Pathway
Homeless & Inclusion Health

The Pathway Partnership Programme Annual Report

Delivering Under Pressure

March 2025

Edited by Dr Chris Sargeant

Pathway
Homeless & Inclusion Health

Crisis
Together we will end homelessness

Acknowledgements

Pathway would like to thank the following people for their significant contributions to this report-Alex Bax, George Clark, Paul Hamlin, Theo Jackson, Dee O'Connell and Stephanie Sykes.

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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Foreword
The Pathway Partnership Annual Report

Pathway's mission is to tackle the extreme health inequalities experienced by people in inclusion health groups.

Our Partnership Programme, and the Pathway teams we support through it – and whose work we celebrate in this report – are perhaps the most direct way we deliver against this mission. Every working day the teams help homeless patients in hospital. Last year, between the nine teams in the programme, they worked with more than 3,700 patients, a 28% increase on the year before.

All the teams tell us that their task is becoming more and more difficult as financial pressures ratchet up across the NHS, and the cost of living and the housing crisis continue to drive increasing levels of homelessness nationally.

Despite these challenges our Partnership Programme teams continue to deliver, whichever way you look at them. They support large numbers of vulnerable people, often literally changing the course of somebody's life, and while doing this, save the health system significant sums of money.

However, due to short-term funding decisions and the fact that teams work across the boundaries of services and budgets ("your work is so important, but not my budget"), the teams endlessly have to justify their own existence. I hope the evidence of benefit presented in this report helps with that task.

We launched our Partnership Programme four years ago to speed the adoption of our simple model of a specialist homeless team in a hospital, and we know there remain many places in the UK that would benefit from having a team but don't have one. I hope this report also helps budget holders in those places see that they can do something practical to respond to some of the most extreme health inequalities in Britain.

Of course, by themselves, Pathway teams are only a small part of the answer to the gross health inequalities that define the lives of people experiencing homelessness and people in other inclusion health groups. Since the 2024 election Pathway have been working to persuade our new Government to act on inclusion health. We use the benefits delivered by our network of Pathway teams as a practical example that change is possible. Over the next 12 months we will keep on making the case for a national programme of change.

In conclusion I want to thank the staff in every team for their commitment to their patients over the last year. I know just how hard the work they do can be. I also want to thank Pathway's core Partnership Programme team for their work supporting colleagues across the country. And finally I want to thank those enlightened commissioners and budget holders who have decided, despite the challenges that they also face, that health inequalities are a priority, and who support the Pathway Partnership Programme.

Alex Bax
Chief Executive of Pathway

"All the teams tell us that their task is becoming more and more difficult as financial pressures ratchet up across the NHS, and the cost of living and the housing crisis continue to drive increasing levels of homelessness nationally."

Alex Bax
Chief Exec of Pathway

Executive Summary

This is the second annual report on the Pathway Partnership Programme (PPP)[1].

Through patient case studies, individual team profiles and performance monitoring data the report shows the incredible hard work, compassion and dogged determination the nine hospital teams in the programme, and the results they continue to achieve for their patients. This is despite a backdrop of increasing rates of homelessness and intense funding pressures within health, housing and wider community services.

The data section consolidates statistics from all the teams in the programme. It shows that the number of homeless patients helped by the teams increased by 28%, to 3,377, compared to the previous year. We believe this increase in numbers of homeless patients is a consequence of rising rates of homelessness in society, at the same time that services in the community are under ever more pressure.
Pathway teams work to improve the quality of care received by homeless patients in hospital and use the moment of a hospital admission to try to end people's homelessness. During the last year they reduced returns to rough sleeping by 43% and to 'sofa surfing' by 21%, comparing the patient's status on admission and discharge.

Homelessness is strongly linked to both poorer health outcomes and increased use of more expensive unscheduled care[2]. People experiencing homelessness use emergency care more regularly than the housed population. Helping people in hospital to get appropriate accommodation, care and support in the community when they leave hospital is obviously much better for them. It also reduces readmissions and most importantly improves long-term outcomes. And it makes direct financial sense: reducing costs by £10,000-£15,000 per person, per year. Supporting our NHS partners to achieve these combined human, service and system outcomes is the core purpose the Pathway Partnership Programme[3].

The individual team reports celebrate specific local successes and the challenges the teams face. They also talk about future ambitions for their services. One of the repeated challenges they face is chronic funding insecurity and the impact of last-minute funding decisions. The team's work is high stress enough without staff having to worry about their own job security. In the last year we have seen experienced, dedicated staff leave for alternative jobs with more security and difficulties recruiting staff to key roles on short term contracts.

Despite these pressures, our Partnership teams remain hugely positive about their work, inspired by their patients and the improvements they see in their lives, and the strength and solidarity they draw from their fellow team members and from being part of the Pathway Partnership Programme.

Chapter 1. Introduction

What are Pathway Teams and what do they do?

Pathway teams are NHS-employed staff who work with patients to bridge the boundaries between health, housing and social care. They are clinically led, multi-disciplinary teams that provide holistic support for patients experiencing homelessness within acute and mental health hospital settings. Teams typically consist of a variable combination of GPs, Nurses, Housing Workers, Social Workers, Occupational Therapists, Physiotherapists and Care Navigators. The overall goal of a Pathway team is to maximise the benefits of a hospital admission by ensuring that the person involved completes all the necessary treatment, and is connected on discharge to the necessary health, housing and support services, with the ultimate aim being to improve health outcomes for people experiencing homelessness and multiple exclusion.

Teams achieve this through a wide range of activities including:

- Conducting holistic, patient-centred assessments
- Providing 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 drug and alcohol services
- Establishing patients' legal entitlements to benefits and housing support
- Training and educating local colleagues to promote culture change

History of The Pathway Partnership Programme

Professor Aidan Halligan founded Pathway as an independent charity in 2009 to improve the care of people experiencing homelessness, following the death of a patient sleeping on the street close to University College London Hospital (UCLH). The patient had been discharged from the hospital a few hours before. Aidan was a senior leader at UCLH. He won the backing of the hospital charity, recruited a small clinical team, and the first Pathway team began to work at UCLH the same year. As initial data began to show benefits to patients, the charity raised funds to support the launch of additional teams in London and beyond. In 2016 a randomised controlled trial of the intervention was published, confirming the positive outcomes from the intervention[4].

After an earlier development grant from them in 2018, The Health Foundation invited Pathway to join a three-year funded programme to explore how well-evidenced improvements to care quality and patient outcomes could be replicated and spread more quickly across the NHS, and to test whether subscription-based or quasi-franchising funding models might meet the costs of the 'originator' of an intervention to share its learning and knowledge. That funding allowed us to design and launch the Pathway Partnership Programme.

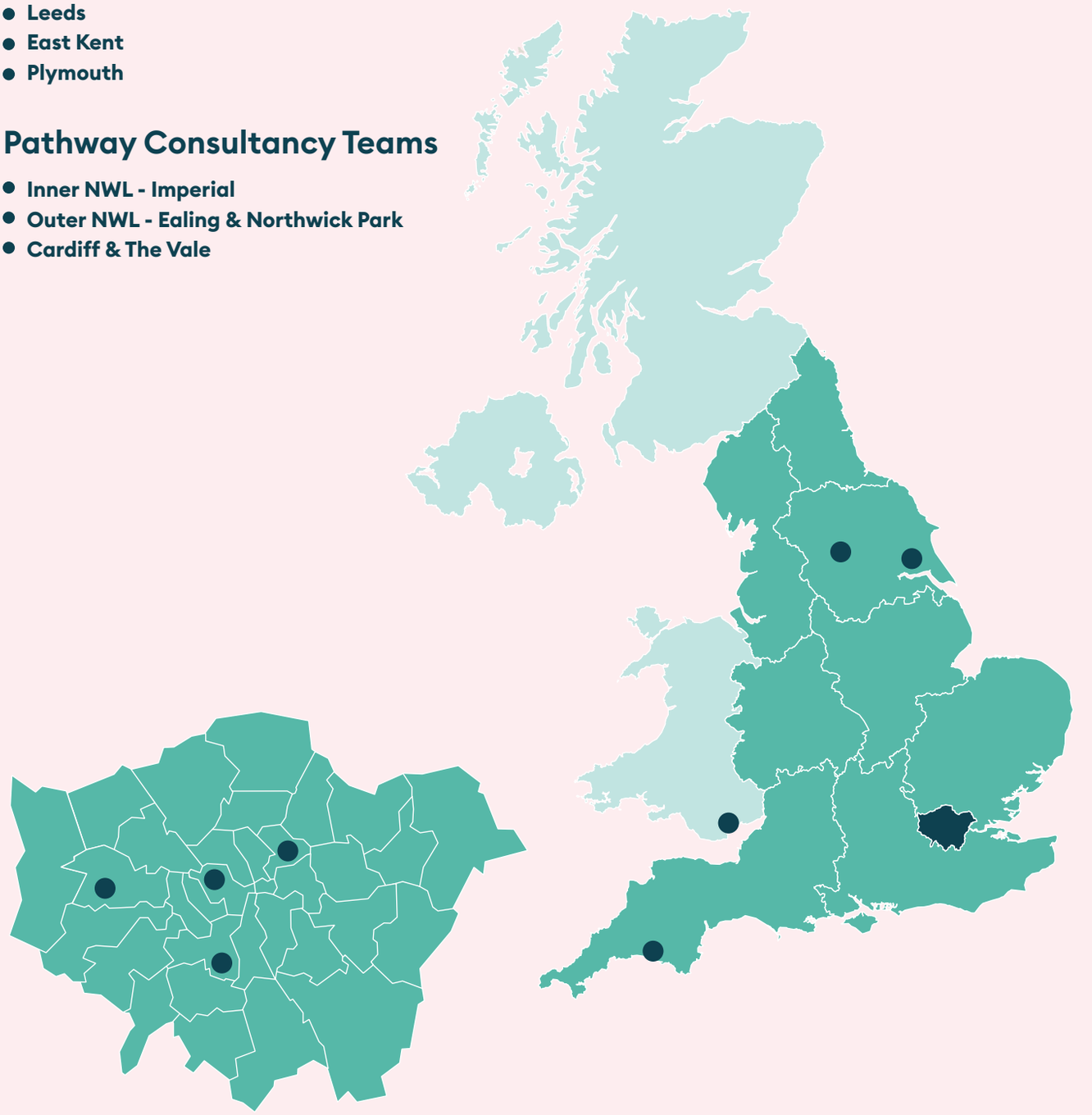
In return for an annual subscription (£25,000 plus VAT in 24-25), the Pathway Partnership Programme offers hospitals and their partners a practical way to help people experiencing homelessness. Organisations that join the Programme get access to 15 years of distilled experience and best practice in costing, designing, recruiting, training and launching a Pathway team. We work with commissioners to assess local need and build business cases, and once teams have gone live, we give team members access to a range of expert practical support, an online support manual, regular training, peer networks and quality improvement benchmarking. In return we ask our partners to share service activity and performance data with us, work to meet our minimum quality standards, and commit to our collaborative network and core values. Together we work to keep learning and improving and to use our shared experiences, knowledge, skills, clinical and patient voices to campaign for wider changes in the NHS and beyond. We want to change the system, improve outcomes for deeply excluded patients and end homelessness for good.

Pathway Partnership Teams

- Hull
- Hackney
- St Georges
- Leeds
- East Kent
- Plymouth

Pathway Consultancy Teams

- Inner NWL - Imperial
- Outer NWL - Ealing & Northwick Park
- Cardiff & The Vale



The maps show the nine places where we were working in 2023-24 to support a specialist team. In each of these places we have a formal agreement with local NHS organisations, based on our Partnership Agreement which commits Pathway and our local partners to work together to improve care for our target population. In some places our partner is the acute hospital trust, in others the team is commissioned by a community provider, and the team 'in-reaches' to the hospital.

Pathway currently uses charity funds to subsidise the costs of running the programme, although we have a strategic objective to develop the programme to the point where subscriptions from our NHS partners cover its costs. Where we can we also bring in additional charitable funds to develop and test enhancements to the programme or develop research in specific areas of interest to the teams. For example, with a grant from the Frontline Fund, we currently provide access to specialist legal advice for most of the teams across the network; we use a London Housing Award prize fund to pay for regular reflective practice sessions for our London based teams; and in 2023/24 a Burdett Nursing Foundation grant supported our national project to consolidate best practice in diabetes care for patients experiencing homelessness.

