

Closing the Gap through Changing Relationships

Final report for Closing the Gap through Changing Relationships (award holders)

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Lead organisation: The London Pathway

Partner organisations:

- **TB Find and Treat**
- **University College London Hospital NHS Foundation Trust**
- **Barts Health NHS Trust**
- **Brighton and Sussex University Hospital NHS Trust;**
- **Royal Free London NHS Foundation Trust**

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Abstract

Physical and mental health problems are both cause and consequence of long-term, chronic homelessness. Improving physical and mental health can play a major part in supporting someone who is homeless to come off the street. Chronic homelessness is characterised by tri-morbidity, a combination of physical and mental ill health with substance misuse. Bad experiences of health services can reinforce an individual's feelings of isolation and worthlessness. Pathway's aim is to help the NHS transform the way it cares for homeless patients. We focus on innovation in practice not policy.

For hospitals we have developed a simple model of integrated care that puts a homeless patient at the centre. Our hospital teams build relationships with homeless patients who have complex needs, support them as individuals through their time in hospital, and coordinate their care and their discharge from hospital with the many different professional teams who may be working with our patients beyond the confines of the hospital. Pathway care navigators give patients extra support while in hospital. Where the need is greatest we go out with our patients when they leave hospital to make sure there is the smoothest possible handover of their care to community services.

Using our pioneering approach to healthcare for homeless people, we are proud to produce clinically and academically rigorous data that support our dedication to compassion. We influence policy and processes because of our results.

Despite general improvements in the health of society as a whole, the average age of death for a homeless person remains shockingly low – between 40 and 42 years of age – and highlights the fundamental unfairness and injustice inherent in the increasing inequalities of our society. In the face of such odds, we must regain and retain hope that change can occur, by keeping compassion at the heart of everything we do.

1. Introduction

1.1 Background knowledge

Homeless people attend casualty six times more often than the housed population, are admitted four times as often and stay three times as long, resulting in secondary care costs eight times the average. Yet the average age at death for homeless patients is 40.2 years. Tri-morbidity is characteristic; with physical and mental ill health combined with drug or alcohol abuse, in a chaotic life style lacking social support. This complexity often results in friction with specialised hospital teams focused on medical care and a lost opportunity to use the pause caused by admission to plan and coordinate care for the future.

On admission to hospital the homeless patient is usually much more ill than the non-homeless patient, resulting in the average longer stay. In most acute hospitals there was and still is no structured coordination system in place for a group of patients defined by their multiple co-morbidities and social exclusion. The emphasis sometimes seems to be on getting these challenging and difficult patients out of the hospital as quickly as possible, rather than seeking to engage with homeless people about their full range of problems, all of which will be bound up with their reasons for being in hospital. Before the advent of our pilot service there was no hospital-based specialist homeless health service for these patients at all. Homeless patients would be repeatedly readmitted, often discharged without proper planning, and regularly discharge themselves. For homeless people in hospital there is routinely no specialist medical interest and little if any coordination with voluntary sector or other support agencies. Staff might privately admit to being pleased to see them leave.

1.2 Local problem and context

Why University College Hospital?

The initial service was provided at University College Hospital (UCH), a large NHS acute hospital in north London. Patients are admitted to UCH as emergencies by ambulance from all over London; many are visitors to London from all over the UK and from overseas. UCH perceives itself as a provider of highly specialised hospital-based planned care for a wide range of conditions; it does not view itself as a district general hospital responding to the particular needs of its local population.

The rationale for the development and introduction of the Pathway model into UCH was because a homeless man, who had been treated at the hospital many times as a patient in A&E, was found dead on the steps of the hospital. The subsequent investigation found that the hospital had not done anything wrong and there was no hint of neglect, but it was considered that with more care and compassion similar incidents could be prevented. Hence, the Pathway model was created. (See video clip of Prof Aidan Halligan talking more about this on our website: www.pathway.org.uk/video-links/)

Why was a new model of care for homeless patients needed?

There are many good primary care services for homeless people in London and the UK, but they struggle to connect effectively with the hospital sector for a number of complex reasons. Once admitted to hospital the care provided for homeless patients often falls short of the standards expected of our health service. The combination of inattentive hospital care and the lack of proper integration between hospital and community health services can be fatal.

What is the Pathway model?

The Pathway model aims to target this problem, working like a primary care service but based in the acute hospital sector. We work across administrative and institutional boundaries, tailoring services to each individual's needs, with the fundamental aim to transform the dynamic of the interaction between health workers and homeless people, leading to a measurable increase in the quality of healthcare and resulting in improved life expectancy and life chances. Our work starts on the wards or in the A&E departments of acute hospitals, and for this particular project in UCH. During the patient's admission our team liaises with specialist GP practices, housing offices, benefits offices, drug and alcohol outreach services, mental health services and other charitable and statutory organisations that will help improve the outcome for the homeless patient on discharge.

1.3 Intended improvement

What does Pathway aim to do?

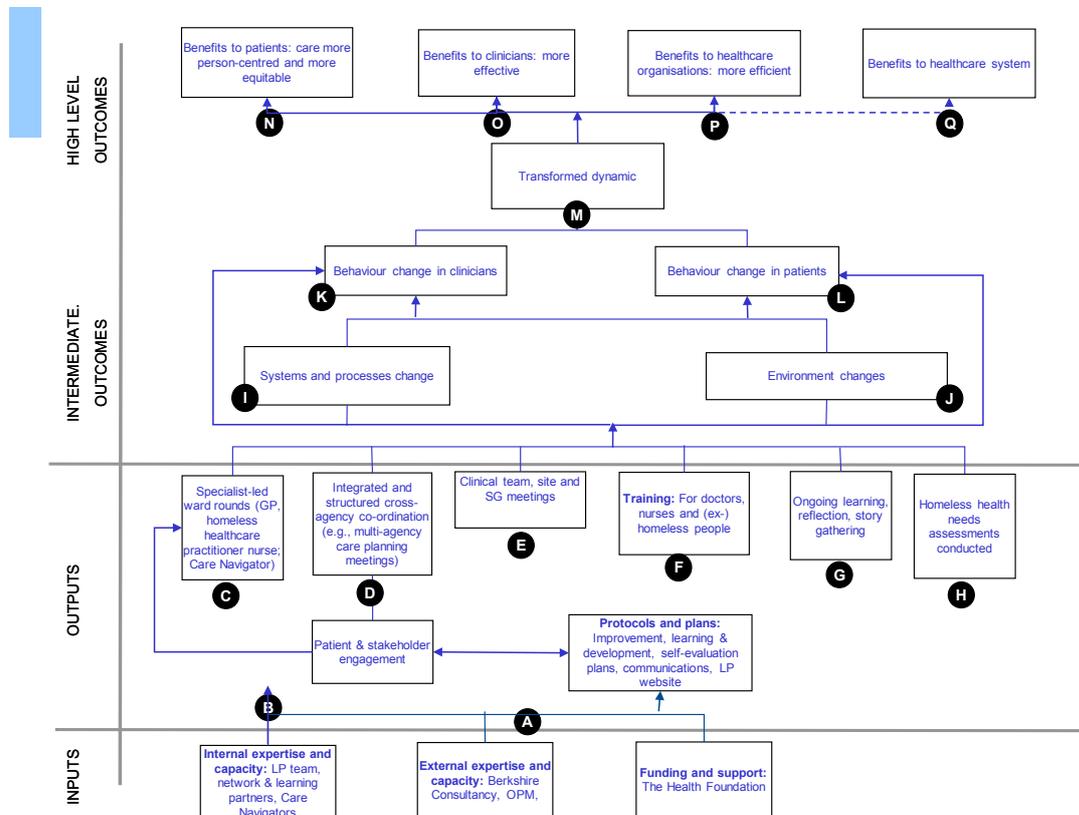
Pathway's overall aim is to transform the dynamic of the interactions between health workers and homeless people, leading to a measurable increase in the quality of healthcare and resulting in improved life chances and life expectancy. The three project specific aims were:

1. Over the life of the project and beyond to transform homeless patients' experience of being in hospital and being discharged from it through transforming the quality of patient/staff relationships, and changing staff behaviours, attitudes and practice.
2. To test, enhance and prove during the project that the Pathway model is both replicable and transferable to other acute trusts with significant numbers of homeless patients.

- To improve connections around patient care between primary and secondary care, leading to long-term reductions in admissions and repeat admissions to hospital. The Pathway model brings compassion and commitment to homeless healthcare, changes how staff across the hospital view homeless patients and changes homeless patients' experience of care. Through our ethos of working alongside and advocating for these most difficult patients, and through our care navigator programmes, we expect to have a wider impact on perceptions of healthcare among the street homeless community.

We aim to transform the dynamic from the first visit from our specialist nurse, who may be supported by a care navigator – a person with a personal experience of homelessness. Our staff establish an empathic relationship with the homeless patient and offer support in hospital continuing after discharge. As a result, the ward sees a patient who is valued by a specialist team modelling core values of compassion, commitment and quality, and gains understanding of the issues. We have regular ward rounds led by a GP from a specialist homeless practice, and this closes the gaps between secondary care and community care and encourages a holistic assessment in collaboration with the patient and brings specialist knowledge of tri-morbidity treatment and community resources. A weekly multi-agency meeting coordinates care, prevents unnecessary delays and fosters a patient-centred collaborative approach which overcomes the usual adversarial interactions between agencies with different values and objectives, such as voluntary sector advocacy, medical treatment, social care and housing support; the patient is put back at the centre of care.

