# Pathway Partnership Programme Showcase

10th April 2025

pathway.org.uk

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Pathway
Homeless & Inclusion Health

# Welcome!

**Please add your names, organisation and job role in the chat.**

**Feel free to put your questions in the Q&A and we will come to them at the end.**

# Lived Experience Perspective

- Compassion
- Dignity
- Caring
- Thoughtfulness
- Understanding trauma
- Challenging stigma
- Treating people like **human beings**

# About Pathway

**A unique national charity working to improve the health outcomes of people experiencing homelessness, and other Inclusion Health groups, particularly in hospital.**

**By…**

- **Creating and supporting specialist Pathway Hospital Teams**

- **Promoting Lived Experience Voice**

- **Regular reporting e.g. Barometer and Annual PPP Report**

- **Influencing health policy to tackle extreme health inequalities**

# What are we trying to achieve?

Reduce the extreme health inequalities/inequities facing the Inclusion Health population (people experiencing homelessness, people who sell sex, vulnerable migrants, Gypsies and Travellers).

By...

- ✓ collaborative working (maximising benefit of existing services)
- ✓ providing accessible, appropriate, trusted services
- ✓ filling gaps by starting new services
- ✓ working across gaps between services and budgets
- ✓ co-design of services with those who use them
- ✓ reducing need for hospital admission and re-admission

# What is the problem that we are trying to solve?

- Poor outcomes-SMR 10 times that of general population, premature frailty and early death.
- Repeat admissions and attendances.
- D2A/Duty to Refer not working, leading to expensive delays
- Guidance not followed (e.g. NICE 214,discharge guidance, IH framework)
- Poor joint working hospital/community
- Not enough evidence-based interventions (Pathway, Intermediate Care step-down)
- Lack of staff training (OST, withdrawals, Mental Health, housing) so self-discharge or discharge to street follows.
- Staff overwhelmed and need support.
- 4-8,000 hospital discharges to the street annually (11-22 people per day)

# How can we help?

## Pathway Teams:

We support the scoping, commissioning, implementation and ongoing operations of homeless hospital teams.

## Needs Assessments:

- ❑ Gain in-depth knowledge of the health needs of people experiencing homelessness in an area
- ❑ Understand how hospital systems provide care for, manage and discharge people experiencing homelessness
- ❑ Identify gaps in services and recommend potential improvements
- ❑ Forecast the potential health and cost improvements that could be made if a Pathway team or other changes to services are introduced

## Bespoke consultancy:

- **Tell us your needs:** We can customise our inclusion health analyses to explore your specific local challenges.
- **Collaborative approach**: We will work alongside you to help design and deliver service improvements and measure-able outcomes for patients.
- **Commissioners and providers:** We are experienced at working with partners at every level of the NHS.

# What are Pathway Teams?

- Hospital based, clinically led, multi-disciplinary teams
- Clinically led – nurses, GPs, OTs, other specialists
- Housing, care navigators and other expertise available

## What they do:

- Find, support, clinically advocate, and plan safe discharges for people who are experiencing homelessness
- Overarching objective of **improving health outcomes** for patients experiencing homelessness