We continue to support our growing national network and the passionate and dedicated homeless and inclusion health professionals that work in these hospitals across the UK. When a team is commissioned to join Pathway's network, it effectively also joins a national movement for change and is making a visible commitment to tackle the worst health inequalities.

Pathway Consultancy Teams

Pathway also offers flexible support options tailored to local need. Over the years we have completed 18 specialist homeless and inclusion health needs assessments for local commissioners. Commissioners also ask us to help with the development of a particular service or role, with a service business case, or seek general advice about how best to improve inclusion health services in their area. During 2023/24 we delivered bespoke support through an Expert Partner Agreement with North West London ICB to provide specified, targeted support to two teams working across several NHS Trusts. We also provided bespoke implementation support for the new Cardiff & The Vale Inclusion Health Service.

Pathway Legacy Teams

Legacy teams are teams which we have helped to launch and supported in the past, and are still part of our wider network, but do not have a formal support contract in place. They are usually in places where services have been in place for longer and are more developed. We do not report on or monitor these teams formally and they don't have access to our bespoke team support offer, but we continue to help them through membership of the Faculty of Homeless and Inclusion Health and where we can by providing educational, developmental and networking opportunities.

Full Details of The Pathway Partnership Programme can be found at:
www.pathway.org.uk/partnership-programme

Chapter 2. Summary of Activity and Quality Data for 2023/24

Monitoring data collected from our Partnership teams during 2023/24 shows rising demand for these services and increasing clinical complexity in patients seen by the teams

Despite positive activity indicators, the data also suggest that achieving positive outcomes for patients became even harder in the last 12 months, probably because of the increasingly difficult external environment in which the teams are working, and in which our patients must survive.

For a fuller report and more detailed analysis of 2023/24 monitoring data see section 6 of this report on page 54.

Pathway teams accepted 3377 referrals in 2023/24, a 28% increase on the 2640 accepted in 2022/23.

Age, gender and ethnicity distributions of accepted referrals remain similar to the previous year, but the proportion of patients with No Recourse to Public Funds (NRPF) continues to rise, with 20% of accepted referrals to the London teams having NRPF in 2023/24.

Mental health and substance misuse needs were both more common in 2023/24 (both over 60% of accepted referrals), and nearly 2 in 5 (38%) had both, i.e. dual diagnosis.

Rough sleeping was reduced by 43%, lower than the 50% reduction seen last year. This is despite extremely positive activity data relating to housing advocacy, highlighting the huge challenges of improving someone's housing status in the current climate.

Achieving GP registration for patients continues to be a challenge for teams, with around 50% of those without GPs being appropriately registered on discharge, lower than the 58% seen last year.


Brandon
MAJORS
B3
hello my name is...
Caroline

Chapter 3. Overview of the year 2023/24

Pathway Partnership teams continue to provide outstanding care to people who are not otherwise well served by the health and care systems.

The number of people helped by the teams has increased significantly compared to the previous year. The teams have continued to reduce the most extreme forms of homelessness (rough sleeping) and have helped even more people into more stable situations and away from 'sofa surfing'. These reductions, and the rate of GP registration have, however, fallen compared to the previous year. We believe this reflects increasing pressures on a wide variety of services outside hospital as numbers of people experiencing homelessness rise and local government continues to experience intense financial strain.

People seen by the teams continue to give very positive feedback, often saying that they did not expect to get so much meaningful help and support and that the care they have received has given them hope. It is heartening to see more established teams continue to develop their wider relationships both within and outside of their Trusts and influencing local services to work in a more collaborative way. The programme continues to support new teams to become established and our first Wales-based Partnership team was developed during the period of this report.

Beyond our rolling national housing crisis, the standout challenge the teams report is the negative impact of short-term funding, insecure funding and late decisions on the continuation of services. An annual funding cycle and the uncertainty this brings undermines staff morale, leads to instability in the teams, and results in high rates of staff turnover in some teams.

In response to the huge challenges our teams face advocating for their patients every day they highlight their need for specialist psychological support, including individual counselling and group reflective practice, very well evidenced to be of value to staff working with profoundly traumatised client groups. They also bring up the need for more understanding generally in mainstream services of the conditions affecting inclusion health populations at a younger age such as frailty, alcohol-related brain damage, head injury and complex psychological trauma. This training need is perceived particularly among other clinical colleagues and people working in Adult Social Care.

Many of the teams are working to find ways to get improved responses for their patients from other specialist teams they work with, such as Mental Health services, Adult Social Care, Adult Safeguarding and rehabilitation services. Many of the team's individual reports highlight service gaps that are common across the individual sites, particularly the need for additional community services with a good evidence base, such as specialist intermediate care step-down facilities.

The extreme lack of options for people who have been judged to not warrant Local Authority housing assistance or are deemed to have 'no recourse to public funds', is a persistent challenge. The latter is particularly prevalent in London teams with 20% of people seen by the Pathway teams in London falling within the NRPF category.


Garry
Discharge Planning Support Worker
St George's University Hospitals NHS
Mr. Garry Castelino
Discharge Support Worker
Plastic Surgery

Costs and benefits

In our 2022/23 Partnership Programme annual report we presented a crude estimation of the savings Pathway teams deliver for the health system, and we here calculate an update based on the data from 2023/24. These calculations are based on some broad assumptions, and we offer them here to give an order of magnitude suggestion of what the relative costs and benefits of this work may be to the health system. We have sought to be cautious in our assumption so these estimates likely understate the system benefits of the Pathway teams.
In March 2023 Will Quince, Minister of State, told Parliament that the average cost per day of a non-elective hospital stay was £901[5].

3,377 patients who were homeless or at extreme risk of homelessness were accepted by our Pathway teams in the year covered by this report and using the current average length of stay figure for an unplanned hospital admission of 8.3 days, we can estimate that these patients might have occupied 28,029 bed days. At £901 per bed day this equates to a cost to the NHS for these admissions of £25.25 million.

We have a range of studies about the impacts of Pathway teams[6] but several have reported that before and after the introduction of a Pathway team, in-patient bed-days occupied by homeless patients in a hospital trust fall by around 30%[7]. If that reduction was achieved by the patients seen by Pathway Partnership teams in 2023/24 this would equate to avoided health service costs of £7.6 million over the reporting period. An estimate for the annual revenue cost of an average Pathway team is around £350,000, or for eight teams £2.8 million. So, the eight current teams may be saving the NHS £4.8 million per year in avoided costs or making 8,400 bed days available for other patients. Across England we think that there are at least 40 more hospitals which would benefit from the Pathway team intervention. Based on these estimates, un-scheduled hospital care for homeless patients in those 40 hospitals could be costing the NHS close to £126 million per annum. Pathway teams in all those locations would cost £14 million a year in salary costs plus £1.2 million for Pathway's specialist support.

After this funding is accounted for, they would reduce costs of homelessness to the hospital system by £23 million per year, while delivering better health and housing outcomes for the 16,000 plus homeless patients we might expect them to help.

A 2010 Department of Health study reported that patients who are homeless are admitted to hospital three times as often, stay twice as long, and are five times as sick as age-matched housed patients, so their actual costs and length of stay are higher than this, and hence the potential savings are significantly greater[8].

Looking at rough sleeping alone, we have a good estimate that each person having to sleep rough costs the system £10,000-15,000 per year of additional resource[9]. In 2023/24 the eight Pathway teams stopped 540 people returning to rough sleeping on discharge from hospital.

The cost of those teams with Pathway support was £2.8 million. Assuming each person on average ceases rough sleeping for one year, on rough sleeping interventions alone, the teams save between £5.4 and £8.1m across the wider system or £1.80-£2.70 for every £1 spent.

The 2016 randomised controlled trial of the Pathway intervention showed significantly reduced return to rough sleeping on discharge: 3.8% in the intervention group compared to 14.6% in usual care. The study also showed significantly improved EQ-5D-5L quality of life scores. The quality-of-life cost per quality-adjusted life-year (QALY) was calculated at £26,000, meeting the National Institute for Health and Care Excellence level for cost effectiveness[10].

If this reduction in rough sleeping could be accessed by the additional 40 hospitals we think would benefit from a Pathway team intervention, the reduction in people leaving to rough sleep per year would be 1,728 people and this could realise £17 - £26m in cost savings, or net of team and Pathway costs, £2-11m.

In 2023/24 the eight Pathway teams stopped 540 people returning to rough sleeping

Chapter 4. Living in a cold climate – the current policy context for the Partnership Programme

This report comes at a time of policy limbo; our teams are still feeling the harsh effects of the previous 15 years, but reforms and funding decisions announced by the current Government exist only in broad brush strokes and have yet to have much impact on frontline services.

Housing policy choices made over the last decade and a half continue to drive up homelessness, depressingly manifested in the marked increase in the numbers of patients our teams have supported this year. The most recent official figures show that the number of households facing homelessness exceeded (320,000) in 2023/2024[11], the highest on record. 3,898 people were sleeping rough across England on a given night in Autumn 2023, an increase of 27% on the previous year[12] and 120% higher than when data collection began in 2010.

Mounting NHS pressures in recent years continue make it more challenging for people facing homelessness to access the care they need; mainstream services that are stressed and stretched cannot offer the flexible, trauma-informed care that the evidence shows people facing homelessness need[13].

Meanwhile, specialist inclusion health services continue to face a rising tide of demand and complexity[14], but are too often seen by local decision makers as 'optional extras', rather than core business. This results in a pattern of short-term funding and contracting, with promising practice in some Integrated Care Systems (ICSs) not widely mirrored across the country. Most Pathway teams are funded through short-term contracts, despite clear evidence of impact, in common with many other specialist inclusion health services[15]. There is currently nothing in the Government or NHSE policy toolkit to address this. The sharp incentives deployed to drive change have historically been used to respond to high volume, mainstream political pressures such as elective recovery and A&E waiting times[16].

The hostile immigration environment is another background component to the increased pressures our teams report. The ongoing policy of denying access to certain health services and to housing support services to people with no recourse to public funds continues to trap many in an intractable situation, with no solution to their overlapping health and housing problems. Predictably people facing destitution get sick, and unable to access primary care end up using hospital services. This is a growing challenge for our Pathway Partnership Teams, with the proportion of patients with No Recourse to Public Funds continuing to rise, reaching with 20% of accepted referrals in our London teams in 2023/24.

Pathway's first Homeless and Inclusion Health Barometer, published last year, pointed to positive policy developments, such as NHS England's first Inclusion Health Policy Framework[17] and the potential of Integrated Care Systems to create joined-up, holistic services that can meet the needs of individuals with complex medical and social needs. We know from our work with ICSs[18] that the Framework in particular is helping to raise the profile of healthcare for people facing homelessness and other excluded groups in their systems.

But as the remarkable case studies and monitoring data in this report show, these developments do not go far enough in driving the long-term, sustainable reform needed to address the extremely poor health of people facing homelessness and other forms of social exclusion. This Government has an opportunity to achieve transformational changes in outcomes for these groups, and the 'three shifts' it wants to see in the NHS through its forthcoming ten-year plan are a good starting point. In turn, a focus on inclusion health can and should be part of the solution to make the three shifts a reality, lighting the way for solutions and progress for other medically and socially complex groups of patients.

Shifting care from hospital to the community

Shifting care from hospital to the community will be harder to achieve for people facing homelessness and for other inclusion health groups. Their access to care in the community is poor, leading to intensive use of hospital-based services. People experiencing homelessness attend emergency departments six times as often as housed people, are admitted three times as often, and stay on average twice as long[19]. Hospitals will realistically continue to be a significant part of the care the NHS provides to people facing homelessness and other inclusion health groups for the foreseeable future. Making a reality of this shift for people facing homelessness, therefore, relies in part on driving up the quality of their hospital stays, to make sure that a hospital stay sets people on a trajectory towards better health and connects them to community-based services. As this report shows, specialist multi-disciplinary teams such as Pathway teams are critical to these efforts (and are the approach recommended by NICE in Guideline NG214[20]), but too often they are only funded on a short-term basis and the Pathway team approach has only been adopted in some places (indeed the reports from the more established teams in the following section strongly suggest that the positive impact of the Pathway approach increases over time, as the teams build stronger connections with other services and become better known within their local systems).