Pathway's logic model



What we expect to happen and why

- A. Relies on effective partnership between CTG team, Berkshire Consultancy and OPM, bringing different sets of expertise to enhance likelihood of successful set-up, with protocols and plans that support effective delivery and ongoing monitoring/evaluation. The protocols and plans then need to inform how the various other outputs (eg training, resources, etc) need to be designed and delivered in a coherent way to support a 'whole systems' approach to change. The Health Foundation, as funder, also needs to be clear about requirements and expectations.
- B. Effective stakeholder and patient engagement will be essential to effective, specialist-led, ward rounds involving care navigators (CNs) and to developing wider buy-in – eg developing pool of CNs.
- C. Employing people with lived experience as CNs, who explicitly use their own experience to inspire and support others, and to influence more positive attitudes in staff, has the potential to transform delivery of health and other services to homeless people, homeless people's experience of healthcare and longer-term prospects.
- D. Success relies on being able to work effectively across sector, institutional, administrative, professional, and patient/clinician boundaries. Overcoming the 'usual adversarial interactions between agencies with different values and objectives' will require buy-in and comment from all sectors/people involved. Besides general references to culture/behaviour change and visible modelling of desired attitudes/behaviours, it is not entirely clear how boundaries will be negotiated or removed.
- E. There are a number of different meetings referred to – it will be important to be clear about the purpose and benefits of these meetings to all who need to attend.
- F. Targeted training builds knowledge and capacity among clinicians and homeless patients. Homeless patients are trained to act as CNs, supporting other patients. Need to be clear about what the training involves, frequency, what trained patient-to-patient support may look like and what support is in place for CNs. Role of CN defined quite broadly. Will negotiation between clinicians and CN about role and responsibilities be required for relationship to work effectively?
- G. Opportunities for reflection and shared learning are built into the Improvement Plan (IP) page 10 (Appendix i), as is the collection of stories from patients 'to illustrate their journeys and the impact of LP services on their experience'. Case studies built on such stories and reflection can be useful tools for engaging stakeholders in the 'emotional' (rather than rational) side of the LP model, which can in turn help with culture change.
- H. Full homeless health needs assessments will be carried out in each of the partner hospitals. Further information about how the needs assessments will inform later processes and, in turn, enable the transformed dynamic, would be useful.
- I. Systems and processes change includes the following.
 - i. Improved admissions processes (staff alert LP when homeless patients present). IP process measures includes collection of data on time taken for admissions teams to notify LP team of presence of homeless patient – IP page 4 Measure 1 (appendix i).
 - ii. Improved discharge: unplanned self-discharge means links with wider support networks difficult to put in place and can lead to increased readmissions. IP process measures include collection of data on unplanned discharges – IP page 4 Measure 2 (appendix i).

- iii. Reduction in readmission of homeless people: IP process measures include collection of data on number of repeat admissions and time from discharge to second or subsequent readmission – IP page 4 Measures 3 and 4 (appendix i).
 - iv. Closing gap between secondary and community care: increased recognition and understanding of multiple needs (eg housing); improved and increased multi-agency work and development of wider support networks are vital to achieving this – IP, Stakeholder Engagement and Communications proposals (appendix i).
 - v. CN role becomes integral to the delivery of care for homeless patients: recruitment processes are more streamlined and efficient – IP recognises challenges here, page 17 (appendix i).
- J. Clinicians and staff within the healthcare organisation can change the physical environment (perhaps with input from patients and core team) to enable clinicians to act in a more effective and person-centred way, and to enable patients to complete treatment and reduce self-discharge. Part of the transformation of homeless people’s experience will involve being treated with dignity and having their personal (as well as direct clinical) needs cared for, which could mean small changes to their immediate physical environment. Clinicians may be enabled to change their behaviours directly through the activities and outputs (C to H) and indirectly through I and J. It will be important to assess whether behaviour change is sustained over time, and to identify the factors that enable this.
- K. Patients may be enabled to change their behaviours directly through the activities and outputs (C to H) and indirectly through I and J. It will be important to assess whether behaviour change is sustained over time, and to identify the factors that enable this.
- L. The level at which the dynamic changes might be that between the patient and the clinician, or at the organisation level or at the wider system level (high level outcomes). For each enabler, we need to be able to specify the level of transformation: different enablers might support transformation at different levels. As noted below (Q), transformation at the wider system level is unlikely to be achieved during the funding period. However, it will be important to try to understand the enablers of wider system change in order to generate narratives about these higher level outcomes, even if we are not able to measure them.
- M. The transformed patient–clinician dynamic is intended to bring about patient-level outcomes that include increased levels of satisfaction with the transformed dynamic and also being more in control and empowered (eg measured by PEI, CARE or discourse analysis).
- N. The transformed dynamic is intended to bring about clinician-level outcomes that include levels of satisfaction with transformed dynamic as well as measures of effectiveness.
- O. The transformed dynamic, through improvements in the four enablers discussed above, is likely to lead to organisational-level outcomes in terms of improved efficiency. We will identify proxy measures, and efforts are underway to identify more direct measures of organisational efficiency. The team is also exploring with OPM the extent to which some form of economic evaluation may be conducted to demonstrate efficiency or cost avoidance through the improved consultation dynamic.
- P. It is clear that the emphasis (at least during the funding period) is on achieving the transformed patient–clinician dynamic. Realistically, therefore, the focus on impact is unlikely to extend beyond patient-, clinician- and organisational-level. Nonetheless, the team have started thinking through how (and in what ways) wider system-level impact may be achieved.

The interface between the more immediate impact likely to be experienced by the clinicians and patients, and the more diffused impact for the wider healthcare system is, however, being mapped. The IP plan suggests some potential hindrances to spreading the model – page 12, points 8 to 11 (appendix i) – and it is clear that stakeholder engagement will be crucial to wider uptake of the Pathway model. Key messages for different stakeholder groups have also been identified – IP page 13 (appendix i). Tests planned with the Royal London and Brighton, to see how quickly their staff teams begin to contact the Pathway team and communicate their progress – IP page 3 (appendix i) might also provide valuable information about how to effect wider system change.

1.4 Changes along the way

The basic intervention has not changed, but publication of results from our continuous improvement process showing a 30% reduction in bed days has resulted in National Institute for Health Research (NIHR) funded projects at Royal London and Brighton and Sussex University Hospitals, and a Quality Innovation Productivity, Prevention (QIPP) funded project at Royal Free with further services planned for Bradford, Manchester, Guy's and St Thomas', King's, and South London and Maudsley Mental Health Trust. This has required coordination and support visits to newly established teams then quarterly meetings of all Pathway teams to provide mutual support and share learning. The issue of dealing with patients with personality disorder has resulted in plans for regular psychologically supported reflective practice for all teams and these are scheduled to begin in July 2013.

We have also developed further our training package for care navigators. This is now a modern apprenticeship opportunity for people with lived experience of homelessness, and requires the trainee to commit to a year of paid work and study at the end of which the apprentice will have a recognised, accredited (level 2 or 3) Diploma in Health and Social Care.

2. Methods

2.1 What was the intervention?

The Pathway model was the introduction of a specific team of staff into a hospital. The role of the team was to support and advocate for homeless patients during their hospital stay and also to support the hospital's core clinicians and nursing staff, with the specific aim of bringing about better health outcomes for the homeless patients, and to make a hospital stay a better experience. We also wanted to help clinical staff in the hospital understand and be more compassionate to the needs of this vulnerable group of patients. The model brought together primary care and secondary care with the introduction into the hospital of a GP specialised in treating homeless patients who would lead the Pathway homeless team. The GP was supported in the hospital by one or more homeless health nurse practitioners – experienced, senior nurses who are chosen for the compassion they show towards the most vulnerable patients. In addition, the team would have trained and trainee peer support workers: care navigators who have personal experience of homelessness and who work with the homeless health nurse practitioners to ensure that all the needs of the homeless patients are met as far as practicable.

2.2 Pathway's model of healthcare

Our model of healthcare that has been used with these patients can be summarised as:

The hospital pathway

A Pathway hospital team is led by a specialist homelessness GP who is supported by a specialist homeless health nurse practitioner and a Pathway Care Navigator.

1 THINK HOMELESSNESS!

Check housing status for all patients on admission. If homeless, in a hostel or in temporary or insecure housing, refer to the Pathway team.

2 HOMELESS TEAM COORDINATES CARE

The Pathway homeless health nurse practitioner needs assesses patients and then works with the patient to create their individual Homeless Care Plan.

3 CARE PLAN MEETING

Following weekly homeless paper ward rounds, the Pathway team works with complex needs cases to create and manage a multi-agency care plan, including possible referral for respite centre assessment.

4 COMMUNITY SUPPORT

Care Navigators work with the patient to plan community support, including taking the patient to a new placement or housing option and afterwards handing care over to community teams.

2.3 Was anything else added to the service at UCH?

At UCH, where the core project is up and running, we have added a number of specific elements to the project, each of which we are evaluating as a specific innovation, and from which learning will be made available to our partner organisations. These include:

- i) Ex-homeless care navigators included in our team in the hospital. We believe their introduction to the team helps reduce repeat readmissions. Our qualitative survey activity with hospital staff measures the impact of this enhanced resource on staff experience and attitudes across the hospital and how dynamics around homeless patients change.
- ii) From our regular and growing contact with clinicians across the hospital, we instituted a structured process to capture meaningful anecdotes that illustrate clinical attitudes towards homeless patients and the changes to those attitudes over the life of the project.
- iii) To ensure the earliest possible notification of the presence of a homeless person in the hospital, we introduced additional training for hospital nurses in the relevant wards to encourage more sensitive questioning about home addresses and their viability as a home to return to. Our measure for this is the achievement of a reduction in time taken to notify the Pathway team of the admission of a homeless patient.
- iv) We have introduced more structured Pathway team meetings with regular reporting on our own data and reflection on practice and individual cases.
- v) Other small interventions have been introduced over the course of the project and these were subject to a PDSA (ie Plan, Do, Study, Act) cycle where appropriate.

2.4 Who is in the Pathway team at UCH?

In UCH, the Pathway team consists of:

- a specialist GP, initially Dr Nigel Hewett, and from 1 July 2012, Dr Tim Robson
- two homeless health nurse practitioners – Trudy Boyce and Florence Cumberbatch

- one care navigator, Josie Mavromatis, who received hands-on training from March 2011, and who from 1 April 2013 is starting an accredited Level 3 Advanced Apprenticeship in Health and Social Care with the London Pathway
- another trainee care navigator spent six months with us during 2012
- Dr Nigel Hewett, Pathway's Medical Director, oversees the work of the team.