# Who is a typical Pathway patient?

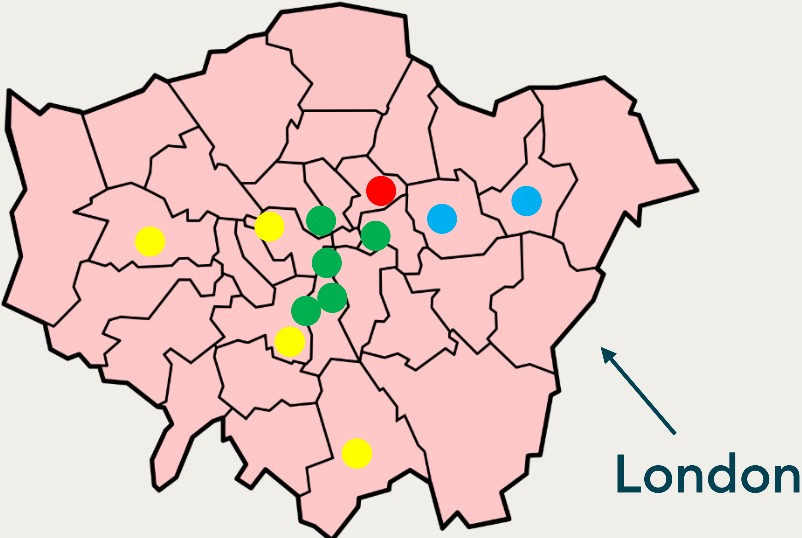
- High rates of **physical health problems, mental health problems and substance misuse**.
- Face **stigma and systemic barriers** to accessing and engaging with healthcare
- Often their **complex health issues cannot be successfully resolved without significant input** from social care, housing, and other support. But without Pathway Teams, there is often a lack of coordination around this.

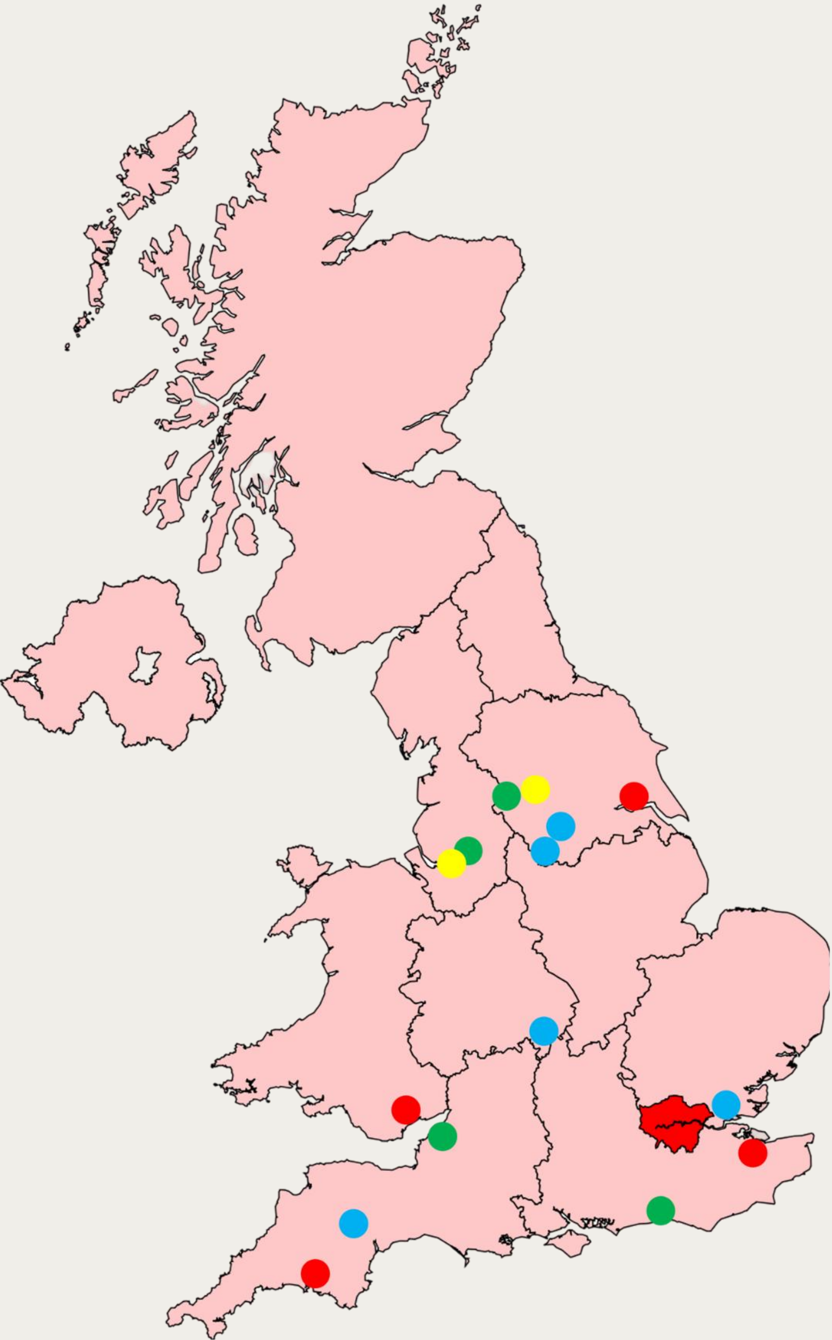
## Who are Pathway Patients?