Providing safe places for people to recover after a hospital admission, to improve health and prevent readmissions, will be another key enabler of this shift. Our Pathway Partnership Teams, in common with hospitals around the country, face a postcode lottery of safe discharge options for patients experiencing

homelessness. The combination of pressures to free up hospital beds, a policy and legal framework that drives unsafe discharges for people facing homelessness, and a lack of specialist intermediate care beds combine such that more than 4,000 patients every year are discharged from hospital to no fixed abode[21], and this will often mean to the street. Patients discharged from hospital back into homelessness are highly likely to return to hospital pretty rapidly (see many of the individual case studies in the next section). This problem could be addressed through a national programme to commission specialist intermediate care beds, which we have shown would be cost and quality effective[22] and for our population would be a vital part of shifting care from hospital to the community.

Shifting care from analogue to digital

People experiencing homelessness and other inclusion health groups face significant digital exclusion[23], locking them out of tech-enabled health care. Requirements from many mainstream services to book appointments online and conduct consultations by phone limit access for the many people in inclusion health groups who don't have the money for a smartphone or data, or have language or literacy issues. Pathway teams go to significant lengths to keep in contact with patients after a hospital admission to ensure access to follow-up care, and this highlights the importance of policy continuing to support 'analogue' contact and access options for people who need them.

Shifting from sickness to prevention

People facing homelessness have particularly poor access to general practice. Addressing this will be at the heart of making this shift for this population and getting upstream of the significant multi-morbidity that affects patients cared for by our Pathway teams.

Patients frequently experience difficulties with GP registration[24], and total triage and more remote and digital consulting have created new barriers[25] and worsened existing ones for this population. This poor access to primary care contributes to persistently poor health outcomes, with people finally presenting late with high levels of need into urgent and emergency care.

This is driven in part by the policy and funding landscape for primary care. The structural barriers to providing adequate care for inclusion health groups in general practice are significant. There are no mechanisms that incentivise a health inequalities approach or monitoring to ensure progress is made systematically. Under the Quality Outcomes Framework (QOF), working with more complex patients brings no additional funding and makes practices less likely to achieve full QOF renumeration. Practices in deprived areas, which are more likely to serve people in inclusion health groups, receive up to 7% less funding and care for 10% more patients[26]. Without funding to match need, delivering the aspirations of the NHS England Inclusion Health Framework, such as longer, more flexible appointments, continuity of care in a trauma informed environment, and acting on social determinants will remain a fantasy.

Reforming GP funding and incentives to improve access should not only shift care from sickness to prevention for people experiencing homelessness, but could also show the way to improve access and outcomes for other multi-morbid and socially complex patients.

Mission-led approach

Beyond the 10 Year Plan, a mission-led approach by Government, much heralded in the opening days of this administration, holds huge promise in resolving the complex, overlapping and entrenched social and clinical difficulties our patients experience daily.

As evidence continues to mount about the link between health and the housing crisis[27], providing the 90,000 social homes a year that England needs must be a priority, along with ensuring that there is coherence between the new NHS 10 Year Plan, the national homelessness strategy and long-term housing plan.

Reforms that drive integration locally to ensure that joined up, holistic services are sustained are also needed. A good first step would be the creation of a single budget focused on achieving the outcomes of better homes and better care for people in inclusion health groups, with a view to improving their health and wellbeing, and to reducing health inequalities.

The legacy of the 'hostile environment' continues to leave many patients with no way to access routine care, as this report has shown, so reforming policies around no recourse to public funds will also be critical in addressing the needs of the substantial minority of our patients in this position, especially in London.

Not a single patient treated by a Pathway team presents with only one issue. Their complexity and multiple disadvantage require an intelligent, flexible response, bringing together action and resources across systems, budgets and professionals. Achieving this seems to align perfectly with the ambition of a mission-led Government. Delivering it should be the legacy of this Government.


St George's University Hospitals NHS
NHS Foundation Trust
Magalhaes Heath

Pathway Policy Papers

In late 2024 Pathway commissioned a set of Policy Papers from leading inclusion health practitioners to offer summaries of evidence and best practice in a selection of key inclusion health policy areas and to make recommendations for improvements in each area in the short, medium and long term. The papers were timed to respond to the call from the newly elected Labour government for ideas and evidence to feed into its review of health and care services and to inform plans for the coming years.

Several of the policy papers are particularly relevant to the experience of Pathway teams and therefore to this report, especially the papers on Secondary Care, Stepdown/Intermediate Care, General Practice and Primary Care, Adult Safeguarding and Health Data. The most relevant recommendations for Pathway teams and inclusion health services in hospitals are that the Government should:

Establish a hospital safe discharge programme, incorporating Pathway teams and specialist intermediate care stepdown facilities, ensuring that no one is discharged to the street and that every hospital admission is seen and an opportunity for longer-term prevention. Introduce and inspect against targets for Trusts to prioritise improvement areas for inclusion health groups

Mandate self-assessment against current standards and guidance for all NHS Trusts

Take urgent steps to provide General Practice with the support to provide appropriate levels of care for complex multi-morbid populations.

Implement a major reform programme to drive routine recording of all patients' housing status when they interact with health services, based on a nationally agreed set of housing codes. This would require investment in training for frontline NHS staff, to drive the culture and behaviour change necessary to achieve routine and meaningful recording.

Make an explicit cross-departmental commitment to ending the premature deaths of people from homeless and other inclusion health populations.

The full papers are available:
www.pathway.org.uk/resources/pathway-policy-papers

Chapter 5. Pathway Partnership Team & Pathway Consultancy Team Reports

In late 2024 we asked each of our Partnership Teams and Consultancy Teams to send us a summary of their team's work over the previous year. Teams were asked to include illustrative case studies to highlight the complexity of the challenges they and their patients face. We also asked them to report on successes in the year, service challenges they had faced and to share their ambitions and concerns looking into the future.

East Kent Homeless Pathway Team

The East Kent team was established in 2021 and works at three sites in the East Kent Hospitals University Foundation Trust. It is known locally as the East Kent Pathway Team but will change names to Homeless Health Team, to make the remit of the team clearer to other local services. The team has five members who are:

- **Millie Waters.** EKHUFT / Full time Homeless Health Nurse.
- **Helen Burnett GP.** Part time 20 hours / Homeless Health GP.
- **Lorraine Seago.** Full time / Porchlight Homeless Health co-ordinator and outreach support .
- **Nicola Rees.** Full time / Canterbury City Council Homeless Health Housing Officer.
- **Karen Nicholson.** EKHUFT / 15 hours / Homeless Health administrator.

During the last year the team cite their three most significant achievements as delivering training across all the wards within the Trust about their role and homelessness and health; maintaining the amazing flexibility of the team in covering the three geographically remote sites (William Harvey Hospital, Queen Elizabeth the Queen Mother 'QEQM', and Kent and Canterbury Hospitals) while maintaining the ability to assess patients within 48 hours of referral; and winning the Trust Safeguarding award and Healthwatch awards.

A very positive development over the last year was starting formal reflective practice. The team meet regularly once a month, which boosts morale and provides a structured place to speak about patients, emotions and relationships. The greatest challenges facing the team have been the lack of social care support for people who self-neglect, and the lack of local services for people with Alcohol Related Brain Damage. They have experienced a similar lack of support from the wider system for neurodiverse patients, particularly for patients in transition from young peoples' to adult services.

Looking ahead the team report that funding has been secured for an additional full-time member of staff, who will be an Occupational Therapist.

"It's amazing that there is a team here that will help me with my homelessness, and problems I have due to sleeping rough for all these years."

Pathway patient

Case study:

The team supported a young man who attended the Emergency Departments (ED) over one hundred times in crisis. He was experiencing homelessness, had ADHD, and struggled with drug and alcohol addiction.

Every time he attended ED, he would be treated and sent back out onto the streets. He would very often present again hours later and was constantly being admitted and discharged. During his last attendance the team were able to arrange admission, working with the Trust and Adult Social Care.

He remained an inpatient for a few days which allowed Adult Social Care to complete a Care Act assessment. Following this he was placed into a supported living placement, and he has not been back to the hospital for six months.

His family report he is doing well. This case highlighted how important and successful collaborative working can and should be. It also shows that prior knowledge of a person and looking at their wider situation, rather than just at each acute issue, enables services to support people to improve outcomes.

Hackney Pathway Homeless Team

Hackney Pathway Homeless Team was established in January 2022. They operate across Homerton Healthcare NHS Foundation Trust and East London Foundation Trust, however due to staffing issues have had to limit themselves to the Homerton Hospital this year.

There are 6 people in the team:

- **Mary-Jane Bertin.** Nurse/team leader Homerton / HNFT 1FTE.
- **Javaize Fenton**. Housing worker / London Borough of Hackney / 1FTE.
- **Maxwell Richardson.** Community link worker, Providence row / 1FTE.
- **Eleanor Watson.** Community Link Worker / Providence row / 1FTE.
- **Laura Jacobs.** OT Homerton / HNFT 0.8 FTE.
- **Dr Theresa Murphy De Souza.** GP/Clinical Lead / ELFT 0.6 FTE.

The team describe their three biggest achievements of 2023/24 as survival in the face of staff turnover and significant gaps in their staff team, re-recruiting a full staff team, and embedding their service within the hospital where they are now respected by colleagues (and discharge planning together). As a result, patients are now rarely discharged to the street. A full staff team allows proper teamwork as opposed to firefighting and crisis management.

The staff vacancies have been their biggest challenge over this period, as have the numbers of patients with no recourse to public funds. The team often feel like the only service advocating for these patients within the hospital. They have also faced challenges with establishing relationships with Adult Social Care Services outside of their home borough of Hackney. Now with a full staff team, they are feeling optimistic about being able to do more in the Emergency Department and establish a service in the Mental Health side of the hospital.

However, concerns remain about potential loss of funding and impact on discharges to the streets.

Case study:

JF had a council tenancy for many years. He was a frequent attender and repeatedly said he could not return to his flat as he had unwanted people staying there, he was scared of them, they threatened him, exploited him and “he” was subject to many complaints about ASB. He was repeatedly discharged back to his flat.

After referral to us we convened an extensive, well attended TAP meeting. His housing officer (and others) thought he should give up his tenancy and go into supported accommodation. We strongly advocated against this; he was granted dual housing benefit to stay at the team’s step-down unit, Lowri House. He thrived there and became engaged with his health goals and was stabilised on opiate substitute prescription. He went briefly to Temporary Accommodation (TA) after Lowri, but then was given a new council tenancy in a different part of Hackney. He was supported throughout by one of our community link workers.

He was very anxious about going to TA (as it was out of Borough), but the link worker managed to help him stay on track and he didn’t have to stay there very long.

“Thank you, I think I can make a fresh start here”

Pathway patient

Hull Homeless Health Team

The Pathway Partnership team in Hull was established in 2019 and works at two sites, Hull Royal Infirmary and Castle Hill Hospital. It is Known as Hull University Teaching Hospitals (HUTH) Homeless Pathway Team-Inclusion Health Team and is run by Modality Partnership.

There are currently 10 people in the team:

- **Helen Thompson.** Head of Operation / 1 FTE.
- **Emma Nicholson.** Team Manager / 1 FTE.
- **Dr Jennifer De La Cruz.** 0.2 FTE.
- **Dr Anthony Okwukaogu.** 0.2 FTE.
- **Anna Darwick Lead Nurse.** 1 FTE.
- **Michelle Cochrane-Booth Nurse.** 1 FTE
- **Christpher Cooke.** Care Co-Ordinator / 1 FTE.
- **Briony Sergison.** Care Navigator / 0.6 FTE.
- **Dr Sarwat Malik.** Trainee / GP 0.4 FTE.
- **Ken Hearson.** Community Nurse / 1 FTE.

The team cite their greatest achievement over the last year being better joint working within the Trust with other teams. They have worked hard on collaborating with other services and strengthening their visibility within the hospital.

There is improved liaison with other services within the Trust which has led to improved discharges. Closer working relationships with other inclusion teams have led to a new multidisciplinary team meeting with a focus on patients from inclusion health groups. There is also a strengthened clinical presence in the team.

The team have developed detailed discharge letters for their patients to be sent to patient GPs after discharge to improve awareness of medical issues and medication changes made while patients are in hospital. The biggest challenges have been building better relationships with ward staff within the hospitals and a change of manager within the team.

The team feels optimistic about the next 12 months, and plan specific work to improve the way they support patients with nutrition issues. The ongoing lack of a step-down or intermediate care facility in the local area for patients leaving hospital is their greatest challenge.

“Your words and tone are warming, you really listened to me. You are the only one who didn’t run when I was covered in fleas.”

