

We look forward to another year, continuing to support and develop our existing Teams, exploring together how we might improve and extend what we do, and welcoming new partners into the programme. We long for the day when we have a decently funded housing, social security, employment and a health system that works consistently to prevent most homelessness before it happens and intervenes rapidly and effectively when it does happen.

Annexe One

The Pathway Partnership Programme Support Package

The programme offers continuous direct support to Teams from Pathway's experienced core support Team, access to our detailed online Operations Manual, and the benefits of being part of our national network of Pathway Teams.

As part of their membership of the programme, Teams receive the following support:

Direct Support

- Initial 2-day Team Induction Training, plus refresher training
- Monthly support calls with Teams to provide support on clinical and operational issues
- Support with data collection, analysis and reporting quality metrics and outcomes to commissioners and other stakeholders
- Support to produce in-depth service evaluations, such as Annual Reports
- Ad hoc advice as needed – open to all staff on each Team
- Bi-annual visits from the Pathway Partnership Programme Core Support Team (years 1 & 2)
- Annual Practice Audits

Operations Manual

- Guidance on all areas of service delivery
- Template documents and resources from existing Teams
- Service standards
- With input from existing Teams, it's maintained and updated by Pathway

> **"The portal [manual] is incredible - it is such a valuable resource. The hours and hours I will have saved by not having to set all of that stuff up myself. I just have to go to the portal and retrieve the information I am looking for. And if the information that I need is not on there, I can approach one of the Team and they will either point me in the direction or send me something that has been created elsewhere in the country. There is very little reinventing the wheel, which is so valuable for me and our Team."**
>
> *Heather Walker, Commissioner*

The Pathway Partnership Programme Annual Report 2024

National Network Benefits

Monthly Masterclasses and All Teams Meetings
Both current and legacy Pathway Teams are invited to monthly masterclass sessions which involve inclusion health training on a wide variety of topics, delivered by expert speakers.

All-Teams meetings bring together current Pathway Teams and Legacy Pathway Teams several times per year to discuss shared challenges, share improvement and best practice and celebrate successes.

Conference places
Pathway Teams receive free places to the annual two-day Faculty of Homeless and Inclusion Health international conference. The Faculty is a national multidisciplinary network devoted to developing inclusion health and hosted by Pathway.

Faculty for Homeless and Inclusion Health newsletters:
The newsletters contain a range of information relevant to the Teams, including key policy developments, new research, training opportunities and job openings in the inclusion health space.

Faculty for Homeless and Inclusion Health Specialist sub-networks
These networks meet approximately quarterly. The current sub-networks are: Mental Health, Outreach & Mobile Services, Primary Care, Occupational Therapists, System Leaders and Managers, Students.

NHS Futures Pathway Teams workspace
Includes discussion forum for Pathway Team staff and a library of previous Masterclass recordings.

Additional Offers when Funds Allow:

Patient dignity funding
Providing Teams with petty cash to improve our service users' experience while in hospital through provision of such items as deodorant, shower gel and other essentials.

Reflective practice for London Teams funded by London Homelessness Awards prize money

Pathway considers reflective practice to be essential to support Team members as they assist people facing a system which repeatedly fails to adequately meet their needs. In 2022 the Partnership Programme was awarded first place in the London Homelessness Awards, with the funding attached used to fund monthly group reflective practice sessions for each London-based Partnership Team.

Specialist Legal and Immigration Advice

Over the last seven years Pathway has brought in significant amounts of charitable funding to commission access to specialist legal advice for Teams (focussed on housing, immigration and social care law). Pathway uses this funding to commission dedicated telephone and face-to-face legal advice from local specialist legal advisors (often community law centres or similar). This specialist legal advice helps Teams present their patients' cases to other services (housing, or adult social care for example) in the best possible way. In some cases, legal advisors can see that the patient would be entitled to legal aid and can take on the case and become the patients' legal advisors.

Access to legal advice can transform what Teams are able to get for patients in terms of housing, support and legal status, but after seven years Pathway is finding it increasingly difficult to find charitable funds to pay for this legal advice. We believe there are very strong arguments in terms of outcomes for patients and permanently resolving someone's homelessness, for commissioners of Pathway Teams to include the costs of legal advice in base budgets.

Annexe Two

The Pathway Partnership Programme Support Package

Pathway Needs Assessments

Our specialist homeless and inclusion health needs assessment offers a robust method for a service provider or commissioner of whatever size, from individual NHS Trust to ICS, to assess how far their local services meet the needs of people experiencing homelessness or people with multiple and complex needs. Pathway needs assessments were developed particularly to assess need and make recommendations to improve the care and treatment of people experiencing homelessness in hospital, but our method necessarily means we identify gaps in care across a local system.