- Patients ranged in age from 16 – 89 with an average age of 44
- Over 77% were male
- The most common reasons for admission included:
  - Abscess
  - Alcohol withdrawal
  - Assault
  - Cellulitis
  - Chest infection
  - Deep vein thrombosis
  - Drug overdose
  - Leg ulcers
  - Seizures
- At least 40% of patients were admitted for an addiction issue as well as a physical health problem.
- Over 5% of patients are known to have died during the admission or shortly afterwards. The actual number of deaths is likely to be significantly higher as hospitals are often not notified.

# Where are we currently working?

- **5** Partnership Teams
- **6** Previous Partnership Teams
- **9** Legacy Teams
- Needs Assessment and consultancy work



# How We Support Teams: Commissioners and Service Providers

**Building a Case**

- Early stakeholder engagement
- Needs assessment (if needed)
- Support around making a business case

**Service Design**

- Develop service Specification
- Identify partner providers
- Support to engage relevant stakeholders
- Partnership agreements

# How We Support Teams: Implementation

**Commissioner, Provider and Hospital Trust: Service Set-up Support**

- Team recruitment
- Comms strategy, including for launch event
- Advice around practical start-up needs of team
- Baseline data and ongoing data collection process set up
- Two-day team induction training

***All supported by Pathway's experienced multi-disciplinary Team***

# How We Support Teams: Ongoing Support

**Direct Support**

- Initial team training
- Structured monthly calls
- Ad hoc advice
- Annual quality visit
- Support with QI and service development
- Online Operational Manual

**National Network Support**

- Monthly masterclass sessions
- Network of all PPP teams
- Conference
- Specialist professional network opportunities
- Lobbying and system change power of network