2.5 Who are the stakeholders to the Pathway project?

The main stakeholders for the project and their roles are:

- Pathway GP deployed on UCH wards – advocates for the patient's treatment with hospital clinicians; will seek delay in discharge if deemed necessary; will provide written intervention for housing; will provide ongoing support for rehabilitation of the patient
- Pathway homeless health nurse – ensures high quality nursing care and support is given to the patient; seeks a 'housing solution' for the patient on their discharge; leads the multi-disciplinary team (MDT) meetings; facilitates links to other stakeholders; records statistics to be able to assess continuous improvement; will assist A&E staff when homeless patient attends but is not being admitted
- Pathway care navigator – befriends and mentors homeless patient in hospital; accompanies patient to new home and makes sure they are settled in; assists with the completion of benefit forms; provides clothes for patients; accompanies patients to follow-up appointments after discharge; supports Pathway's homeless health nurses and GP
- UCH employed clinicians – provide medical care, prescribe treatment and decide when fit for discharge
- UCH employed nurses and health assistants – provide nursing care and support to homeless patients
- UCH management – facilitates and supports the Pathway team in their work
- homeless patients admitted to UCH and attending A&E – receive the Pathway model of care
- staff from statutory and other health agencies and charitable organisations that are involved in the MDT meetings: these include housing providers, specialist homeless GP practices, outreach teams, organisations running rehab programmes for alcohol and drug addiction, Department for Work and Pensions, social workers – implement the care plans and packages for individual homeless patients developed with the Pathway team
- Pathway staff employed on other hospital sites (Royal London, Brighton and Sussex and Royal Free) – learn from the experience at UCH and share any different experiences from their own sites
- core Pathway staff and trustees – support and oversee the service at UCH, including providing project management of the specific project; facilitate the sharing of learning from specific services across all Pathway sites; promote the learning and services to new sites to ensure sustainability and spread.

2.6 Services beyond UCH

Beyond UCH, we have spread the service into the Royal London and Brighton and Sussex Hospitals; these are both NIHR-funded randomised control trials (RCTs), which will end in June 2013. We have also introduced a one-year pilot service into London's Royal Free hospital which is funded by the hospital's QIPP programme. As a result, we have trained an additional four specialist GPs and three specialist homeless nurses into the Pathway model. We are currently working with Bevan Healthcare CIC to recruit a nurse and specialist GP to work on the development of a needs assessment and pilot service in Bradford.

3. Results – outcomes

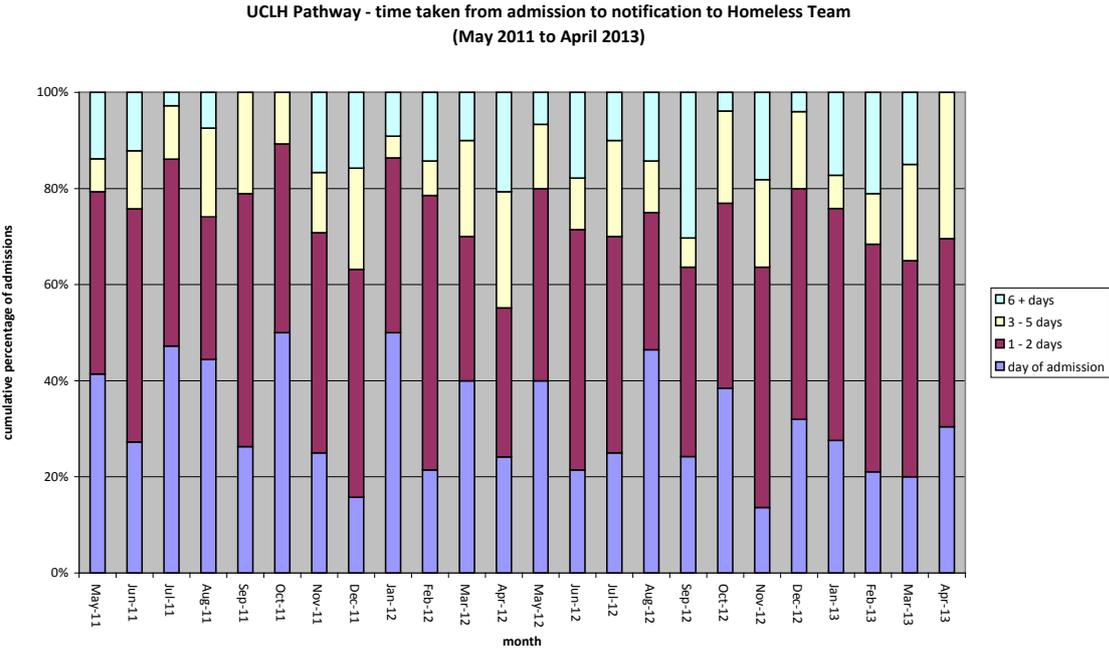
3.1 How did we measure the outcomes of the Pathway project on changing relationships and improved quality of care?

We selected eight outcome and process measures to use to measure our outcomes and impact, and the detail of these and the results are listed below.

Measure 1. Time from admission to notification to Pathway team – *Delays in notifying our team of the presence of a patient who is homeless in the hospital reduce our time to work with them and therefore our chances of improving outcomes; a good number of patients’ homelessness emerges during their admission but we believe more sensitive admission procedure, and greater awareness of homelessness among staff throughout the hospital should lead to more patients disclosing their homeless status earlier in their admission. This is therefore both a process measure and a measure of wider staff awareness.*

What we recorded and what it showed

We have recorded the date of admission of the patient to hospital and the date that the Pathway team were notified of their presence, and calculated the time lag. The results of this measurement can be seen in the following chart, but generally it can be seen that for every month since the start of the project, we have been notified of the presence of most homeless patients within two days of their admission to hospital:



More detailed analysis of this measure

There have been 578 admissions of complex homeless patients referred to Pathway in the two years since May 2011. In this period, 74% of homeless patients have been notified to Pathway within two days of admission. As can be seen in the chart above, the percentage of admissions notified to us within two days has been above 60% throughout the period measured, except for April 2012 when it dipped below. The high rate of referrals is testament to our success in ensuring staff across the hospital know about our service and to refer patients to us, and also the diligence of our staff in checking the records of admissions to see if patients we know are homeless have been admitted to hospital. However, inevitably in a big hospital there are occasions when a patient will slip through the net and we have no way of knowing how many of these there are. But we continuously try to find different ways in which to publicise our service

to ensure that new staff are aware of our work and the need to refer homeless patients to us. These have included our homeless health nurse practitioners and care navigator giving talks and presentations to groups of nurses in the hospital, and our medical director giving a talk about the Pathway service model to groups of new doctors as part of their induction.

Occasionally, there are patients who 'become' homeless while in hospital – this may be because they declare they are homeless just before they are discharged or it becomes apparent when preparations are being made for their discharge that they cannot return to the address they gave when admitted to hospital. These patients are notified to Pathway at this point of their admission, and these notifications have been included in the 6+ days statistics illustrated in the chart. In the period covered, there have been 18 admissions, equivalent to just over 3%, where the patient has been in hospital more than 20 days before the homeless team have been notified of their presence – there can be no improvement measure applied to these cases because the delay is caused by change in circumstances, rather than lack of action by hospital staff. However, the support given to these patients after they have been reported to the team includes helping them, wherever possible, to secure accommodation and access benefits on discharge from hospital, and this is considered to be an improvement.

It is not possible for us to explain how specific interventions have impacted on changes to the data for this and other measures, because we are unable to establish a meaningful relationship between specific things we have done and particular events within the data. The nature of our work means that change happens through a slow build-up of ongoing activities rather than through major interventions that have an immediate impact on the data.

Measure 2. Number of unplanned discharges (self-discharges against medical advice) – *An unplanned discharge (against medical advice and with incomplete liaison around discharge) is a measure of failure around our patient group. Capturing this measure will allow us to reflect on where things go wrong in individual cases.*

Why we chose this measure and the overall results

At the start of the project, we decided that homeless patients may be likely to discharge themselves against medical advice, and thought that our intervention might reduce this activity. The results show that over the life of the project there have been minimal discharges against medical advice, and therefore we are unable to conclude whether our intervention has contributed to an improvement.

Detailed analysis

There have been just 13 unplanned discharges (self-discharges against medical advice) since May 2011. This represents 2.2% of all discharges of patients referred to the Pathway team at UCH during the period. There were five fewer self-discharges in the period May 2012–April 2013 than in the previous year. However, because of the nature, vulnerability and complexity of Pathway's patients, and because of the small absolute numbers of Discharge Against Medical Advice incidents, it is hard to know whether Pathway's intervention has contributed to improvement on this measure.

Measure 3. Number of repeat admissions – *A key measure for Foundation Trusts in the NHS. The overall impact of the Pathway service should be to reduce readmissions through improved quality of care on the first admission and better discharge planning.*

What we recorded and what it showed

From the start of the project, we recorded the date of a homeless patient's first and every subsequent admission, and calculated how long had elapsed between admissions. Overall, our data shows that for the first year there was a significant downward trend in patients being readmitted, although this appeared to be reverse slightly in the second half of 2012. This could be because only the more complex patients are being referred to the Pathway team, as hospital staff are becoming more confident in dealing with routine homeless patients, but overall the downward trend seems to have continued. We have also seen a slight downward trend overall in patients being readmitted within 30 days of discharge.