Our needs assessment process is a synthesis of qualitative and quantitative data. With help from local partners, we carry out interviews with people with lived experience of homelessness and multiple exclusion who have used services locally (these interviews are often led by a member of the Pathway Lived Experience Group) to gain insight into the challenges people face when approaching or using services. We seek to interview a wide range of staff from all relevant Teams and services within the hospital, local NHS community services and people working in charity, community and local government are also interviewed to gain their perspective. We have a standard method to extract data from hospital systems to establish both whether adequate recording and coding of the group is happening locally and to assess the numbers of homeless patients in a local system.

Findings from the interviews and data analysis are combined to generate a summary of needs in a locality. At the end of the needs assessment process, we make a series of recommendations on the steps a local area should take to improve care for people experiencing homelessness and multiple exclusion.

Common Themes

Over the last decade Pathway has been commissioned by systems across the country to carry out one or two local needs assessments every year. From all these studies some common themes have emerged.

Generally, there is a lack of accurate data regarding people in inclusion health populations on hospitals' systems, so many of the needs in these groups are not visible and are going unmet. In relation to hospital care, where specialist homeless or inclusion health Teams do not exist there is a high level of potentially unsafe discharge of patients in these groups. Patients are regularly discharged (or leave hospital) prior to treatment being complete, and there are high rates of re-attendance and re-admission. The management of conditions which have a high impact on these groups, such as mental illness, drug and alcohol dependence, acquired brain injury and chronic pain, is generally sub-optimal; national protocols are not applied well and, in some cases, not at all.

Our needs assessments routinely discover a lack of understanding and empathy towards patients in these groups from some members of staff. To some extent, staff attitudes mirror attitudes in the population at large towards homelessness. Additional targeted education and training can help shift these negative attitudes.

Discharge to unsafe destinations, such as the street or unstable sofa surfing, is common practice, and little is done during an admission to have meaningful contact with community or housing services to try to change the situation, resulting in a 'revolving door' of admission, discharge and worsening health for the person involved.

Our needs assessments routinely report problems for inclusion health populations with access to primary care medical (GP) and dental services, and extra support services to help people navigate the system are only patchily available.

Accommodation options, where they do exist, are often limited, of very poor quality, and have become scarcer over time. This applies both to emergency accommodation for people experiencing homelessness, as well as specialist supported accommodation services for those with ongoing accommodation-related support needs.

Examples of Recent Needs Assessments

Pathway's Partnership Core Support Team can be commissioned to carry out a full needs assessment for a whole ICS area, or for an individual Trust or ICB footprint. Alternatively, data gathering can be led by colleagues in local services or public health with Pathway giving advice on the process and helping with the analysis and service recommendations.

Devon ICS Pathway Needs Assessment for People Experiencing Homelessness

This report, published at the end of 2022, presented an assessment of the current picture in homeless healthcare provision across Devon. Sixty-four interviews were conducted with people working in a wide variety of relevant services across the county, and seven with service users. There was a particular focus on hospital discharge and how this is currently working across the different areas of the county.

The study also explored the extent to which local hospital discharge processes linked with other key homeless services in primary and secondary care, in statutory services and in the community.

A summary report highlighting issues which affected the whole county was produced alongside a set of individual reports for the East, South, North and West Devon sub-regions. **Key recommendations included:**

- Introducing a co-ordinated approach to service commissioning, planning, implementation and delivery for people experiencing homelessness across the whole of Devon.
- Increasing multi-disciplinary working around people experiencing homelessness.
- An overhaul of management of patients experiencing homelessness in hospital and discharge practice across secondary care, with a co-ordinated approach including: in-reach input from housing, the introduction of specialist Pathway Teams, an end to discharging people to the street or away from their support networks, provision of step-up and step-down facilities, and improving access to rehabilitation, improvement in the availability and range of discharge accommodation.
- Supporting existing services which are centres of excellence and spreading good practice from these centres to cover the whole of the Devon area.
- Improving access to Primary Care and Dentistry across Devon for people experiencing homelessness.
- Introducing a shared approach across services including mental health, alcohol and substance misuse, Adult Social Care, and housing, in the assessment of clients, outreach and planning of services.
- Introducing an education programme for all staff working within clinical services in Devon regarding the health, care and support needs of people experiencing homelessness.

Hull City Council Pathway Needs Assessment: Multiple Unmet Needs within Secondary Care Health in Hull

This needs assessment focussed on the experiences of people experiencing multiple unmet needs when using secondary care health (hospital) services in Hull. It was commissioned by Hull City Council as part of a wider piece of work examining the needs of this group in the Hull area. The qualitative and quantitative data were gathered in 2023, and the work was completed Autumn 2023.

The work included 13 extended interviews with people with lived experience of using services, carried out by peer (lived experience) interviewers, and 22 interviews with staff from both community and secondary care services.