**Support to Access / Set-up Locally**

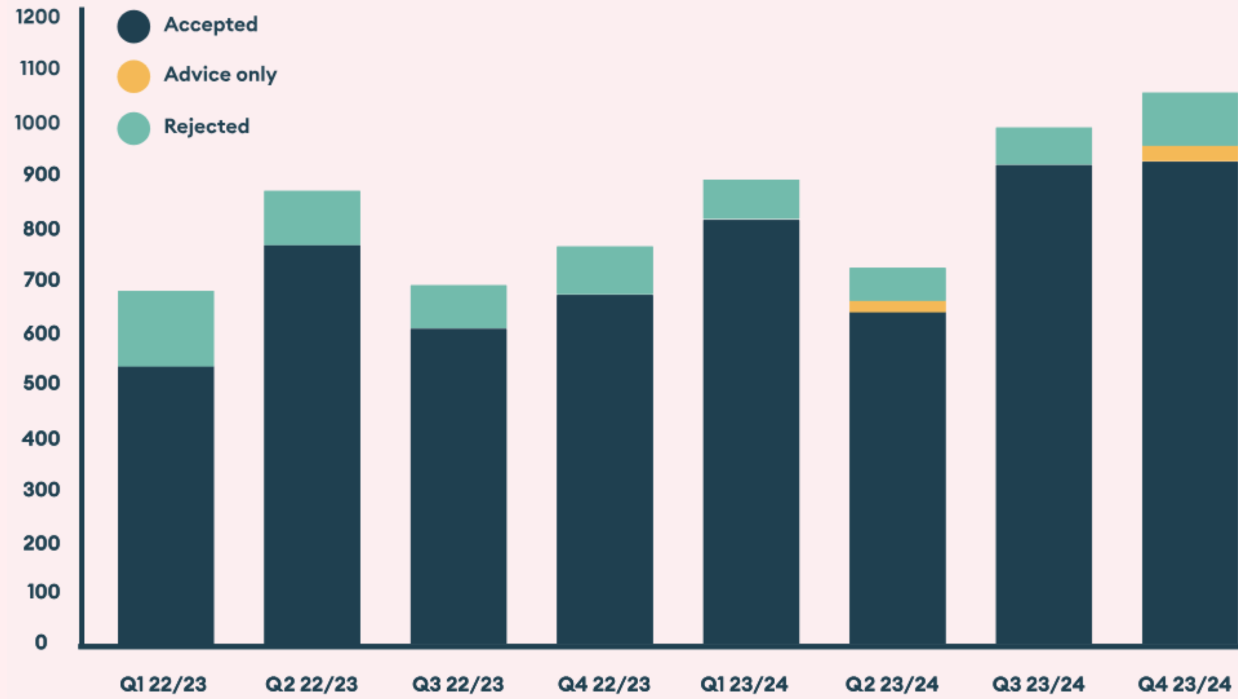
- Reflective Practice
- Legal advice

***All supported by Pathway's experienced multi-disciplinary Team***

# Data & Outcomes

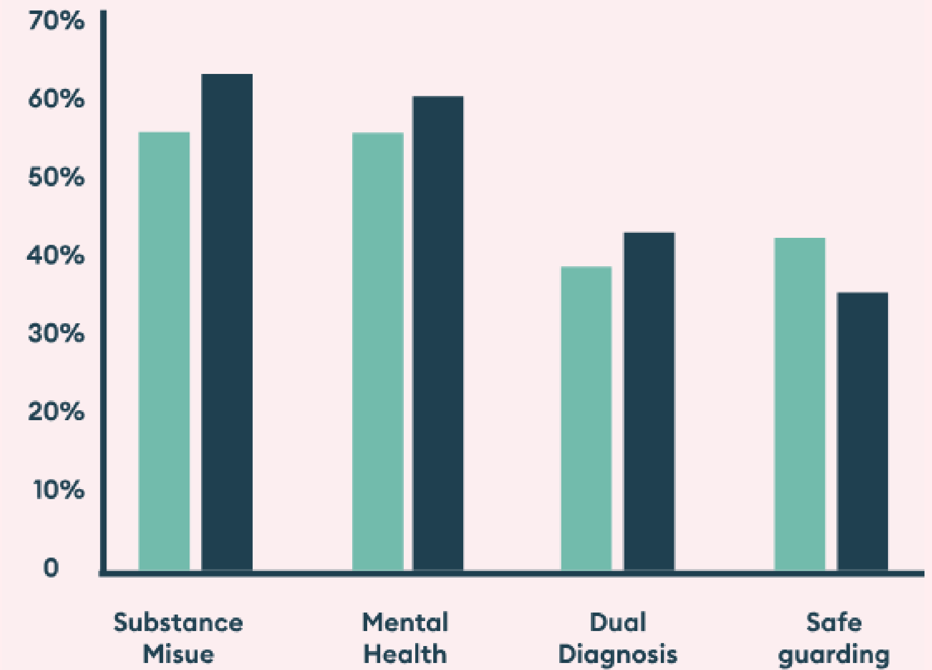
**Pathway provides a range of support to help teams collect data, evaluate and evidence their impact;**