Pathway patient

Case study:

This case study presents a snapshot of the care of a person who attends hospital frequently. Two months of interactions are outlined below, to highlight the level of specialist support which some people need to make progress. During this period the patient attended A&E on seventeen separate occasions, and on a further six occasions was admitted to a ward from A&E. Two of these admissions ended in self-discharges. The team saw him thirty-seven times, twenty-seven times while he was in hospital, and ten times in the community (not including planned visits in the community for wound dressings and other treatment).

The patient has complex mental health and physical health problems including schizophrenia, heart failure and respiratory failure. He often was 'not-concordant' with his treatment and this raised questions around his capacity to take this decision.

He was initially accommodated in an 'E-bed' (an emergency bed in a homelessness shelter) but lost this due to the complexity of his medical issues and seemingly declining capacity. Following this he self-discharged from hospital and returned to the streets. The Pathway team made safeguarding referrals and led on Vulnerable Adult Risk Management (VARM) meetings which involved multiple services agreeing actions and delivering a plan to help him complete the necessary treatment and to find a place for him to stay which would be appropriate to his multiple health and mental health needs.

The team also liaised with his primary care provider and with the Mental Health Liaison Team (MHLT) to take the opportunity of a hospital admission to re-instate his anti-psychotic treatment.

Other teams both within and outside the hospital involved in his care were: Rough Sleeper Team, Frequent Attenders Team, Safeguarding- hospital and community teams, Adult Social Care, Renew, Community Nursing Team, Mental health teams MHLT and the Community Mental Health Team (CMHT), Hostel providers, GP, Pharmacy, Liaison and Diversion

The team's Community Nurse spent time working alongside the district nurses when the district nurses were unable or struggled to offer treatment. The patient's final admission came when he was found sleeping rough on the street with no shelter, open to all the elements, partially clothed and very unwell. He was taken to the hospital, where he was admitted long enough for his capacity to be assessed, treatment to be completed, and ultimately transferred to a suitable residential placement, where he remains.

This case illustrates the importance of persistence in being able to make progress across multiple admissions, working with multiple teams, and drawing the right people together around the person involved for a positive outcome.

Leeds Homeless and Health Inclusion Team

The Leeds Pathway Partnership Programme team works within Leeds Teaching Hospitals NHS Trust and are employed by Leeds Community Healthcare Trust (LCH), and Bevan Healthcare. The team has been in operation since September 2013.

They are known as the Homeless and Health Inclusion Team (HHIT), and work at five sites: Chapel Allerton Hospital, Leeds General Infirmary, St James's University Hospital (including Leeds Cancer Centre), Seacroft Hospital, and Wharfedale Hospital. There are nine people who work within the team including the two GPs who provide five half day sessions in total.

The community team is an integrated team that incorporates HHIT team, Leeds City Council and Bevan Primary Care and works across the hospitals and the community. A full-time social worker and a housing officer are employed by Leeds City Council.

The HHIT team members are:

LCH

- **Liz Keat.** Integration lead band / 8a 1FT.
- **Rebekah Besford.** Clinical lead band / 7 0.6 FTE.
- **Amanda Padgett.** Nurse band / 6 0.8 FTE.
- **Louise Elwen.** Nurse band / 6 0.6 FTE.
- **Dawn Benge.** Care navigator / band 4 / 1FTE.
- **Nirmal Nangla.** Care navigator / band 4 / 0.9FTE.
- **Lucy Staveley.** Peer navigator band / 3 0.4 FTE.

Bevan Healthcare

- **Mark Astill.** GP / 3 session per week.
- **Heather Coles.** GP / 2 sessions per week.

"Thanks for everything, thanks for listening. Very grateful for the hat and the wordsearch- really made up. How did you know this is just what I needed? Thank you so much"

Pathway patient

The team cite their greatest achievements of the last year as contributing to the Pathway-led national diabetes and homelessness project and the resultant e-learning materials, employing a person with lived experience as a peer navigator in a joint post with a local health inclusion Palliative Care team, and establishing a fully commissioned out-of-hospital service arm to their overall structure.

Other highlights this year are:

- Recently started weekly Transfer of Care (TOC) meetings with Hospital Matron and Head of Social Care and hospital discharge.
- More than twelve sessions of training delivered to hospital staff including to Emergency Department (ED), Junior Doctors, and discharge teams.
- Hospital staff starting to do routine Duty to Refer (DtR) referrals to Housing Options teams in housing.
- Leeds being a pilot site for Improving Hospital-based Opioid Substitution Therapy (iHOST), an NIHR-funded research project.
- Increasing partnership and improved integrated team working in the city with jointly commissioned posts.
- Leeds is now a Making Every Adult Matter (MEAM) city and HHIT were part of the Interview process for this.
- The ongoing Marmot City collaboration.
- Being part of a Housing and Health meeting chaired by elected members.

The team also highlight a number of challenges they have faced over the last year.

One is staff sickness within the team. Another is described as the cumulative emotional labour of dealing with people with complex problems, when suitable services or resources to address their needs do not exist. This 'moral injury' is common in inclusion health services because services are not commissioned in a way which allows the multiple and overlapping needs of the group to be coherently addressed, for example commissioning drug dependency services separately from mental health services which then exclude people who experience both. This issue is particularly pertinent for this team as they do not have access to the psychological support, structured reflective practice or supervision from which other teams are able to benefit.

There is also a commissioning gap with a lack of emergency accommodation for people discharged from hospital and issues with people who do not meet specific criteria not being able to access services. Early prison releases add to the pressure on accommodation within the city.

The team is also commissioned to provide Gypsy and Traveller outreach. They are very aware that there is more work they could be doing with these communities but their practical capacity to offer more has been limited due to staff shortages resulting from sickness and vacant posts.

Looking ahead to the coming year, the team leaders are aware of the impact of staff vacancies and the consequent increased pressure on the team. The team believe that patient presentations are becoming more complex, and other support services are more stretched. Every year they feel they are expected 'to do more with less'. However one positive development is that Leeds will receive Single Homeless Accommodation Programme (SHAP) funding for entrenched rough sleeping, and the team will be employing a Band 7 Nurse to develop this offer.

Case Study:

AB is a 55-year-old man who has been seen by the team a number of times over the years. He has a history of alcohol and drug dependence. In November 2023 he was admitted to the ICU, he left and returned to street living and temporary accommodation. At Christmas 2023 he was again admitted to the ICU following a gastric bleed. He engaged with the team and was placed in a one of the few crisis short stay community beds available on discharge.

AB then went into temporary housing and was discharged by the team. At the end of February 2024, he was found by an off-duty fireman on a roadside, close to death, hypothermic with a very low body temperature of 27'C. He was taken to ICU and placed in a drug induced coma. He recovered and re-engaged with the team.

He was supported to remain in hospital, to return to his temporary accommodation and to link back with Forward Leeds. He had a support worker allocated, and he was drug and alcohol-free. He was subsequently assaulted by another resident in the house, returning to hospital with fractured ribs and concussion. He engaged again and was supported in hospital during his admission.

Following this discharge the team decided to remain involved for a longer period. He was supported to get glasses and dentures, and to accept a tenancy with Leeds City Council. He is now living independently, in a flat, with furnishings to help him get started. He has a bus pass, his benefits have been claimed, and he has a secure bank account. He is engaging well with Forward Leeds. He has remains free from drugs and alcohol. He has been seen by GP for a management of his newly diagnosed COPD. And lastly, but very importantly, he told the team he can now smile, as he has a full set of dentures.

This case study illustrates how the team often need to engage several times with people at risk of homelessness, and the wide range of interventions needed, which all play their part in enabling someone to make progress towards a stable tenancy and a better life.

"You treated me with respect, I never felt you judged me"

Pathway patient

Health Inclusion Pathway Plymouth

The Plymouth Pathway Partnership team started in 2022, and is known as the Health Inclusion Pathway Plymouth, or HIPP team. They work across the hospital and community with the hospital site being the Derriford Hospital, part of University Hospitals Plymouth (UHP) NHS Trust. Two thirds of their work is done in the community, meaning they work with people in the community and then if they are admitted to hospital and discharged there is continuity of work.

The team currently consists of eight members:

- **Darren Lloyd.** Operational lead and Mental health nurse / FTE.
- **Ben Jameson.** Clinal Lead and GP / 20 hours.
- **Hannah Creasy.** Social worker / 30 hours.
- **Kait Burn.** Physical Health nurse / FTE.
- **Jenna Hayward.** Healthcare assistant FTE.
- **Sally Moss.** Occupational Therapist / FTE.
- **Danny Fay.** GP / 7.5 hours.
- **FTE Support Worker.** Starting December 16th.
- **Rosina Russell.** Team administrator 33 hours.
- **FTE Clinical Psychologist.** Starting January 20th.

The team report their greatest achievements in 2023/24 as being a very low rate of discharge to the street, with only 2 people discharged rough sleeping in the year. The team has also been instrumental in the development of both the Physical Health Nurse role, and the Drug Liaison Worker role which helps with keeping people in hospital for the full duration of their stay and leads to better discharge planning. Good links have been developed with the Harbour, With You and Together community drug and alcohol services. Kait Burn has also forged links with local Sexual Health services and can now undertake STI testing in her clinic.

The challenges the team have highlighted during the year include the lack of mental health teams and services within Plymouth which has a knock on effect on the team needing to provide additional support for people with mental health issues. The geographical footprint of the UHP catchment area, means that the team has to deal with more distant local authorities, so plans for discharge from hospital are more difficult.

There is also an increased demand from the emergency department to quickly solve issues, as there is a perception that the cohort of people experiencing homelessness are responsible for causing backlogs and a belief that some are presenting for purely social admissions.

The team has a good reputation which they continue to build on and the longer they have been working, the better they feel the understanding of what they offer and their place in community services has become. In UHP there is now a better attitude towards the client group, and a network of agencies in the hospital that link in with the team. Better links have also been forged with Plymouth City Council services.

Looking ahead to the coming year, there is both optimism and concern. The optimism relates to the team having developed a good reputation on which to build and the longer they are operating, the better understanding of what they can offer and their role within the community services. In UHP there is a now a better perception of and understanding for the homelessness client group. There is a network of agencies in the hospital that link into the community alongside the team, and better links to Plymouth City Council which can be further built upon.

There are concerns regarding the retention of staff, not just within the team but also other related services such as Bournemouth Churches Housing Association (BCHA) who provide housing and support services locally. When staff members leave, some knowledge is always lost with them and this takes time to regain.

> “The team have found the service a huge support as it has fed very nicely into the holistic support we offer at Blossom. A high proportion of women would not have prioritised any of their health needs without the input.”
>
> Manager of Blossom Women’s House

Case study:

This case study is about PK and illustrates the power of the multi-disciplinary team (MDT) team approach and persistence. People working closely with PK were HIPP team members Sally and Darren, colleagues from Public Health, UHP, and the homeless hostel.

PK was referred to HIPP in February 2024 in Plymouth. He had previously been given diagnoses of personality disorder and excess alcohol intake. With support from his wife he had been able to cope, until she died around 5 years earlier. She had been his main care giver and decision maker. He had a complex grief reaction following the bereavement.

He had been placed in temporary accommodation in George House (via BCHA), in a B&B, and in the Salvation Army hostel. His alcohol and drug use had increased while in the latter.

In September 2023 he was the subject of a Multi-Agency Rough Sleepers meeting and in February 2024 he was diagnosed with Tuberculosis. He was supported to stay in hospital and completed two weeks of intensive treatment. There was anxiety around the diagnosis from professionals and other service users. Following this there was a period where PK travelled between Plymouth and London.

The team worked on building trust and understanding with him and creating a supportive network including the Church, his hairdresser, the London hospital and housing services.

Wider system support included:

- Adult social care
- General practice
- Public health
- Respiratory medicine

Public Health were able to provide accommodation and funded a flat for six months in an over 60s supported living flat, to help encourage PK to complete his Tuberculosis treatment. There is an opportunity for him to continue this tenancy after his treatment has been completed.

St George's Homelessness Inclusion Team

The Pathway Partnership team at St George's University Hospitals NHS Foundation Trust was established in 2021 and works on the St George's Hospital site in Tooting, London. It is known locally as the Homelessness Inclusion Team or HIT. There are currently six team members and one vacancy.

The team consists of:

- **Danielle Williams**. GP / 0.5 wte.
- **Carolina Gonzalez-Rodriguez.** Nurse / 1 wte.
- **Jamie Robinson.** Housing Officer / 1wte.
- **Georgina Earthy.** Housing Officer / 1wte.
- **Sally Bartolo.** Violence Prevention Practitioner / 1wte.
- **Rosabel Magalhaes Heath.** Care Navigator / 1 wte.