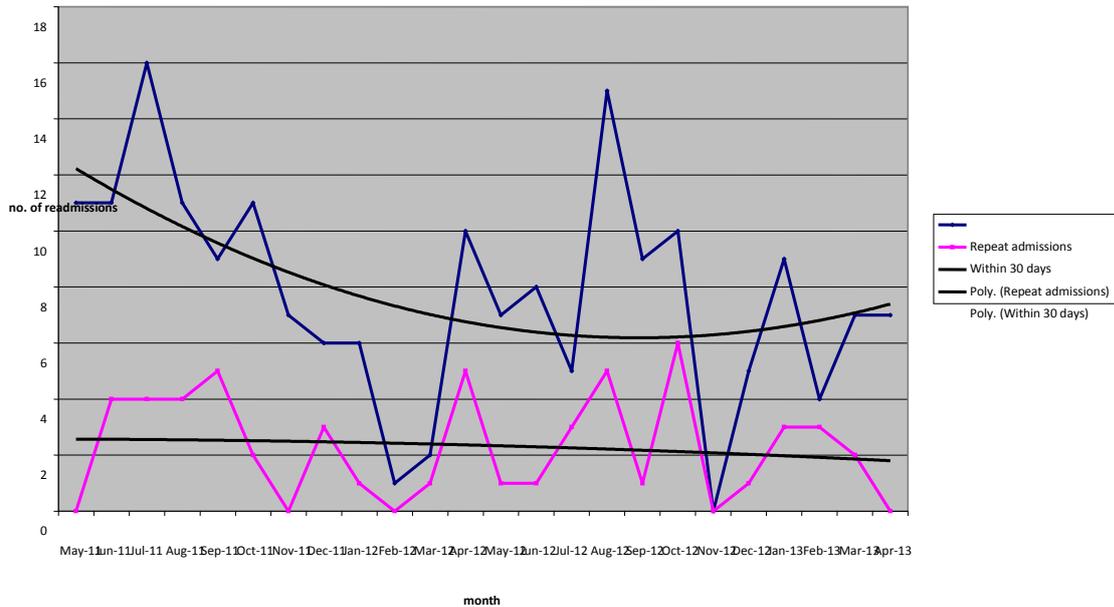
Detailed analysis and conclusions

In the first four months of 2013 there were eight readmissions within 30 days, the same number as in the previous four months and compared with 10 in the four months before that. Looking back over the two years, less than 30% of readmissions of homeless patients referred to the homeless team were within 30 days of discharge. Quarter by quarter this percentage varies between 21% and 46%, with 26% being recorded in the most recent quarter. It doesn't appear that Pathway is routinely reducing the rate of readmission within 30 days. Also, we know that during the first quarter of 2012, a number of homeless patients who should have been notified to the Pathway team were not, and although we do not have the exact figures for these, we do not think these omissions make significant differences to our overall trend, which appears to be downward. The omission was because these were less complex patients, where a UCH nurse dealt with their care needs at discharge without reference to the Pathway team.

The following chart shows the numbers of patients readmitted who had been referred to the Pathway team previously, and also shows numbers of patients who were readmitted within 30 days of discharge. Over the two years, a significant decrease in year on year total readmissions is noted: 101 readmissions in the year ended April 2012 and 86 readmissions in the year ended April 2013. The particular low points in February and March 2012 are probably due to some homeless patients not being referred to the team when they should have been. However, the referrals are back on course, and the chart shows a small peak in June, which fell back in July, with a larger peak in August, which again fell back in September. In the most recent six months, the readmissions have fallen back significantly with no readmissions recorded in November 2012. However, the figures are small, and one additional admission shows as a significant peak in the chart. The cause for the variances could be multi-factorial, as discharge is dependent on multi-agency coordination and the individual's social and psychological status. Readmissions could also reflect clinical needs.

The trend lines show that the number of readmissions within 30 days over the duration of the project is consistent, whereas the total number of all readmissions recorded has tended to reduce. This data cannot reveal what would have happened without the Pathway intervention.

London Pathway - UCLH repeat admissions of homeless patients May 2011 to April 2013



However, the data that we record includes only the patients who are re-referred to the Pathway team at UCH. If the patient is readmitted to UCH with an address, they are unlikely to be referred to the Pathway team, and it would be only if Pathway staff picked them up during one of their trawls of the hospital-wide database that this patient may be seen again by the Pathway team. Similarly, if the patient was readmitted to another hospital we would be unaware. Therefore, although the trend during the two years has been in the right direction, it is impossible to conclude whether and how far having a Pathway service in a hospital impacts on the readmission of homeless patients.

Measure 4. Number of times LP staff called to assist in A&E (with a patient) – LP service works with admitted patients but aims to change relationships around patients in all parts of the hospital, including A&E. We now provide regular support in A&E working with regular homeless attenders.

What we recorded and what it showed

We recorded details of the patients who we were called to see in A&E. At the beginning of the Pathway service in UCH we were not working in A&E, and the clinicians within A&E were sceptical of our presence in the hospital. However, it can be seen that over time our presence and skills have been accepted and calls to Pathway staff for help with homeless patients in A&E have generally increased. We conclude from this, and also from the more welcoming attitude and gratitude for our help, that the A&E staff are now convinced of the value of our presence.

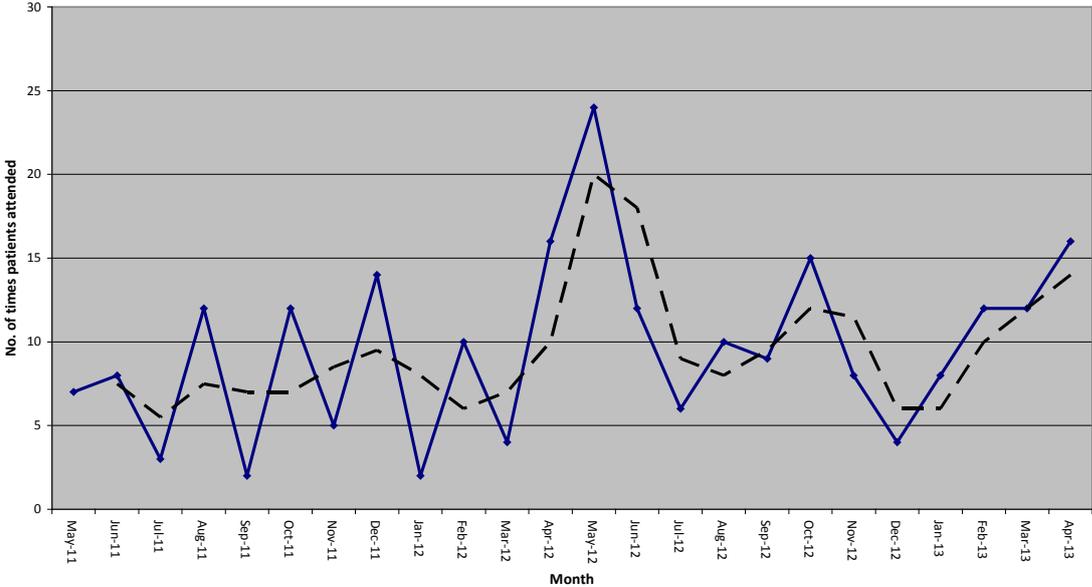
A recent development has been following up homeless discharged patients by encouraging them to return to the discharge lounge of the hospital to seek help with benefits, housing or medical appointments rather than Pathway’s staff visiting them in the community, which is very time consuming for our small team. We started to collect data on this activity in April 2013.

Detailed analysis and conclusions

The following chart shows the number of times Pathway’s staff at UCH have been called to assist with patients in A&E. Although the number of occasions varies month on month, the trend line shows a relatively even track, falling off slightly at the end of 2012 but rising again in

2013. In the second quarter of 2012, there was a significant increase in the times Pathway staff were called to attend A&E, and although this has fallen back slightly since then it is still significantly higher than in 2011. This could be as a result of hospital staff being more aware of the benefits of intervention by Pathway staff. However, there is only a small Pathway team at UCH, and when one of the two nurses is away, as one was for the whole of July 2012 and again in December 2012 and January 2013, inevitably there is an impact on how often we can attend calls to homeless patients in A&E. This could account for the dip in number of times patients were attended over these periods.

London Pathway - No of times Pathway Staff attend patients in A&E May 2011 to April 2013



In April 2013, we recorded 12 homeless patients who had been discharged from hospital visiting the discharge lounge over 21 visits, seeking help with benefits, housing and other associated issues.

Measure 5. Patient satisfaction at discharge and broad clinical attitudes to homeless people –
We planned to test this in a number of ways, including using an agreed set of standard patient satisfaction questions which included feedback on staff attitudes. We were also keen to find out about staff attitudes to homeless patients because this is extremely important for compassionate healthcare and we planned to quick poll junior doctors’ attitudes at the beginning of their rotations and at the end after they have been exposed to Pathway staff at work. We planned to use the questions tested on junior doctors in surveys with other staff groups in the hospital.

What we tried to measure and the results

We started off by running patient satisfaction surveys and before and after surveys of junior doctors’ attitudes to homeless patients at their placements with UCH. Neither of these gave us conclusive results, partly because of the small size of the samples but also because patients are often extremely grateful to clinical staff at the time of discharge, and we were unable to run follow-up surveys because of the mobile nature of our patients. Therefore, we decided to rely on capturing unsolicited feedback and commissioning interviews of patients and clinicians to prove Pathway had made a change to how homeless patients view clinical staff and vice versa. This work is still ongoing and we have not got conclusive results, although we have captured many positive comments.

Detailed work and analysis

For both of these measures, we have trialled surveys. Firstly, surveys of Pathway patients being discharged were conducted during the period September to December 2011, and although responses were generally very positive, because of the small number of responses we were able to achieve we were unable to draw firm conclusions about the impact of Pathway's services on the patients. Secondly, we have twice run surveys of newly recruited junior doctors; these consisted of a set of questions at the start and end of their placement. For the second end survey, we received only one response, which indicates that the people involved cannot see the point of responding. Due to the poor responses, we decided to stop surveys as a way of capturing this attitudinal information. Instead, we used storytelling to capture experiences and attitudinal change – through interviews captured on film or as case studies.

Meanwhile, we continue to capture unsolicited feedback from people associated with our work, and specific examples are set out below.