- **Recommended quality monitoring data framework**
- **Working with local IT/BI teams to develop data collection processes**
- **Data analysis and reporting**
- **Materials and support to collect case studies and patient feedback**
- **Detailed annual evaluation reports**
- **Economic/return on investment analysis**




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

## Identified patient needs



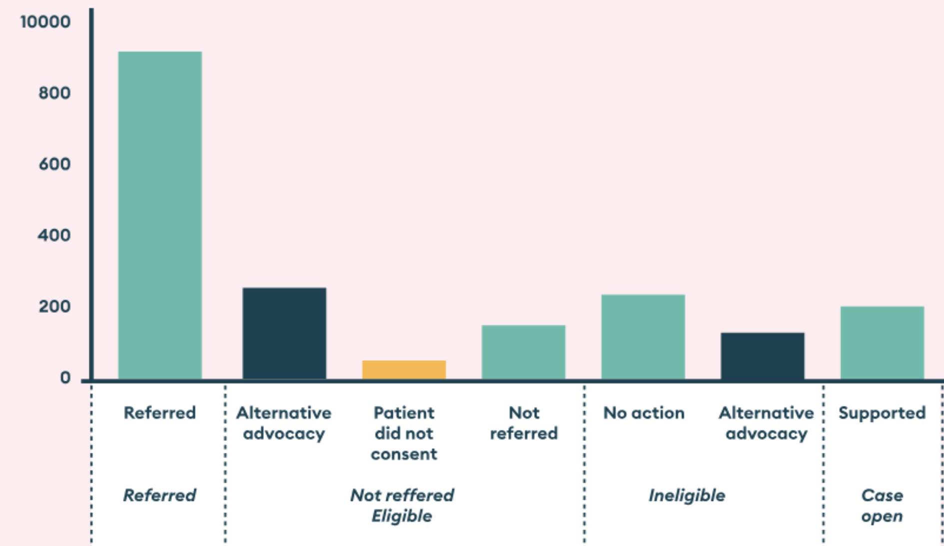
Rough Sleeping
Sofa Surfing
Temporary Accommodation
Hostel
LA / HA /PRS Rented
Own Home
Night Shelter / Refuge
Other Hospital
Care / Nursing Home
Prison / Police Custody
Step-Down

0% 5% 10% 15% 20% 25% 30% 35% 40%

Admission
Discharge

## As a result of clinically-led housing advocacy, Pathway teams achieved;

- **89% of all consenting patients** received housing advocacy, through the Duty to Refer or alternative
- A **43% reduction** in the number of people rough sleeping, comparing admission to discharge
- A **21% reduction** in the number of people sofa surfing
- A **62% increase** in the number of people with temporary accommodation placements



# Other key quality outcomes

85% of all patients seen received a holistic assessment and comprehensive care plan

97% of patients were seen and assessed within 48 hours of referral

255 patients supported to register with a GP

# Financial benefits of Pathway teams

- Costed case studies show **avoided costs of between £6,402 and £17,585 for individual patients,** due to reduced reattendances and readmissions following referral to teams.

- Analysis of secondary care use data from patients seen by Pathway teams show a **66% reduction in the average number of A&E attendances per patient,** and a **61% reduction in emergency admissions per patient,** following team interventions.

- Studies of the Pathway model show a **30% reduction in inpatient bed days used by homeless patients** following the introduction of new teams. On average, Pathway teams saw 422 patients per year, of which 60% were inpatients (253 patients). Across the NHS, the average length of stay for unplanned admissions is 8.3 days, and at £901 per bed day, these patients could have incurred bed-day costs of £1.9 million. Applying the 30% reduction, a single Pathway team could generate **£570,000 in reduced bed day costs alone.**

# Commissioner Perspective

# Questions?

# Next steps

## Get in touch now to explore how you can join our Partnership Programme and start to improve outcomes for this most vulnerable patient group

## Contact us for further discussion:

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# References

1. Hewett N et al. A general practitioner and nurse led approach to improving hospital care for homeless people. BMJ 2012; 345:e5999.