Quantitative data was provided by the hospital data Team.
Members of Pathway's Lived Experience Group helped to steer this assessment by conducting interviews, reviewing this document and contributing reflections and highlighting points they felt needed to be emphasised, including to the final recommendations. **Specific needs identified were:**

- Awareness raising and training for staff around multiple unmet needs is required to influence understanding and empathy.
- Both specialist and universal services need to be designed to support people with multiple unmet needs.
- Assessment, management and discharge of people with multiple unmet needs in hospital should be improved.
- Both staff and patients would benefit from a 'psychologically informed' physical environment to support their needs.
- Hull needs to find ways to offer greater availability and a greater variety of accommodation and step-down options.
- Greater awareness and understanding of multiple unmet needs are required across all local communities, organisations and systems.

Recommendations to address these needs included:

- Mandatory training on the issues facing people experiencing multiple unmet needs would help staff to consider the wider context around their admission to, or contact with, hospital services, and to be better equipped to support them. This should include safeguarding in the context of multiple unmet need and the rights to Care Act Assessments.

- A comprehensive review of community services should be undertaken through the lens of accessibility and suitability for people with multiple unmet needs and consideration be given for improved hours of availability of services.
- An understanding of the importance of appropriate, person-centred and equitable pain management for this group should be prioritised.
- Protocols for the prompt management of alcohol and opiate withdrawal syndromes should be developed and the importance of implementing these consistently at all times of day and night should be part of annual mandatory training.
- An assessment of the need for supported step-down/intermediate care provision for people with multiple unmet needs (agreed during the time this work was underway) within the city should be completed.
- The local authority should consider ways to increase wider public understanding of people with multiple unmet needs to reduce the stigma and discrimination they face.

Annexe Three

The Pathway Partnership Programme Core Support Team

Our core support Team aims to mirror the skills and expertise needed by the frontline Teams.

- Dr Chris Sargeant, Medical Director and Pathway Partnership Programme Clinical Lead (and Secretary to the Faculty of Homeless and Inclusion Health)
- Dr Peter Buchman, Deputy Medical Director and Deputy Pathway Partnership Programme Clinical Lead
- Samantha Dorney-Smith, Senior Nursing Fellow and Nursing Practice Lead
- Paul Hamlin, Pathway Partnership Programme Project Manager (and housing advice practice specialist)
- Sophie Koehne, Mental Health and Occupational Therapy Policy and Practice Lead and Lived Experience Lead
- Theo Jackson, Research & Data Lead
- Mandy Pattinson, Lived Experience Program Manager
- Jacqui Conaty, Homeless and Inclusion Health Nurse
- Emma Thomson, Senior Project Manager
- George Clark, Administration Officer

Annexe Four

Published Evidence of Benefit for Pathway Hospital Teams

The first Pathway Partnership Team was launched in 2009. As well as a randomised controlled trial, the intervention has been subject to a range of other research studies, service evaluations, and audits. The Pathway Team approach was cited as best practice in a case study in the 2019 NHS Long Term Plan and listed by NHS England as an approved Evidence Based Intervention to Reduce Heath Inequalities. The randomised controlled trial is endorsed as a high-quality study in NICE guidance 214. The list below presents these studies chronologically, with brief summaries of the key findings. This published research supports three key benefits of providing a Pathway Team:

Pathway improves outcomes for homeless patients. Better health 90 days after discharge (see 3 below), less rough sleeping (see 3 below) and improved housing outcomes on discharge (see 4, 5, 6,11 below)

Pathway improves capacity in a busy hospital by reducing the average duration of admissions for homeless patients (see 1, 2, 5, 6, 7 below) and by reducing subsequent A&E attendance (see 2, 5, 8 below) and the number and duration of subsequent unplanned admissions expressed as total bed days. (see 1, 2, 5, 7, 8 below)

Pathway is cost effective. This has been calculated using Quality Adjusted Life Years (see 3 below), and by comparing the costs of the Team to the reduction in secondary care activity for involved patients (see 7, 9,11 below). In an in-patient mental health setting a study has shown reduced service use costs at 3 months to approximately half of the baseline measure (see 10 below)

Relevant Materials and References

Relevant Materials

1. Hewett N et al. A general practitioner and nurse led approach to improving hospital care for homeless people. BMJ 2012; 345:e5999 . An observational study of the first Pathway pilot, this compared outcomes for homeless patients identified from hospital records (No fixed abode, hostel address or registration with homeless practice) for two years before the service began and two years after implementation. A 30% reduction in bed days was observed, with positive feedback from patients and colleagues.

2. MPath. A review of the first 6 months of the pilot service. July to December 2013. Reportingoutcomes for 100 homeless A&E frequent attenders showed a 47% reduction in A&E attendances, 48% reduction in admissions and 39% reduction in bed days.