The team see their top achievements as including contributing to a 44% reduction in new rough sleepers to Wandsworth Borough compared to the previous year, through their working alongside the council and reducing the number of people who return to the street on discharge. The self-discharge rate from hospital in the homelessness group has also markedly reduced to 6.9% from a previous rate of 14.4%. The team have worked hard to achieve a 93% compliance rate for Duty to Refer referrals for patients from the target group within St George's Trust, meaning that over nine out of ten people who needed to be put in contact with their local housing services while in hospital had this done for them.

St George's Emergency Department (ED) and the HIT team were the regional winner in the 2023 NHS Parliamentary Awards after being nominated by the MP for Tooting and St George's ED doctor, Dr Rosena Allin-Khan.

The NHS Parliamentary Awards recognises the outstanding contribution of NHS staff, volunteers and other health and care sectors. HIT was also able to showcase their work and support for patients when NHS England Medical Director, Professor Sir Stephen Powis, visited the team in May 2023 with senior Pathway staff support.

"Before, I felt depressed, lonely and hopeless. Your service gave me some strength and belief that my voice will be heard."

Pathway patient

Having a close to full staffing complement has had a positive impact on outcomes for the team. Having a settled team has allowed them to make themselves well known in both the ED and on the wards around the Trust and has led to increased referrals and the improved rates of Duty to Refer activity.

A number of challenges have been faced during 2023/24, the most significant of which has been the instability of funding, and fraught discussions around the future of the team between the Trust and commissioners. At the time of writing in early January 2025 no funding has been agreed, with current contracts due to expire at the end of March 2025.

Other challenges have been the complexity of issues facing patients on the caseload, with many clients having significant physical and mental health conditions, legal needs and immigration needs. These challenges are compounded by a lack of specialist placements for more complex clients with additional needs, and there is also a high proportion of clients with no recourse to public funds and hence few options for assistance.

Looking to the future, the team is understandably concerned regarding funding for 2025/26. It would be extremely disappointing to lose this well-established team with their outstanding knowledge which is a great asset to their clients and the Trust.

Case study:

R is a 62-year-old lady who presented to St George's Emergency Department (ED) twenty-four times in nine months, prior to being referred to the HIT. She had been rough sleeping with her husband P for several months, sleeping in parks with only a duvet for cover. Rough sleeping had caused a deterioration of her chronic health conditions. Her presentations included chest pain, leg swelling and severe blisters on both feet associated with numbness. Her chronic health conditions include Type 2 diabetes, hypertension and possible heart failure. She required urgent referral to Cardiology and the Diabetic Foot Team. R and P struggled to access regular food and maintain their hygiene, leading to further deterioration of R's Type 2 diabetes and foot care. The HIT completed a holistic assessment with R and discovered she had been evicted by an abusive landlord. Following this, the team approached their local council for housing assistance but R was deemed not in priority need, despite her providing evidence of her medical conditions.

HIT was able to advocate for R by collating medical information and providing a medical letter to the council. After weeks of advocating for the couple the Local Authority accepted the duty to house as an emergency. During the wait for the council to provide housing HIT provided support and monitored R's health. This included daily calls for advice and emotional support which helped them gain control over their lives whilst waiting for housing. HIT signposted R and P to local homelessness services. They spoke highly of the day centre and how it provided them with a sense of community. They would visit the service every day to have their clothes washed, take showers and eat a hot meal. Having their basic needs met was both a social intervention and a health intervention as they were able to maintain nutrition, hygiene, and positive mental health while rough sleeping. During this period the HIT were able to support R to engage further with community case workers. Crucially, R and P felt they had a support system which led to reduced reliance on St George's services, particularly the ED.

In a more direct community health intervention, R was referred to a community health nurse at the day centre, as well as being encouraged to register with and seek support through a GP. R saw the nurse weekly to have her health monitored and treated.

R and P have now been housed. R has stopped having to attend the ED, and P has been able to return to his job as a carer. The couple demonstrated great resilience through R's determination to maintain engagement with as many services as possible, and P's unwavering organisational and administrative capacities, necessary for the homeless application. The HIT also supported them to access independent immigration advice to support their housing. The couple shared that they are very happy with their experience with our team and are back to cooking nourishing homemade dishes for their family.

This case illustrates that with help to access appropriate local community health and support services patients can improve their physical and mental health and wellbeing. They can regain the stability they need and reduce their reliance on the emergency health system.

The Cardiff and Vale Health Inclusion Service

The Cardiff and Vale Health Inclusion Service (CAVHIS) is a Cardiff and Vale University Health Board service that provides care to inclusion health groups. CAVHIS has been evolving since September 2020. Initially focused on providing assessments and public health screenings for asylum seekers and refugees, CAVHIS has expanded its remit to include new models of care for broader health inclusion groups.

In November 2023, CAVHIS placed a Band 7 nurse in the Emergency Unit (EU) to pilot an 'in-reach' service, operating Monday-Thursday from 8am to 4pm. The in-reach service formed part of wider service delivery and was supported by the CAVHIS community team, including the service's Band 8a lead nurse. Evidence from this pilot was included in a business case submitted to the health board in May 2024. This business case requested funding to embed and expand both the CAVHIS outreach (GP/nurse outreach in hostels, probation services, and sex parlours) and in-reach programmes. In June 2024, the health board committed to the funding.

Since June 2024, the in-reach service has expanded to Monday-Friday, 8am-4pm, with support from a Band 6 nurse. By April 2025, the service aims to provide a 7-day week service, with the addition of a small inclusion health team comprising a GP, an adult social worker, and support from a housing officer and an inclusion health navigator. This Pathway team will provide holistic health and social assessments for individuals admitted to secondary care.

While there are limited resources in the EU and hospital, data suggests that the team may already be having a positive impact. A study tracking 462 people experiencing homelessness has shown that between 2022/23 and 2023/24, there was a:

- Drop in EU 'did not wait' cases from 24% to 12.6%.
- Reduction in total bed days from an average of 12.5 days to 6.8 days.
- Reduction in overall cost of the cohort.

Challenges for the team have included demands and pressures from other areas of the service, including CAVHIS providing primary care to a refugee resettlement programme. This has resulted in delays to expanding the resources for the in-reach service.
Over the next few months, CAVHIS will focus on recruiting the additional resources required to expand the service and is excited to officially launch the service in 2025

"The CAVHIS nurse is an absolute asset to us here in the ED and I am so glad that we have her here. CAVHIS have supported us so much with health inclusion in reach and the nurse is an absolute treasure trove of information, rapport and skills"

ED Consultant, University Hospital of Wales

Inner North West London

The Inner North West London Pathway (INWL) team is known locally as the Homeless Health Team and operates across three sites: St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital. The team was established in December 2021 and consists of 7 people:

- **Harriet Neuberger.** Social Worker / 0.8 wte / Operational Lead.
- **Dr Ed Redshaw.** GP / 0.4 wte.
- **Jo Clarke.** Nurse / 1 wte.
- **Stella Ejimadu.** Nurse / 1 wte.
- **Taanisa Mohamed.** Housing Co-ordinator / 1wte.
- **Edward Munteanu.** Housing Co-ordinators / 1 wte.
- **Azeemat Abioye.** Housing Co-ordinators / 1 wte.

The achievements of the team over the year have include establishing a fully staffed team for the first time since the team launched, including the appointment of a GP with experience in homelessness and health, and a full complement of housing co-ordinators.

The team manage a very busy caseload through daily multi-disciplinary discussion, with full information on the number of referrals available in the statistics section of this report.

Importantly the team has been able to improve working relationships with the psychiatric teams across the hospital sites, leading to increased collaborative working and better outcomes for patients.

The challenges facing the team include the inconsistent application of homelessness legislation by different local authorities, making it difficult for the team to advise their clients on what likely outcomes or next steps will be. For example, some authorities do not respond to referrals at all, others place unachievable information requirements on clients, while some seek to meet their obligations under the Homeless Reduction Act following a Duty to Refer referral.

The limited options for people with no recourse to public funds who represent a high proportion of the caseload, in common with other London teams, is another persistent challenge and systemic issue. The lack of private sector rental options for people who are not in priority need or are judged to be 'intentionally homeless' by their Local Authority present another ongoing challenge, because if the person is not accepted by the Local Authority, there is very little chance of them being housed by any other route.

Now that they are up to full staffing with the GP role filled, the team are optimistic about the future.

Case study:

networking and housing advocacy

A white European male inpatient in his 50s with settled status, complex health needs, and history of anti-social behaviour in the context of alcohol use was referred to the team. He had been recently evicted from temporary accommodation.

Our involvement highlighted the safeguarding concerns raised by their decision to evict from previous accommodation, without providing alternative suitable for his mobility, health and behavioural needs.

An initial acknowledgement from housing that he would be better able to sustain accommodation that was supported, was thwarted by the lack of accessible accommodation – however their resultant decision to not offer an alternative was once again challenged both by highlighting his needs, presenting with him at the council base, and seeking legal advice should this avenue fail.

In the eventuality alternative temporary accommodation was provided 2 months after they discharged their duty. Without the networking, engagement, and persistence of the homeless team it is highly likely that he would have been discharged to the streets.

“She’s a keeper!”

Pathway patient

Case study: engagement in hospital

A Chinese female who had been sleeping rough for 3 years with no regularised immigration status was referred to the homeless health inclusion team at the time of admission from A&E with cellulitis. Information gathered from the rough sleeper database indicated that she was well known to services, with suspected mental health issues, due to poor engagement by services. By visiting her repeatedly on the ward, the team was able to establish a relationship, identify her key objective (to return to China) and engage with her to meet her needs. The lengthy process of repatriation involved working with the very services that had struggled to engage with her in the community. Co-working with them while she was in hospital enabled her to be discharged to a placement while documentation and flights home were finalised. The homeless health team were key in ensuring that this opportunity for engagement of an entrenched rough sleeper was maximised.

This case study illustrates how an admission to hospital can be an opportunity to bring services around a person who could not be helped while sleeping rough, to change things in a way which has long-lasting benefits.

Case study: cognitive impairment and rough sleeping

A white British man in his 60s was referred from the emergency department where he had informed staff that he was rough sleeping in Soho, and they were keen to discharge with housing advice only. However, our initial checks on the NHS portal/Summary Care Record and the rough sleeper database suggested he had an address and was rough sleeping. On assessment, he insisted he was rough sleeping but struggled to provide a coherent history, although he did manage to give us a phone number for a friend. The friend explained that the patient had previously worked as a caretaker at the venue he was sleeping rough near, as he was lonely at the accommodation he had been living in. By highlighting some inconsistencies in his presentation (e.g. sleeping rough but having an address, incoherent history) we advocated for an admission to further assess his cognition. During further assessment by the team, he described the poor state of his flat and conceded that he was unable to live independently. More formal cognitive assessments confirmed deficits and led to a referral to adult social care and placement in a dementia 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 the underlying cognitive impairment would have been missed.

The case illustrates the value of a specialist team with access to records and teams in the community and knowledge of a wide range of physical and mental health issues.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Outer North West London

The Outer North West London (ONWL) Pathway Team is known locally as the Homeless Pathway Team and covers two sites, Northwick Park Hospital and Ealing Hospital. The team was established in May 2022 and consists of 8 people:

- **Nina Tissington.** Clinical Lead and OT / 1 FTE.
- **Rula Najim.** GP / 0.2 FTE.
- **Amisha Babla.** GP / 0.2 FTE.
- **Archana Syamkumar.** Inclusion Health Nurse / 1 FTE.
- **Alison Bello.** Inclusion Health Nurse / 1 FTE.
- **Grace George.** Inclusion Health Nurse / 1 FTE.
- **Joe Laws.** Housing Link Worker / 1 FTE.
- **Dami Obe.** Housing Link Worker / 1 FTE.

The achievements of the team over 2023/24 have included increased promotion and expansion of the team, leading to greater recognition across the sector locally. They have been closely involved in the development of a new step-down project, enabling continued and improved work on patient's journey with multiple community partners. In addition, they have worked very closely with hospital staff to educate them regarding homelessness and health and enable discharges of patients at the right time. During the year a new Band 7 nurse has joined and strengthened the team.

The team has experienced a number of challenges over the year, which mainly relate to the other team which they need to work with in order to optimise the outcomes for their patients. There is an issue with lack of Adult Social Care resources for the client group and poor understanding from colleagues about issues which affect people experiencing homelessness. Similarly, there are issues with lack of communication from housing departments in local authorities, and few options of accommodation for people to move into once their hospital admission has been completed.