'I had been wondering if a career in medicine was right for me – now I see that it can really be worthwhile.' **James Smith, medical student** who did a six-week elective attachment from Newcastle University from 3 January to 10 February 2012

On 17 February 2012, Dr Hewett gave a lecture to second year medical students at Leicester Medical School about the Pathway's approach to healthcare for homeless people. Following that lecture, one of the students said: 'thank you, you have restored my faith in medicine as a profession'.

'... could you send my congratulations to the team working in this area? I'm so pleased we have these people working so passionately and caring in our Trust – their work is inspiring and makes me so proud to be associated with the Trust ...' **Fiona McKenzie, Lead Governor, University College of London Hospital NHS Foundation Trust**, following the visit and associated publicity of the Minister for Social Care, Paul Burstow MP, to Pathway's service

'Excellent services provided at UCH' **Prof Steve Field, Chair of National Inclusion Health Board**, speaking on Radio 4's Today programme on 28 May 2012, the day that guidance on hospital discharge for homeless patients produced by Homeless Link and St Mungo's was launched and Paul Burstow MP visited the Pathway ward round

'Working with the Pathway team at UCH has been a hugely beneficial, varied and exciting experience. The team have a very holistic approach not only to the patients they see every day but to homelessness as a wider issue and it was very inspiring to see how they used their practical knowledge to inform and shape their plans for future services.' 'I feel privileged to have had the chance to work with the UCH team and am very grateful for their time, support and enthusiasm. I also greatly benefited from Dr Hewett's academic support and help with organising service visits.' **Eleanor Whittles, mental health student nurse** who did a placement with the Pathway team

Dr Les Goldman, Medical Director of Bevan Healthcare Community Interest Company in Bradford commented that more than anything the values of the service shone out on the London Pathway's website and that compassion and caring were clearly highlighted. He told Dr Hewett that he wants to set up a Pathway service and collaborate with us, and will be in touch. This was at a conference in Liverpool that Dr Hewett attended, and subsequently we have submitted a successful bid for funding to the Department of Health's Innovation Fund to spread the Pathway service to Bradford in partnership with Bevan Healthcare CIC

'Working as part of a team improves outcomes for homeless patients and this applies to all areas of medicine.' **Lucy Weatherall, medical student** on elective attachment for four weeks in June/July 2012

'I have gained a deeper understanding of the impact of poverty on ill health.' **Alex Rouse, medical student** on elective attachment for eight weeks in August/September 2012

'Fantastic service' **Deborah Fortescue, CEO Brain Injuries and Disabilities Trust** during her visit on 16 August 2012

'For the first time since joining the *BMJ* you made me wish I worked in healthcare.' **Harriet Vickers, Assistant Multimedia Editor** at the *British Medical Journal (BMJ)* following interviews with staff and patients at UCH Pathway service

'Many thanks for taking the time on Wednesday to explain your work to me. I was very interested to learn how you and the team operate and was very impressed by the service you offer to our homeless patients, many of whom seem to present with the most complex mix imaginable of physical, mental and social issues. It was particularly striking to meet the two patients and hear about their issues. All in all, the whole session was a real eye-opener for me and very thought-provoking at a number of levels! I look forward to hearing how your bid for funding from the trust goes and also to following how things develop in the trials at RLH and in Brighton. Let's stay in touch. Please pass thanks to the others.' **Richard Murley, Chairman, UCH NHS Foundation Trust**

'... I've learnt a lot more about the effects of homelessness on health and the kinds of barriers homeless people face in accessing healthcare and housing. Until now I'd seen that, although homeless patients might receive appropriate medical care in hospital, the planning for discharge was often less than ideal, with the real issues bypassed in order to ease the burden of perceived complexity. The Pathway team seem to remedy this situation, with time and effort spent getting to know the reason for a patient's homelessness, approaching it in the way other hospital teams would approach cases within their specialityI've been inspired by the team's concerted efforts to do "all it takes" to find a solution for a patient, with Josie (care navigator) and Trudy (senior nurse) often spending entire days with patients, supporting them in attending their appointments or helping them move into new residences.' **Emily Dobell, fifth year medical Student, University of Nottingham** on elective placement with Pathway homelessness team at UCH, 25 March – 19 April 2013

In a video interview entitled *The King of London*, a Westminster drug worker talks about a complex patient who has a history of 100–150 admissions to St Thomas' hospital, all lasting 24 hours or less, who was admitted to UCH and referred to the Pathway team. As part of that admission, the drug worker was able to work with the team to sort out the patient's medication and to ensure it was settled and appropriate by the time of discharge. Also, that the team was able to give reassurance and gain the patient's confidence that he would be found a place to live and not be discharged back to the street. He concludes that if the Pathway team had not been in place there was 'a fair chance that he would not have stayed in hospital'. Following discharge this patient was housed in a care home in Somerset and appears to have settled there. The full edited video interview is part of the suite available on our website: see www.pathway.org.uk/video-links/

As part of their coverage of the Pathway service, the *BMJ* interviewed one of our long stay patients and part of his interview is included in a podcast on their website: a link to this can be found on our website (<http://www.londonpathway.org.uk/index.php/news/>). In the interview, he talks about the specific things that Pathway staff did for him including getting a copy of his birth certificate so that he could access benefits, giving him TV cards to keep him interested during his stay, giving him clothes and befriending him and taking an interest in his family and background. He concluded the interview by saying 'they've been really good to me'.

On 18 September 2012, a Grand Round case discussion of a complex case was held at UCH. It was organised by an immune team consultant, and attended by three consultants with entire junior doctor and medical student teams for infectious diseases, tropical medicine and immune team. The purpose was to address and improve the negative attitudes of some junior doctors, which were revealed following a complaint from a member of the public concerning a homeless patient. In the complaint, the homeless team was praised but the attitude of junior doctors in the hospital was challenged. The consultant team provided excellent feedback following the discussion and thanked the homeless team for their contribution.

We have a range of video interviews of Pathway staff including with: Trudy Boyce, Pathway's homeless health nurse at UCH, talking about her experiences with homeless patients; Dr Tim Robson, who covered the consultant GP role at UCH from July 2012 to the end of March 2013, talking about his experiences with the Pathway team; Florence Cumberbatch, the UCH employed nurse working on Pathway; a Westminster drug worker who talks about his experience of Pathway working with one of his complex clients; Josie Mavromatis, Pathway's senior care navigator talking about her experiences; and a Camden housing officer who regularly attends the MDT talking about his experiences with the Pathway team. A selection of these can be seen on www.pathway.org.uk/video-links/

An interesting anecdote is that filmmaker Dave Grewcock, who recorded video interviews for us, has said that he has found attending the MDT (after which much of the filming took place) a fascinating, enlightening and uplifting experience and thinks it is an exemplar of how hospital services can be developed and improved.

Measure 6. Longer-term patient experience (post discharge) – *We planned to survey patients following their discharge, and we expected to encounter some difficulties with doing this because we expected to lose track of many of our patients following discharge.*

Due to delays in recruiting and training care navigators, we have not had the resource to follow up as many patients as planned, and in any event we have dropped the proposal to use surveys because of the lack of success in using surveys for patients at the point of discharge.

We have recently encouraged patients who have been discharged but who need further help to call into the discharge lounge, where one of our nurses or our care navigator can provide the necessary support.

However, we have captured stories of how we have helped patients at the point of and following discharge, and a selection of these can be found in Appendix ii, and in some cases within the video interviews that we have collected.

Measure 7. Patients helped with basic needs (dignity): Clothes, toiletries, identification survey (what things we did that really made a difference during your time in hospital?) – *We try to record the ‘small things’ we provide to patients. We are interested to see the interaction between this activity and longer-term patient outcomes. Our experience suggests that doing small human things for homeless people is the foundation of building a relationship with them, and a building block of changing relationships around patients.*

What information we collected and our conclusions

We recorded what items we gave to patients to help them when they were discharged from hospital. This included toiletries when they were first admitted, clothing including new shoes, TV cards to be able to watch TV in hospital, and support such as phone cards, furniture and home ware where a flat or room had been secured for them. We have many stories where patients are really grateful for our help in this way – one patient remarked to Trudy: ‘I look a real Bobby Dazzler’ after she had kitted him out in new clothes. We think that helping patients in these small practical ways demonstrates our respect for them as people, helps them to regain their dignity and also helps build trust with us.

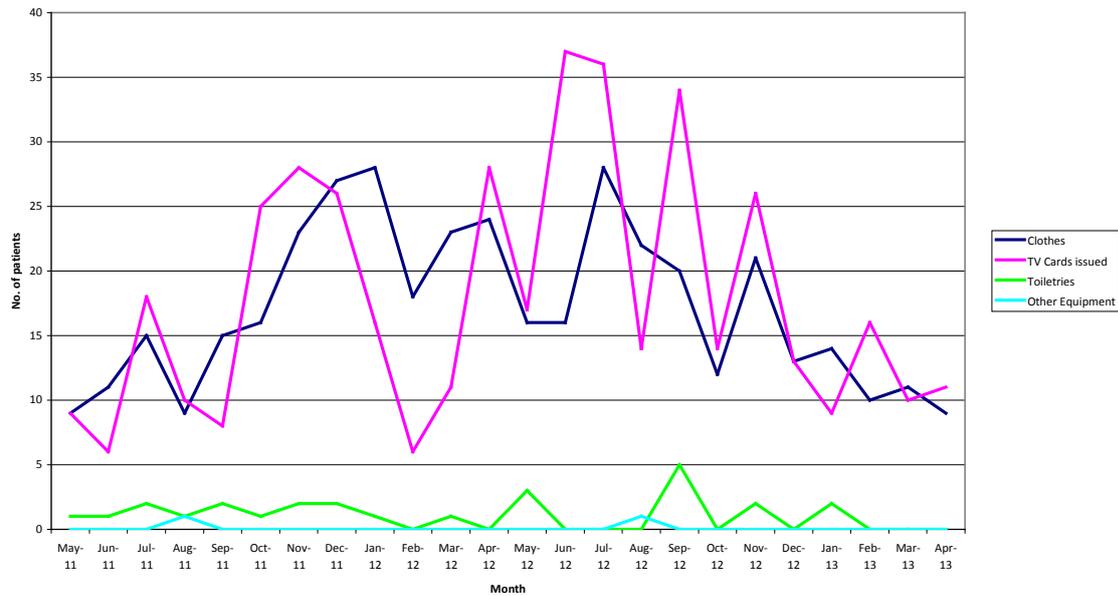
Detailed results

The following chart illustrates the numbers of homeless patients who, each month, were helped with clothes, toiletries, TV cards and so on during their hospital stay and at discharge. As time goes on, more patients are being helped with these things each month, and the cost is being met from charitable funds. Up to the end of April 2013, clothes have been supplied to 410 patients at UCH, some of whom will have been attending A&E, and 428 prepaid TV cards have been supplied to patients, although long-stay patients will have received more than one card during their hospital stay. We have successfully negotiated with the hospitals that have a Pathway service to pay for clothing and toiletries, and have secured a small amount of additional funding to help really destitute patients from London Catalyst. So far, the funding from London Catalyst has been used to make a contribution to the cost of temporarily relocating destitute patients who have no recourse to public funds at the Highway to Holiness Church, which is a charitably run night shelter that provides a place to bed down, an evening meal and breakfast at no cost to the users. We will continue this approach as the service expands, although the TV cards may need to be funded from additional charitable funding. An illustration of this making a difference to patients can be heard in the *BMJ* podcast mentioned under measure 5 of this report.