3. Hewett N et al. Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'). Clin Med 2016;16(3):223-9. A two centre NIHR funded randomised controlled trial, at Royal London and Brighton and Sussex University Hospital. Patients were reluctant to consent to randomisation, so less than half of potential participants were included, and only half of these received the Pathway intervention, limiting the potential for culture change in the hospital. Although the study did not show a difference in length of stay, or re-admission within 90 days, quality of life scores (EQ-5D-5L) improved significantly in the intervention arm and quality-of-life cost per quality-adjusted life-year was £26,000. Street homelessness was reduced, the proportion of people sleeping on the streets after discharge was 14.6% in the standard care arm and 3.8% in the enhanced care arm.

4. Evaluation of the Homeless Hospital Discharge Fund. Homeless Link. 2015. This study evaluated 52 projects set up with a one-off government grant. The table on p37 summarises the outcomes. Projects were of 3 broad types, housing link worker in the hospital, accommodation with link worker, housing and clinical staff working together in the hospital (Pathway). The Pathway approach demonstrated best outcomes with 93% discharged into suitable accommodation, 89% receiving health support on discharge, 92% receiving housing support on discharge and 23% readmitted within 30 days.

5. Dorney-Smith S et al. Integrating health care for homeless people: the experience of the KHP Pathway Homeless Team.British Journal of Healthcare Management 2016;22(4):225-34. Using a comparison group of patients identified as homeless on hospital records before and after introduction of Pathway showed a 9% reduction in A&E attendances, and an 11% reduction in bed days at Guy's and St Thomas' and 56% of patients with improved housing status on discharge.

6. Khan Z, Koehne S, Haine P, Dorney-Smith S, (2019) "Improving outcomes for homeless inpatients in mental health", Housing, Care and Support, Vol. 22 Issue: 1, pp.77-90. This study of Pathway in an acute mental health setting (South London and Maudsley Trust) showed 74% of patients had improved housing status on discharge. Comparison with a control group in the hospital has also shown reduced bed days (in press).

7. Bristol Service Evaluation of Homeless Support Team (HST) Pilot in Bristol Royal Infirmary. Internal evaluation, presented at Faculty for Homeless and Inclusion Health Conference March 2019. This evaluation compared outcomes for a control group of homeless patients identified from hospital records during the needs assessment, with the outcomes for patients seen by the Pathway Team during the first 12 months. Results showed a 74.5% reduction in average duration of stay (11 to 2.8 days), 35.7% reduction in self discharge, 62% reduction in re-admission within 28 days (132 to 50). Estimates of savings in secondary care costs were £921,300. Taking into account the costs associated with the Team this equates to an overall saving of £766,300 annually.

8. Wyatt L. Positive outcomes for homeless patients in UCLH Pathway programme; British Journal of Healthcare Management 2017 Vol 23 No 8: p367-371. This audit examined secondary care activity for homeless patients in the 90 days before and after contact with the Pathway Team at UCLH. This showed a 37.6% reduction in A&E attendances, 66% reduction in hospital admissions and a 78.1% reduction in bed days.

9. Gazey A, Wood L, Cumming C, Chapple N, and Vallesi S (2019). Royal Perth Hospital Homelessness Team. A report on the first two and a half years of operation. School of Population and Global Health: University of Western Australia, Perth, Western Australia. This evaluation demonstrates that the Pathway method is beneficial in other health care systems. Comparing secondary care activity for a year before and after contact with the Pathway Team showed $7,302 cost savings per person, or $4.6 million in aggregate.

10. Khan Z, McCrone P & Koehne S (2020), Impact on the use and cost of other services following intervention by an inpatient pathway homelessness Team in an acute mental health hospital, Journal of Mental Health, DOI. This study shows that Pathway Team intervention in an in-patient mental health setting increases engagement with follow up by mental health, GP, and other community services and reduces service use costs at 3 months to approximately half of the baseline measure.

11. Cornes, M, Aldridge, R, Tinelli, M, Whiteford, M, Hewett, N, Clark, M, et al (2019), 'Transforming out-of-hospital care for people who are homeless. Support Tool & Briefing Notes: complementing the High Impact Change Model for transfers between hospital and home'. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London, London. This work examines the role of in-hospital homeless Teams on outcomes for patients and reports improved outcomes and cost-effectiveness when the Pathway model of clinically-led in-reach is utilised, particularly when used in conjunction with step down facility.

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2. For example, the Homeless Link Health Needs Audit: homeless.org.uk/knowledge-hub/unhealthy-state-of-homelessness-2022-findings-from-the-homeless-health-needs-audit/

3. www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/

4. www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

5. www.nice.org.uk/guidance/ng214

6. www.legislation.gov.uk/ukpga/2022/31/contents/enacted

7. www.legislation.gov.uk/ukpga/2017/13/contents/enacted

8. www.england.nhs.uk/wp-content/uploads/2023/01/B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf

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