Thinking ahead to 2024/25 the team have concerns about the wider system and how factors such as budget cuts, the housing crisis, and ongoing lack of spending in the system on services for people experiencing homelessness will have an impact on their patients and their work.

There is optimism regarding the strengthening of the team and the additional opportunities which are available to network within the local area and more widely. A member of staff who left the team over a year ago has returned, which they have taken as a very positive sign regarding how rewarding and enjoyable the teamwork can be.

Case study:

XX arrived in the UK and had pre settled status, their relationship broke down resulting in homelessness, and a period of rough sleeping began shortly before the Covid pandemic.
XX did not have full EU settled status and was therefore unable to make their own application due to homelessness and pandemic lockdowns, as services were not as open or accessible for them. The team referred XX to Praxis legal advice at the end of November 2023 to assist with making EU settled status claim.
Praxis contacted the team around early March 2024 to update that they were having trouble evidencing XX's residence/rough sleeping in the UK pre-2020.Using the summary care record, team members collected evidence in the form of GP encounters and found two visits to the GP on the summary care record. They also used XX's GP and pharmacy registrations as evidence that he has been in the UK before 2019.

Praxis worked to obtain XX's tax records from HMRC based on his previous self-employment history. In March 2024, Praxis updated the HPT team that an RNS application had now been made with all evidence, and he had already received a certificate of application. This then allowed him to start applying for benefits such as Universal Credit.

XX was not seen again by the HPT until mid-August 2024. When approached, he informed us he had taken the steps to apply for Universal Credit and had been receiving it for several months now. Due to his ongoing health issues, he was unfortunately unable to return to work for the moment and had provided a sick note to Universal Credit.

HPT contacted Praxis who provided evidence of settled status. XX was then eligible for Local Authority housing and a Duty to Refer was made on his behalf. XX was discharged at the end of August into temporary accommodation provided by the Local Authority.

This case illustrates the value of the immigration advice provided by Praxis, joint working with other services, and the ability of the Pathway team to provide information which would be very difficult to access in any other way.

"The help you have given me has been invaluable; it's keeping me here!"

Pathway patient

Chapter 6. Pathway Partnership Programme Data 2023-2024

Performance and quality improvement in 2023-24

As members of the Partnership Programme, our teams collect a standardized dataset that allows us to;

- Report the numbers and characteristics of people seen by Pathway Teams
- Monitor teams' performance against Pathway's set of quality indicators
- Evidence the activity and impact of the teams
- Identify quality improvement opportunities across the programme
- Aggregate data across teams to provide insights for wider policy, campaigning and system influencing work

As ever, the data presented in this section represents a significant amount of work by the teams, both in terms of the activity it represents and the data collection itself.

The data presented in this section covers the period 01/04/2023 to 31/03/2024.

Improving data collection across the Partnership programme

In order to best understand and evidence the activity of our teams, we regularly update and improve our proposed data collection framework. For the year 2023/24, we have implemented several improvements which have improved data coverage and quality, as well as providing a more detailed picture of the activity of Pathway teams:

- Worked with teams to review and streamline Excel data collection templates to reduce the time burden of data recording.
- Updated housing advocacy activity data to more accurately capture the different types of work done by teams.
- Improved indicators to capture activity around holistic assessments and care planning.
- Improved recording of referral and assessments date/time.
- Worked with local IT/BI teams to update templates and data extraction processes.

Despite these improvements, the data is subject to a few limitations, including manual recording errors, incomplete datasets and technical errors with templates and template searches. However, we do see in the data a good level of consistency between teams and over time.

Key points and trends

During the year, Pathway teams accepted 3377/3750 referrals (90%). This is a significant increase on the 2640 accepted referrals in 2022/23.

Mental health and substance misuse needs were both more common in 2023/24 (both over 60% of accepted referrals), and nearly 2 in 5 accepted referrals had dual diagnosis.

The proportion of patients with No Recourse to Public Funds (NRPF) continues to rise, with 20% of London patients having NRPF in 2023/24.

Rough sleeping was reduced by 43%, lower than the 50% reduction seen last year. This is despite extremely positive data around housing advocacy activity, highlighting the systemic challenges of improving housing status.

GP registration continues to be a challenge for teams, with around 50% of those without a GP being registered, lower than the 58% seen last year.

Referrals Numbers

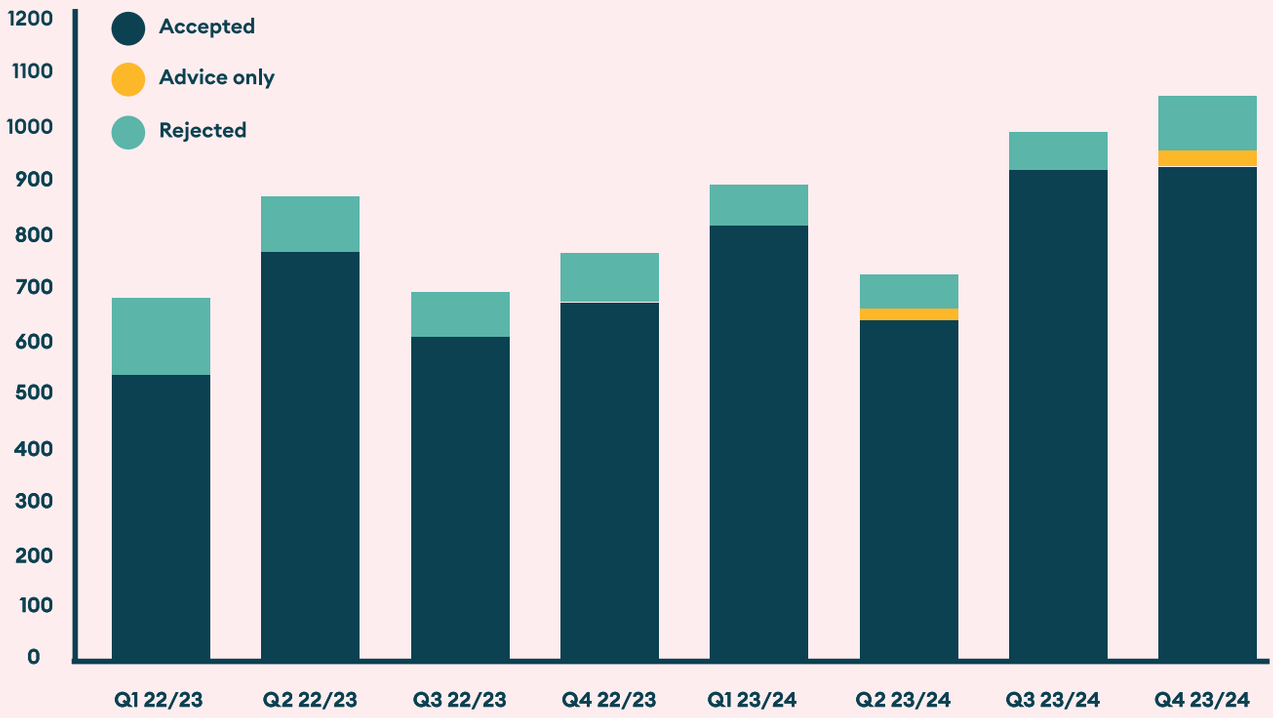
Over the year, a total of 3750 referrals were made across the eight Partnership Programme teams of which 3377 (90%) were accepted (referrals for people who do not meet the teams' criteria e.g. not experiencing homelessness, or clearly needing a care home placement would not be accepted). A further 40 referrals were recorded as receiving 'advice only' (1%), and 333 (9%) were rejected, primarily due to not meeting referral criteria.

Despite the same number of teams being in the programme, we have seen a significant increase in the number of patients being referred and accepted by Pathway teams, up from 2640 accepted referrals in 2022/23. While rising demand for these services is no doubt playing an important role, the increased referral numbers are also due to improved recording of activity. For example, the significantly larger number of accepted referrals seen in at some sites, is due to more accurate and consistent data collection.

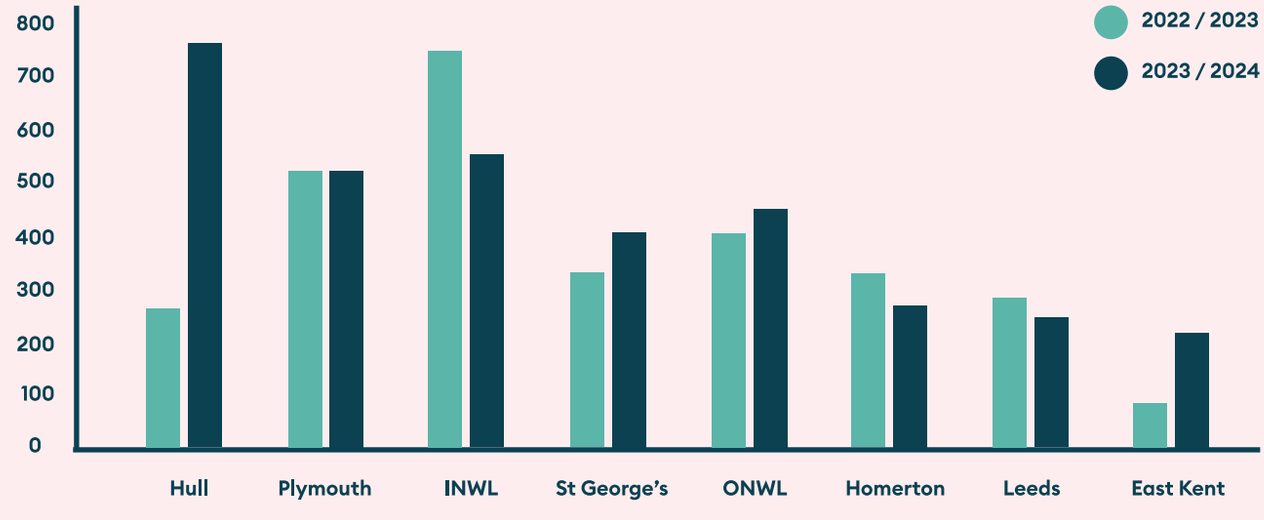
	2022/ 2023	2023 / 2024
Total referred	3028	3750
Total accepted	2640	3377
% accepted	88%	90%

	Accepted Referrals	Active Teams	Average per team
Q1 22/23	548	8	69
Q2 22/23	784	9	87
Q3 22/23	621	8	78
Q4 22/23	687	7	98
Q1 23/25	833	8	104
Q2 23/24	655	6	109
Q3 23/24	938	7	134
Q4 23/24	951	8	119

Referral outcomes by quarter



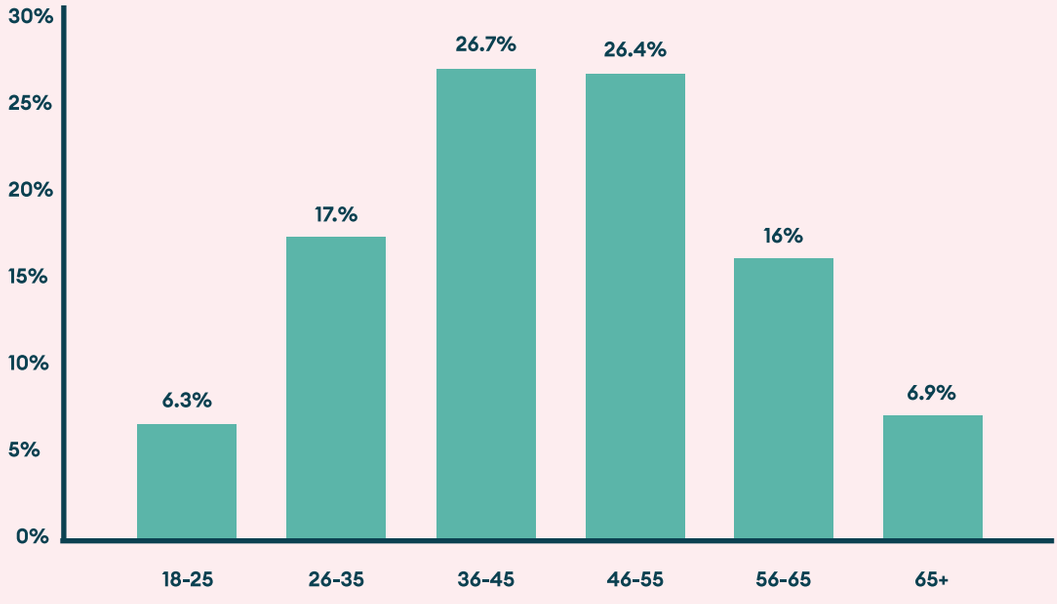
Accepted referrals by teams



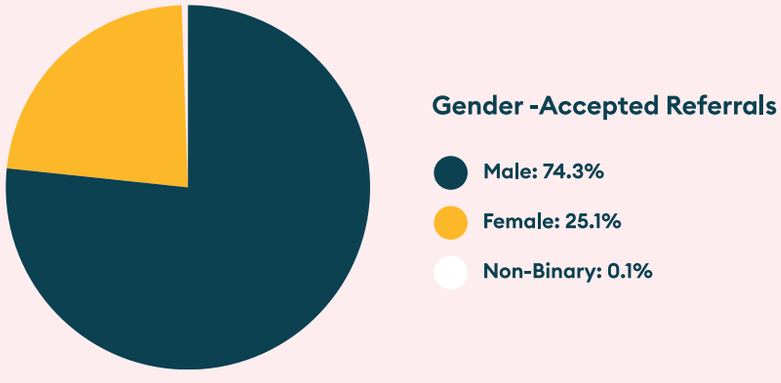
Patient information

The demographic characteristics of patients accepted by the teams remain relatively consistent with last year's data in terms of age, gender and ethnicity. As with 2022/23, over half of all accepted referrals were aged between 36 and 55, with an average age of 45.7 years. Overall, women (43.6 years) were slightly younger than men (46.1 years) and over three quarters of accepted referrals were male. London teams continue to work with a much more ethnically diverse group of patients, with 19% 'White – Other', 11% 'Other' and 9% 'Black/Black British – African'.