More and more patients are being helped with clothing and TV cards. The cost of the cards – £10 per day, £20 for three days or £25 for five days – is prohibitive to homeless patients, and it is one way we can occupy them and encourage them to stay in hospital. The homeless team introduced this intervention, and therefore the trend is unlikely to decline, but may level out over time.

Recently, we arranged and contributed to the cost of one patient’s repatriation to Lithuania. This patient had been part of the RCT at the Royal London Hospital, and we arranged for him to be accompanied home by a fellow Lithuanian who works at Thames Reach charity.

London Pathway Dignity Fund: Items issued May 2011 to April 2013



Measure 8. Number of Pathway-led training activities or events: diary checking - *This is a simple activity measure to capture the team’s activity across the hospital to see which teams and departments are engaging with us. Team members notified us of all formal and semi-formal promotional or training activities they led (talks to nurse groups, wards, teams etc; participation in formal hospital training activity).*

What information we collected and our conclusions

From the start of our project Dr Nigel Hewett, Medical Director and Project Lead, Trudy Boyce, Pathway Nurse and Josie Mavromatis have completed a monthly diary form which collected details of who they met with, what training and events they attended or provided and also captured unsolicited feedback. We also captured details from the diary of Alex Bax, Pathway’s Chief Executive. The results of this information can be seen in Appendix iii. The conclusions that we can draw from this activity are that we are spreading our message widely and building a store of support for and interest in our work. We have also realised that by showing people our work we are achieving greater understanding of it by other agencies. Therefore, we encourage interested people to attend one of our MDT meetings.

Detail of Pathway’s activity

Through discussions at one of our quarterly team meetings, and through recording visits in our diary logs, it has become clear that we have learned that showing people our work, ie by them attending our ward round or MDT meetings, achieves greater understanding of our work and the need for systems in the health and other care services to change, and the visits often also change the mindsets and attitudes towards homeless people of those who visit the ward round. Therefore, we use ‘show’ as well as ‘tell’ to get our messages across. One of our team reported that a senior representative from a housing office attended an MDT meeting to discuss a patient, and went back to his organisation saying it was the best and most productive meeting he had ever attended and recommended that other colleagues attended to learn how services can be more joined up. This is just one example of how Pathway staff facilitate a range of services becoming more joined up on behalf of an individual, and advocating for them while remaining professional in their own discipline.

Many of the entries in Appendix iii exemplify how we have used opportunities to promote our work and ethics, and try to change people’s attitudes to homeless people successfully.

The **balancing measures** we chose to use were:

Measure 9. Costs – *We have routinely reported our direct costs and planned to model on a monthly basis the total costs attached to homeless patient care.*

What information we collected and the conclusions

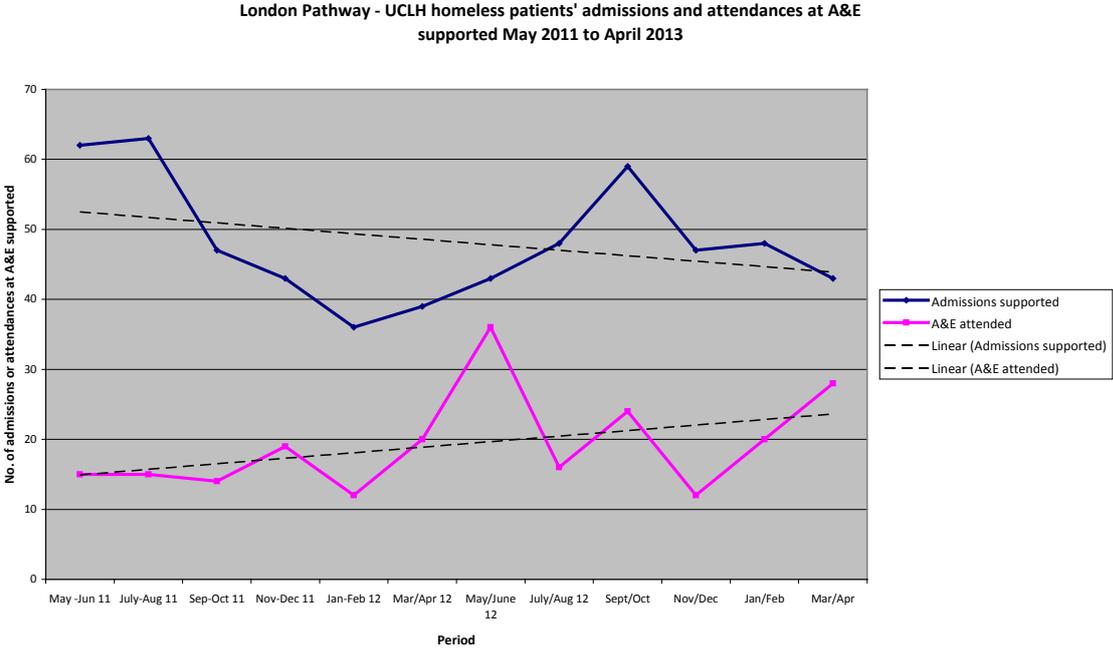
We were unsuccessful in ascertaining the total costs attached to homeless patient care due to the complexity in extracting this from UCH’s accounting system, but instead collected Pathway’s direct costs for the elements of the service funded by the Health Foundation. We also decided to link the costs to the number of admissions and A&E patients supported. The data show that over the life of the project there has been a gradual reduction in admissions supported and a gradual increase in the number of A&E patients supported. Although we may be supporting fewer admissions, they tend to be the more complex cases, and the numbers have reduced because the core hospital staff have become more confident in supporting routine homeless patients themselves. We are able to say this because we have observed ward staff taking pride in managing some homeless patients themselves, without feeling they need to involve the specialist skills of the homelessness team, but also because of the downward trend in the number of patients being referred to us. In the video clip *Gosh. Why?*, Florence Cumberbatch talks about her observations of changes in the behaviour of other hospital staff – see www.pathway.org.uk/video-links/

Detailed data and analysis

The following table presents Pathway’s costs for the elements of the Health Foundation funded project in the table below, along with the numbers of homeless admissions and A&E attendances supported.

Month	LP Direct Costs	UCLH employed nurse	Nos. of Admissions supported	Nos. of attendance in A&E supported
May -Jun 11	£42,000	£9,246	62	15
July-Aug 11	£32,830	£9,246	63	15
Sep-Oct 11	£32,010	£9,246	49	14
Nov-Dec 11	£32,160	£9,246	43	19
Jan-Feb 12	£32,830	£9,246	36	12
Mar/April 12	£32,190	£9,246	39	20
May/June 12	£32,190	£9,246	43	36
July/Aug	£32,190	£9,246	46	16
Sept/Oct	£25,374	£9,246	60	24
Nov/Dec	£25,374	£9,246	45	12
Jan/Feb	£30,374	£9,246	48	20
Mar/Apr	£29,025	£9,246	43	28

The following chart plots the numbers of admissions and A&E attendances that Pathway staff supported in UCH, as displayed in the table above.



The trend lines above show that the numbers of admissions has been gradually falling. The particular low point in February and March 2012 was due to non-referral of a number of homeless patients to the team who would have benefited from our help. We do not know how many these were, and therefore are unable to comment on the impact to our chart. However, the cause of the non-referral was addressed and we are back on track.

Our attendances in A&E to provide support to patients may contribute to reduced admissions and therefore costs overall. There has been a general increase in the number of patients supported in A&E, and the trend line illustrates this.