An observational study of the first Pathway pilot, this compared outcomes for homeless patients identified from hospital records (No Fixed Abode, hostel address or registration with homeless practice) for two years before the service began and two years after implementation. A 30% reduction in bed days was observed, with positive feedback from patients and colleagues.

2. A review of the first 6 months of the pilot service.

July to December 2013. Reporting outcomes for 100 homeless A&E frequent attenders showed a 47% reduction in A&E attendances, 48% reduction in admissions and 39% reduction in bed days

3. Hewett N et al. Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'). Clin Med 2016;16(3):223-9.

A two centre NIHR funded randomised controlled trial, at Royal London and Brighton and Sussex University Hospital. Quality of life scores (EQ-5D-5L) improved significantly in the intervention arm and quality-of-life cost per quality-adjusted life-year was £26,000. Street homelessness was reduced, the proportion of people sleeping on the streets after discharge was 14.6% in the standard care arm and 3.8% in the enhanced care arm.

4. Evaluation of the Homeless Hospital Discharge Fund. Homeless Link. 2015.

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

5. Dorney-Smith S et al. Integrating health care for homeless people: the experience of the KHP Pathway Homeless Team. Br J Healthc Manag 2016;22(4):225-34.

Using a comparison group of patients identified as homeless on hospital records before and after introduction of Pathway showed a 9% reduction in A&E attendances, and an 11% reduction in bed days at Guy's and St Thomas' and 56% of patients with improved housing status on discharge.

6. Zana Khan, Sophie Koehne, Philip Haine, Samantha Dorney-Smith, (2019) 'Improving outcomes for homeless inpatients in mental health', Housing, Care and Support, Vol. 22 Issue: 1, pp.77-90.

This study of Pathway in an acute mental health setting (South London and Maudsley Trust) showed 74% of patients had improved housing status on discharge. Comparison with a control group in the hospital has also shown reduced bed days.

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# References (cont.)

7. Bristol Service Evaluation of Homeless Support Team (HST) Pilot in Bristol Royal Infirmary.

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

8. Wyatt L. "Positive outcomes for homeless patients in UCLH Pathway programme"; British Journal of Healthcare Management 2017 Vol 23 No 8: p367-371

This audit examined secondary care activity for homeless patients in the 90 days before and after contact with the Pathway team at UCLH. This showed a 37.6% reduction in A&E attendances, 66% reduction in hospital admissions and a 78.1% reduction in bed days.

9. Gazey A, Wood L, Cumming C, Chapple N, and Vallesi S (2019). Royal Perth Hospital Homelessness Team. A report on the first two and a half years of operation.

School of Population and Global Health: University of Western Australia, Perth, Western Australia. This evaluation demonstrates that the Pathway method is beneficial in other health care systems. Comparing secondary care activity for a year before and after contact with the Pathway team showed $7,302 cost savings per person, or $4.6 million in aggregate.

10. Cornes, M, Aldridge, R, Tinelli, M, Whiteford, M, Hewett, N, Clark, M, et al (2019), 'Transforming out-of-hospital care for people who are homeless.

Support Tool & Briefing Notes: complementing the High Impact Change Model for transfers between hospital and home'. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London, London. https://doi.org/10.18742/pub01-007 This work examines the role of in-hospital homeless teams on outcomes for patients and reports improved outcomes and cost-effectiveness when the Pathway model of clinically-led in-reach is utilised, particularly when used in conjunction with step down facility.

11. Khan Z, McCrone P & Koehne S (2020), "Impact on the use and cost of other services following intervention by an inpatient Pathway homelessness team in an acute mental health hospital", Journal of Mental Health, DOI: 10.1080/09638237.2020.1755017

This work shows that Pathway team intervention in an in-patient mental health setting increases engagement with follow up by mental health, GP, and other community services and reduces service use costs at 3 months to approximately half of the baseline measure.

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