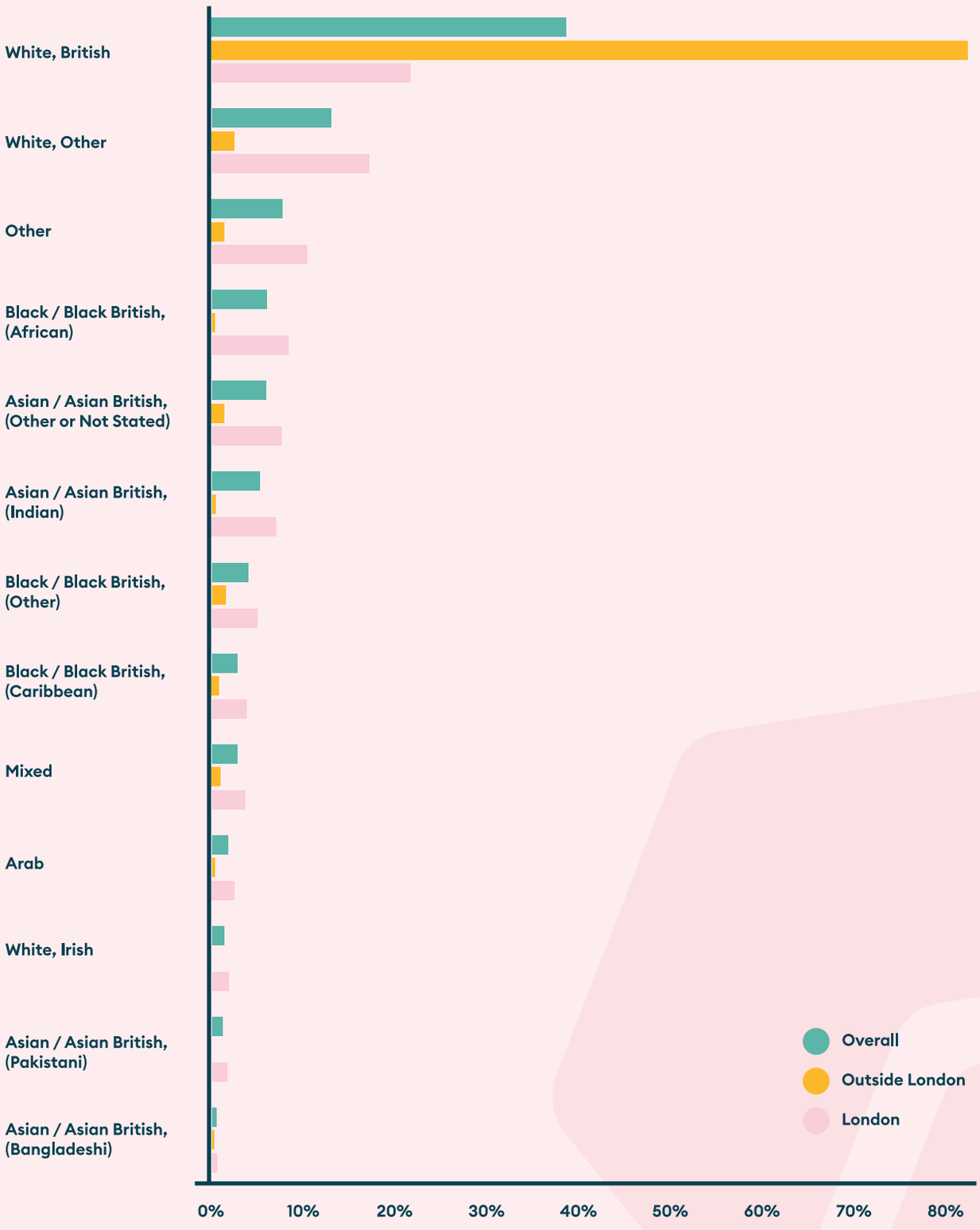
Age, gender and ethnicity



Gender - all accepted referrals



Ethnicity - all accepted referrals

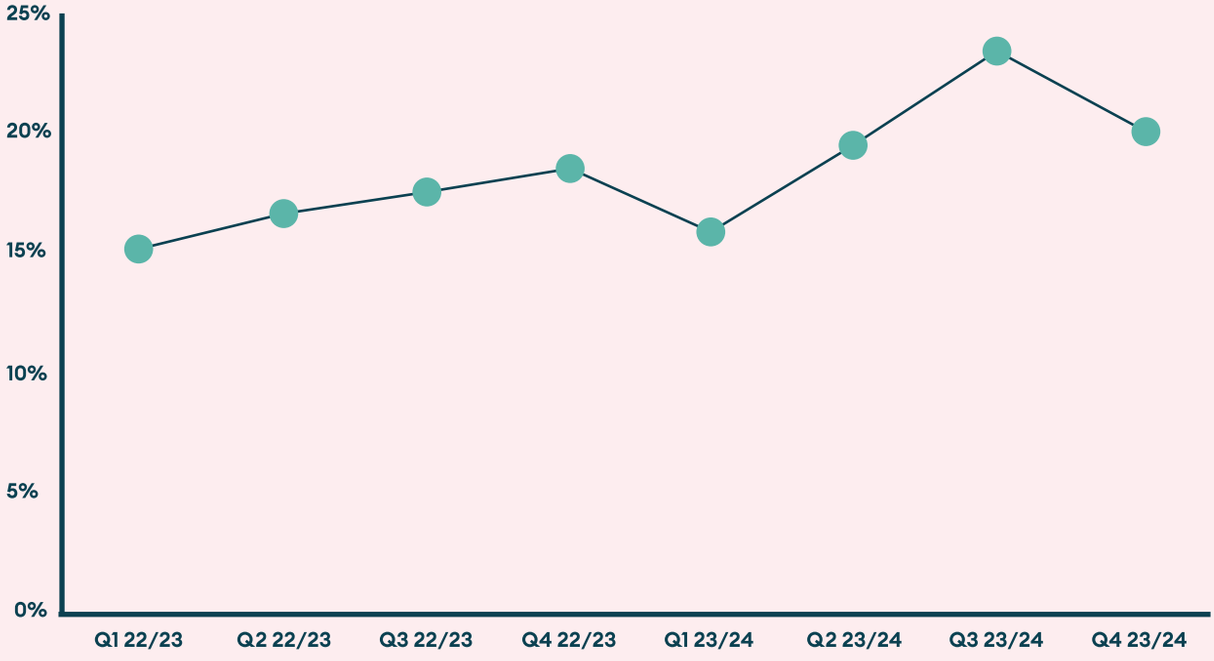


No recourse to public funds

Following the trend from 2022/23, the percentage of accepted referrals who have No Recourse to Public Funds continues to rise. The overall percentage of NRPF patients rose across all teams, for London teams only and for non-London teams.

	NRPF 2022/ 2023	NRPF 2023 / 2024
All teams	13.4%	14.6%
London only	17.1%	19.6%
Outside London	2.2%	2.6%

Percentage of accepted referrals with NRPF - London teams only

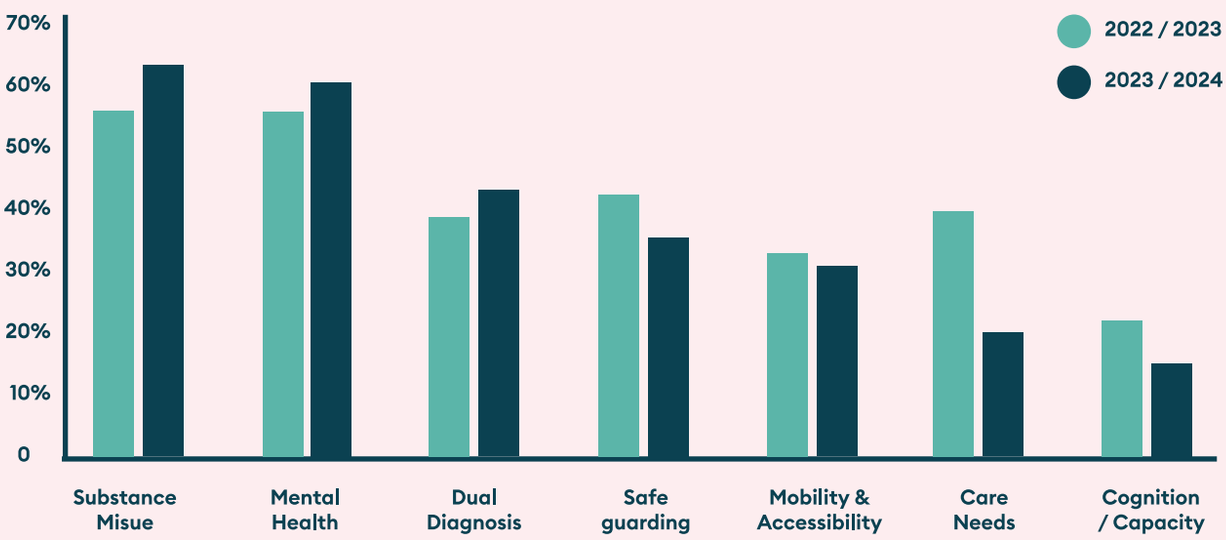


Patient needs

Data collected on the high-level needs of accepted patients continue to demonstrate challenging complexity. Of note, the proportion of people with mental health and substance misuse needs was higher in 2023/24, while new analysis found that almost 2 in 5 patients (38%) had dual diagnosis needs in 2023/24.

The drop in the percentage of patients with care needs is possibly due to ambiguity over whether teams think that a patient has care needs versus whether patients are assessed by social care as having care needs. However, even the 2023/24 level of 1 in 5 patients represents a significant level of need for support from adult social care services.

Identified patient needs



Quality and activity indicators

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. A single indicator is often representative of a huge amount of work conducted by the teams.

GP registration

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.

Data coverage: recorded for 62% (2083/3377) of accepted referrals during the year.

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: During the year, 18% of patients were recorded as having no/inappropriate GP, and of these, 46% were assisted to register with a new GP.
Comments: As with 2022/23, the target of 85% has not proved to be attainable, and the 46% registration outcome is lower than the 58% seen in 2022/23.

Housing advocacy

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.