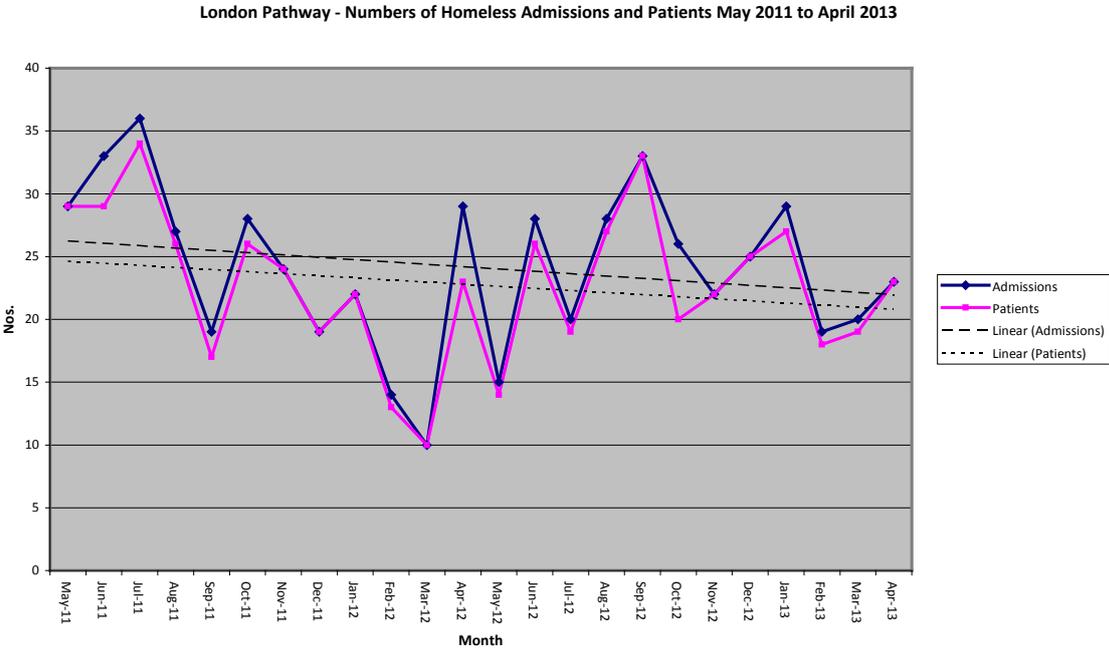
Measure 10. Patient numbers at UCH – *This has allowed us to see changes over time in numbers of homeless patients admitted and attending hospital – something beyond our control – but which may also be influenced by news of the service spreading on the street.*

What we collected and our conclusions

We collected details of homeless patients referred to the Pathway team and their admissions and compared the number of patients seen each month and the number of admissions each month. Over time, there has been an overall downward track of both patients and admissions. We do not know whether or not this is representative of homeless patients’ activity in UCH because the data is only for those homeless patients referred to Pathway. However, we think that it could show that core hospital staff are more confident with routinely dealing with homeless patients themselves and so now only refer the most complex to the Pathway team.

Detailed data and analysis

The chart below shows numbers of homeless patients’ admissions and of individual homeless patients.



The number of admissions in each of the two years (May–April 2012, and May–April 2013) has remained very similar – 290 and 288 respectively. However, we noted a fluctuation in admissions over the months, and we know, as reported in Measure 9, the dip in our recorded numbers of admissions and patients in February and March 2012 was because a number of homeless patients who should have been notified to the Pathway team were not. We do not have the exact figures for these, but we do not think these omissions make significant differences to our overall trends, although it does exaggerate the resulting increase in the chart in April 2012. The numbers dropped away a bit in May 2012, when we had fewer referrals, but have risen again since June 2012. Many of our referrals are becoming more and more complex, and need lots of help and support beyond direct medical interventions. There is no evidence that homeless admissions overall are reducing at UCH, rather that numbers referred to our service are slowly reducing, accompanied by an increase in complexity amongst those who are referred. This seems to indicate that, as the service matures, wards feel able to manage homeless patients with ‘routine’ problems themselves, and reserve referral for those with more complex problems. This could indicate a change in relationship between hospital staff and homeless patients.

Measure 11. Numbers of rough sleepers counted in London – *Monitoring this has allowed us to see whether hospital specific trends in patient numbers relate to wider changes in numbers of homeless people. On the advice of the homelessness team at the Greater London Authority we have used the quarterly London rough sleeper counts drawn from the from the CLG funded CHAIN database as the best regularly collected data to measure homelessness.*

What we looked at and why

We used the bi-monthly recorded numbers of rough sleepers from the CHAIN database, which is published on Broadway Housing database (www.broadwaylondon.org), as an indicator of changes in numbers of people sleeping rough in London. Significant increases in numbers of

people sleeping rough in London have been recorded since summer 2010. However, we know from previous experience that the health harms of homelessness and related mental health and addiction problems take many years to accumulate, so short-term increases in rough sleeping numbers are unlikely to translate into immediate increases in acute hospital admissions.

Detailed data and conclusions

The latest available data drawn from the CHAIN database on Broadway's website are:

Category	Flow (new rough sleepers)	Living on streets	Intermittent/ Returning rough sleepers	Totals
Jul/Aug 10	439	298	406	1,143
Sep/Oct 10	425	361	444	1,230
Nov/Dec 11	392	325	400	1,117
Jan/Feb 11	328	278	414	1,020
Mar/Apr 11	375	307	422	1,104
May/June 11	666	302	547	1,515
Jul/Aug 11	744	339	513	1,596
Sep/Oct 11	656	361	512	1,529
Nov/Dec 11	582	346	505	1,433
Jan/Feb 12	533	291	462	1,286
Mar/Apr 12	648	326	468	1,442
May/June 12	694	324	548	1,566
July/Aug 12	847	348	674	1,869
Sept/Oct 12	875	390	655	1,920
Nov/Dec 12	629	326	563	1,518
Jan/Feb 13	598	289	495	1,382
Mar/Apr 13	620	277	508	1,405

It can be seen that the number of rough sleepers counted in London has generally risen since May 2011 when the Health Foundation's funded Pathway project at UCH started. At the peak, in the September/October 2012 period, the increase of rough sleepers counted in London rose by 816 (74%) compared with the number in March/April 2011 before the start of our project. The most recent period shows a fall of 515 (27%) on the peak recorded in the September/October 2012 months. However, comparing the numbers in March/April 2013 to the same period in 2012 and 2011, there was a decrease of 37 (2.5%) on 2012, but an increase of 301 (27%) on 2011.

The greatest flow has been new rough sleepers where 875 were recorded in September/October, but this fell back by 255 (29%) in March/April. Returning rough sleepers have also increased, with the highest number – 674 – being recorded in July/August 2012, but this has fallen back in March/April 2013 by 166 (25%).

On balance, looking back over the last two years there has not been a massive change in background levels of rough sleeping; therefore any changes in the levels of homeless admissions in UCH are not out of line with this data.

Some people in the homeless sector believe the methodology used to gather this data is flawed, and that the total numbers of rough sleepers in these counts may not relate very closely to the real number of people living on the street. However, as the counts are carried out

each month using the same methodology, the trends illustrated by these figures are probably correct. How much the protracted periods of cold weather and the availability of cold weather shelters impact on the reduction of numbers of rough sleepers during winter months is hard to quantify.

It takes many years for the cumulative health harms of homelessness to present in the health of individual patients. Many of our current patients will have been victims of the previous economic downturns. It is therefore difficult to correlate the increase in the numbers of current rough sleepers with the numbers of patients Pathway currently supports, because they tend to be the most damaged and seriously ill and are likely to have been homeless for some years.

Given economic pressures and changes to welfare benefits, especially housing benefit, we expect the numbers of people becoming homeless to continue to increase in future both in London and across the UK. As stated above, we know that the health harms of homelessness and related mental health and addiction problems take many years to accumulate so short-term increases in rough sleeping numbers are unlikely to translate into immediate increases in acute admissions.

Measure 12. Total bed days – *We were not sure whether this measure needed to go up or down for our patient group but thought it would be interesting to monitor what happens over time. We have been able to calculate average bed days and examine very long stay and seemingly ‘too short stay’ individual cases. Over time we will be able to monitor this measure against other external influences, eg a very cold winter, but the duration of this project is too short for this to be viable.*

What information we collected and our conclusions

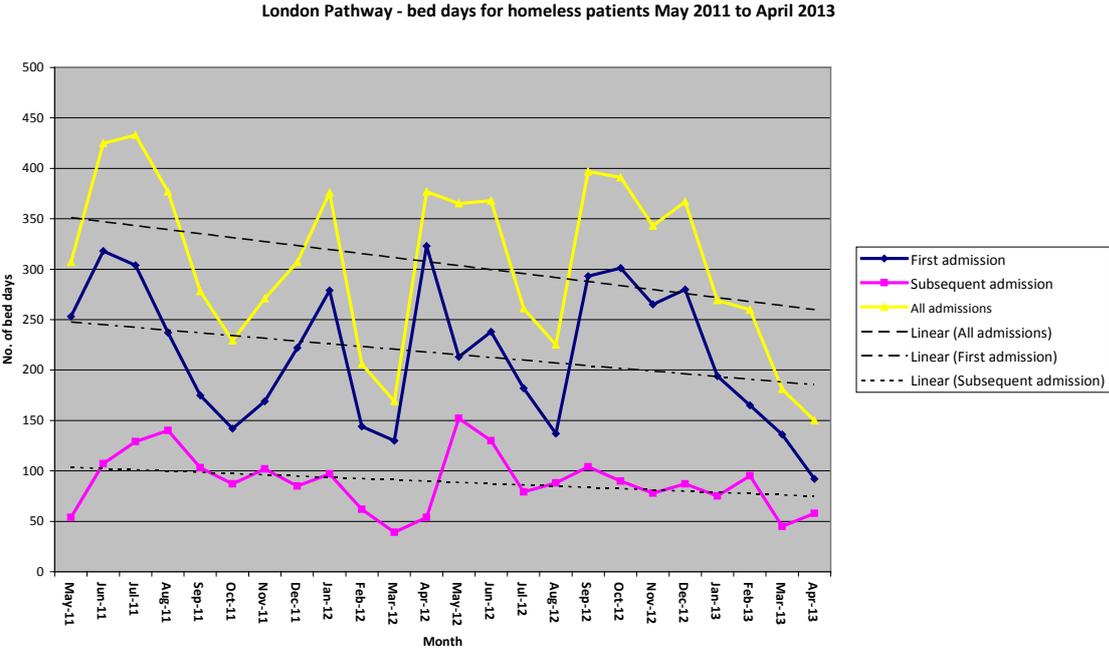
We collected the date of admission and date of discharge for each patient referred to Pathway. This enabled us to calculate the length of stay in bed days. We have compared the total number of bed days recorded each month for all Pathway admissions, with the total bed days of first admissions and with total bed days for repeat admissions. For each group there has been a gradual increase in the length of admissions. However, a small number of admissions are always very long, in excess of 60 days, and these may impact on tracking the general trend. We have also looked at the length of stay in bands of bed days, eg 1 to 5 days stay, 6 to 10 days and so on, and the percentage of patients staying five days or less fell in 2012, whereas the number of patients staying up to 30 days has risen. This trend has reversed in the first four months of 2013, but without more detailed and complex data collection we are unable to draw any firm conclusions about length of admission.