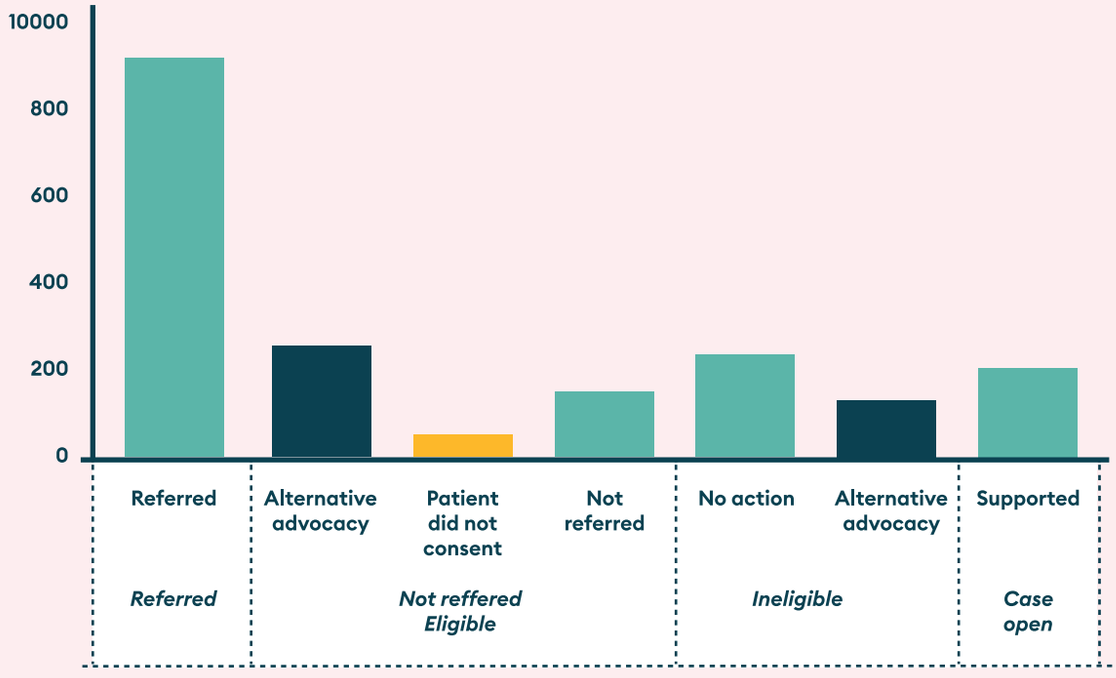
Data coverage: recorded for 60% (2018/3377) of accepted referrals during the year.

Quality Target: 100% of eligible and consenting patients experiencing or at risk of homelessness are referred to a Local Authority under the Duty to Refer or are given equivalent alternative housing advocacy.

Outcome: overall, 71% of accepted referrals were recorded as being eligible for the Duty to Refer, 19% ineligible, and 10% already having an open referral. Of those patients who were eligible and consenting to housing advocacy, 89% received either a DtR referral, or alternative housing advocacy. Of the patients who were ineligible, 34% received some form of alternative housing advocacy. Of all accepted referrals (eligible, ineligible, case open), 80% received some form of housing advocacy and support.

Comments: updated data collection fields for housing advocacy more accurately demonstrate the housing advocacy completed by teams, such as providing alternative housing advocacy, or supporting patients with open cases.

Housing advocay - all accepted referrals



Housing status and outcomes

Accurately recording housing status helps teams to demonstrate the impact of housing advocacy, and to show the local need for the service.

Quality Target: 80% of accepted referrals have housing status recorded at both admission and discharge. No target is set for housing outcomes, as these are often dependent on factors outside of the teams' control, such as local housing availability.

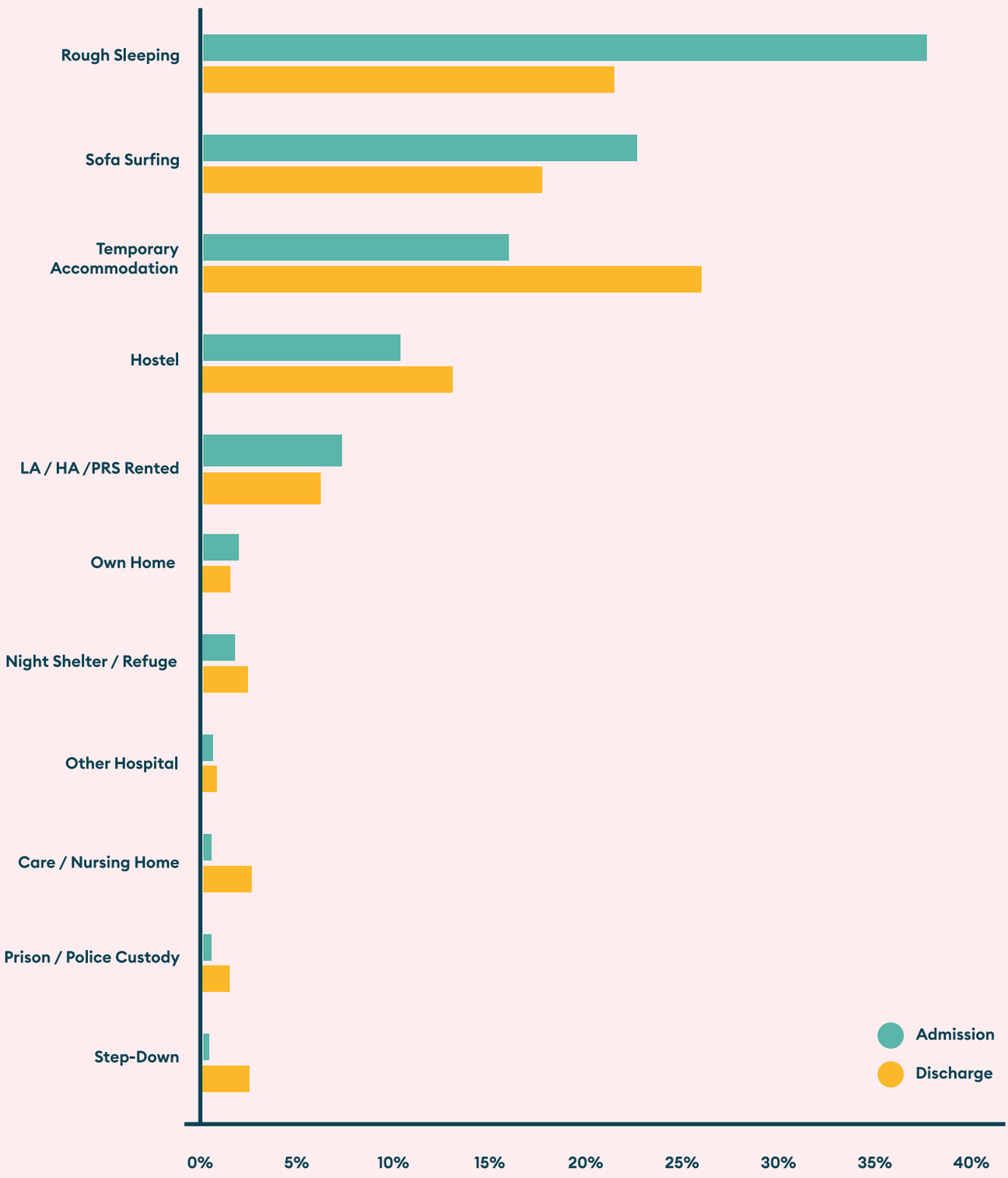
Outcome: across all accepted referrals, 58% (1964/3377) had housing status recorded at both admission and discharge. However, excluding Plymouth (who are currently returning referral numbers only), 69% had both housing statuses recorded.

Housing status data shows a roughly similar distribution of housing status at admission compared to 2022/23, with the same percentages rough sleeping, sofa surfing and living in hostels. 2023/24 saw a slight increase in the percentage living in temporary accommodation (TA) on admission (16% vs 12%) and a lower percentage living in rented properties (7.1% vs 13%). This is perhaps reflective of the reported record numbers of people currently living in TA and continued rises in the costs of renting.

Comparing admission to discharge, rough sleeping was reduced by 43% and sofa surfing by 21%. These figures are lower than what was seen in 2022/23, where rough sleeping was reduced by 50% and sofa surfing by 35%. As with last year, reductions in rough sleeping and sofa surfing were driven by an increase in TA and hostel placements, and discharges to other care settings such as intermediate care, care/nursing homes, and other medical facilities.

Comments: The lower reduction in rough sleeping speaks to the continued and increasing pressure on Local Authority housing services, and the increasing demand on temporary accommodation. These systemic factors seem to make achieving positive housing outcomes for patients more challenging than previously.

Housing advocay - all accepted referrals



Time from admission to referral

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.

Coverage: date of referral and assessment was available for 52% (1769/3377) of referrals.

Quality target: 80% of referrals are seen and assessed within 2 working days of referrals. Outcome: 97% (1709/1769) were assessed within 2 working days of referral.

Comments: compared to last year, improving recording of referral and assessments dates allows us to look at this indicator across a substantial number of patients, as opposed to limited team audits. This quality target is consistently met across teams.

Holistic assessments and care plans

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 personalized care plans that aim to address the complex needs of referred patient.

Coverage: 50% (1688/3377) had holistic assessment outcome recorded, and 49% (1641/3377) had care plan outcomes recorded. Quality target: 85% of accepted referrals receive a holistic assessment and have a resulting care plan documented.

Outcome: 85% were recorded as having a completed holistic assessment and 82% were recorded as having a care plan.

Self-discharges

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 times (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.

Coverage: recorded for 69% (2322/3377) of accepted referrals.

Quality target: regular monitoring and improvement.

Outcome: 14.1% of accepted referrals self-discharged.

Comments: this self-discharge rate is identical to 22/23 (14.2%) and consistent with studies into self-discharge rates for this cohort of patients. Reducing self-discharge continues to be a focus of our quality improvement work across the Partnership Programme.

Delayed discharges

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).

Coverage: recorded for 46% (1566/3377) of accepted referrals.

Quality target: regular monitoring and improvement.

Outcome: 16.8% accepted referrals had a delayed discharge.

Comments: the delayed discharge rate is lower than the 24% recorded in 2022/23, with much higher coverage of this data point.

Chapter 7. Reports and Guidance

During the period covered by this report a number of reports and guidance documents relevant to the work of the Pathway Partnership Programme were published. A summary of each and a link to the full document is provided below.

Out of Hospital Care Fund

This evaluation–published in 2024–reports on the Department of Health and Social Care (DHSC) 'Out-of-Hospital Care Models (OOHCM) Programme for People Experiencing Homelessness' launched in 2020. It provided improvement support and £16 million funding to 17 test sites across England. The aim was to facilitate learning around how to mobilise, integrate, scale and sustain specialist services as part of the D2A hospital discharge and community operating model. The programme ran during 2020-22.

The evaluation reports findings that support the results of previous studies that had demonstrated the benefits of specialist out-of-hospital care services for people experiencing homelessness. Test site services improved outcomes for most patients and were associated with very positive patient experiences and improved quality of life scores. Step-down intermediate care facilities significantly reduced the number of people discharged to the street. Where specialist step-down intermediate care was in place, this figure was between 4% and 5%.

Cornes, M et al. "Evaluation of the Out-of-Hospital Care Models Programme for People Experiencing Homelessness". King's College London, April 2024.
doi.org/10.18742/pub01-178

Discharging people at risk of or experiencing homelessness

In January 2024, the Ministry of Housing, Communities & Local Government and the Department of Health and Social Care published guidance, 'Discharging People at Risk of or Experiencing Homelessness'. It gives examples of good practice, step-by-step guides and tools that can be adopted for local use. In particular, it recommends that specialist housing officers should be embedded in local systems' 'Transfer of Care Hubs'.

"Discharging people at risk of or experiencing homelessness". GOV.UK, January 2024.
www.gov.uk/government/publications/discharging-people-at-risk-of-or-experiencing-homelessness/discharging-people-at-risk-of-or-experiencing-homelessness

Inclusion Health Framework

NHS England's 'National Framework for NHS Action on Inclusion Health' (October 2023), stresses how partnerships across different sectors, including health, housing, voluntary and community sectors, are vital in improving the health of people in inclusion health groups. The framework stresses the role of hospitals and Trusts in ensuring inclusion health groups can access the best possible care and long-term support by collaborating with the other sectors.

"A national framework for NHS – action on inclusion health". NHS England, 2023.
www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/

Intermediate care for people experiencing homelessness: cost benefit analysis - ALMA Economics

This report commissioned by Pathway and delivered by ALMA Economics reports that 32,000 people per year would benefit from specialist intermediate care stepdown and that a universally available service would save £5,200 per patient, £790 in direct savings and £4,400 in reduced delayed discharge costs.

Alma Economics. "Intermediate Care for People Experiencing Homelessness: Cost-benefit Analysis". Pathway, 2024.
www.pathway.org.uk/resources/intermediate-care-for-people-experiencing-homelessness-cost-benefit-analysis/

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Pathway

Homeless & Inclusion Health