There is always pressure to discharge patients when their hospital doctor considers them to be ready, so as to ensure the bed is available for another admission. However, despite this pressure we have found that the consultants and registrars in charge of our patients are now prepared to reconsider a discharge and keep homeless patients in hospital longer when Pathway staff advocate the need to do so. This is brokered on a patient-by-patient basis led by Pathway’s GP or homeless nurses in discussion with the respective patient’s doctor. See *Back on his feet*, a video clip where Florence Cumberbatch, Pathway’s nurse, talks about this (www.pathway.org.uk/video-links/). At the start of the pilot service, we had instances of consultants being unwilling to keep patients in hospital: an example of this has been included in *Appendix ii: patient stories*. However, as time passed, consultants and registrars accepted that keeping patients in hospital for a few more days is sometimes necessary in order to achieve a safe and properly planned discharge. There has been an example recently of a patient who was ready for discharge, but who had nowhere to go, and who still had tubes in his body and

therefore could not be discharged to the streets. It took more than a week and much intervention by the Pathway team to convince the local housing office to accept that they had a responsibility to find accommodation for this man, and during that time he was kept in hospital with the blessing of the doctors responsible for him.

Detailed data and analysis

The chart below shows the numbers of bed days that were occupied at UCH by homeless patients referred to the Pathway team since May 2011. The data illustrate a monthly range between 150 and 433 bed days over the period of May 2011 to April 2013, with significantly more days recorded in June and July 2011. In each of the two years (May–April), we recorded 3,755 and 3,577 bed days respectively. Where individual months have significantly more bed days recorded, the reasons generally reflect the clinical status of several individuals – the complexity of our referrals appears to be increasing. This requires more work to align and coordinate the discharge planning and implementation across different agencies, eg the hospital discharge needs to involve the Pathway team, local hostels, social services and primary care – we try to do this as far as practicable, with some success. Data collection would need to become more complex to enable us to analyse this further, as we would need to be able to differentiate clinical reasons from delayed discharge because of inadequate support systems in the community.



The following table shows lengths of homeless patients’ admissions as recorded on our Pathway database at UCH:

Stay	2010		2011		2012		2013	
	No.	%	No.	%	No.	%	No.	%
1 - 5 days	312	62.78	223	62.46	134	49.26	57	62.64
6 - 10 days	74	14.89	52	14.57	57	20.96	15	16.48
11 - 20 days	53	10.66	33	9.24	35	12.87	8	8.79
21 - 30 days	13	2.62	11	3.08	17	6.25	5	5.49
31 - 50 days	27	5.43	24	6.72	14	5.15	6	6.59
51 - 59 days	7	1.41	1	0.28	1	0.37	0	0.00
60+ days	11	2.21	13	3.64	16	5.88	0	0.00

As can be seen, we are seeing fewer patients year on year and the length of stay for patients was similar in 2010 and 2011. However, there was a noticeable change in 2012, where proportionately more of our patients had longer hospital admissions. However, so far in 2013 there are fewer patients requiring long admissions.

We think this means that our service is ensuring that the most ill homeless patients are being kept in hospital longer so that they are more ready for discharge and leave with better coordinated follow-on care plans than in previous years or before the Pathway service was introduced. It is also likely that the Pathway team are concentrating on the more complex patients, with wards empowered to manage less complex patients without our support.

3.2 What has been the overall impact of the Pathway model?

The service at UCH

The overall impact of our work is that the Pathway service reduces bed days by reducing the average duration of stay. We have two different, wholly independent data sources (UCH Management Information and Pathway's own database) that appear to confirm this, and this has been helped by a slow decrease in first admissions (for which we can't take credit) and despite a slightly faster increase in repeat admissions.

The data obtained from UCH's management information system includes data on all patients classified as homeless, whether or not they were referred to the Pathway service, and this data informed a quality improvement report written by Dr Nigel Hewett, Prof Aidan Halligan and Trudy Boyce and published in the *BMJ* on 28 September 2012 (Appendix iv).

The data in the article represent patient admissions where the address was recorded as no fixed abode (NFA), the patient was registered with a known homeless GP practice, or gave an address matching one of the known local homeless hostels. It is not directly comparable with Pathway's data for a number of reasons: the UCH data will include patients from a stable hostel address, where the case is not complex and therefore Pathway is not involved; record keeping relating to patients known to have no recourse to public funds is not consistent; the Pathway team works with many patients who become homeless in UCH, are hidden homeless (gave an unusable address on admission), or end up in UCH but give an address somewhere distant from the hospital.

We think this data provides further evidence of the need for a medical respite centre, as care coordination appears to improve in-hospital management but is not impacting on readmissions – which suggest that there is simply not the level of coordinated community care available to allow this client group to convalesce effectively.

We recognised that there is a frequent turnover of doctors in the hospital including in A&E. However, the nurses remain more constant with a much slower turnover. Thus we use the stable nursing environment to maintain awareness of Pathway's presence in the hospital and we do this through Trudy Boyce and Florence Cumberbatch, Pathway's nurses who lead sessions in induction and other ongoing training for nurses.

The willingness of A&E to call the Pathway team for help is a remarkable step forward and a great compliment to our service. In addition to calling for help with homeless patients, the A&E staff also notify our team of the names and details of homeless patients who are 'frequent flyers' to A&E. Pathway discuss these patients at the MDT and a short care plan is produced

including details of key workers to be contacted and so on, and this is lodged in a file in A&E for staff to access when the patient returns.

On homeless patients at UCH

Over the period of the Health Foundation's funding, we have dealt with 578 admissions and 231 visits to A&E by homeless patients. It is impossible to know the full impact that the Pathway service has had on these patients' lives, because of the chaotic lives most of them will continue to live, but we tell some of their stories in Appendix ii. We also undertook some satisfaction surveys early on in the project and the following comments from patients illustrate the impact we had on their experience in hospital.

'The Homeless team supported me in staying in hospital. They gave me TV cards and clothes; I know I would have left if it hadn't been for them.'

'... they pushed and made me do it, in a nice way. I would not have got my benefits sorted without them.'

'... made a big difference, the friendliness of them and checking if I needed anything.'

'Homeless team people have helped me with TV cards and food and been there for me.'

'... a very great job, never asked for any help but the homeless team have been brilliant and have been excellent with giving phone cards.'

'... when I was homeless they got me clothes, sleeping bag and tried to get me housed.'

'They gave me £10 towards my gas/electricity – very helpful.'

'Trudy and her team have been very kind to me on several occasions, clothing me, cleaning me up and showing love, time and compassion. Thank you guys and thank you Trudy.'

One patient who is terminally ill with cancer, and who we have helped several times, showed his appreciation by giving Pathway generous donations of money when he received back-paid benefits. He insisted that the charity took these donations, and would have been really offended had we refused. However, we have subsequently used some of this donation to support him in bed and breakfast accommodation as he has once again fallen onto hard times.

In a video clip *The extra mile*, Florence Cumberbatch, Pathway's nurse at UCH, explains how she and the team try really hard to get good outcomes for their patients and tells about the positive response they get from the patients because they see the team are doing their utmost to help them. (View the clip at www.pathway.org.uk/video-links/)

Josie's story – our care navigator

Josie Mavromatis joined Pathway as a volunteer from TB Find and Treat. Prior to this, she had lived on the streets for many years and was a street drinker. Her homeless career started around the age of 16. During this time she had a bad experience at the hands of a nurse in a London hospital who had told her that 'she didn't know why they bothered with such people'. When Josie was well enough to be discharged from hospital she vowed that the next time she went to hospital would be on her deathbed.

Some time later, Josie again became ill and was admitted to hospital with pneumonia – she was very seriously ill and was also diagnosed with TB. She was introduced to a specialist TB nurse who explained that her treatment would be long, at least six months of being treated with drugs. At the end of the six months, Josie received the bad news that she had drug resistant TB and would need to be treated for a further six months – by then the TB nurse had become a good friend to Josie. At the end of the treatment, the TB nurse persuaded Josie to volunteer for TB Find and Treat by becoming a peer navigator with Groundswell, a homeless charity that helps people become peer navigators. She agreed to do this, and soon decided to undertake some ancillary studying off her own back.

In 2010 she was introduced to Trudy and Nigel, and did some volunteering with Pathway at UCH, where the proposal to train and employ care navigators was explained to her. Josie agreed to consider the proposal, but was worried about the demands the role would have on her life and her financial position in particular. After a bit more persuasion, and help with her benefits, Josie agreed to start the care navigator training on a part-time basis. After a year's training with, and shadowing of, our nurses, we assessed that she should be appointed as a fully trained senior care navigator, and she agreed to increase her hours to 30 per week. At this time, she still felt the need to allow herself a bit of free time. However, a few months later, when it was pointed out that she was working full-time hours but not being paid for them, she agreed to accept a full-time contract. In April this year, to our delight, she accepted our offer to undertake the level 3 Diploma in Health and Social Care as part of our new apprenticeship scheme.

Josie's frontline work helping patients in the hospital and following discharge, and supporting Pathway's nurses is invaluable. Our patients feel comfortable with her, and the hospital's nursing staff and clinicians respect and appreciate her work. She in turn gets great job satisfaction and enjoys the role immensely.

Evidence of Josie's development and impact can be illustrated by the following feedback from a senior manager from NHS England's health inequalities team who recently visited Pathway and the MDT at UCH. She told a subsequent meeting that at the MDT she had been convinced that Josie was a nurse with many years' nursing experience, was surprised that she had been wrong, was very impressed with Josie's professionalism and admired her for successfully overcoming her previous, chaotic lifestyle.

We also have a video clip, *Care navigators*, of Dr Tim Robson, who joined the UCH team as the consultant GP in July 2012, talking about the Pathway team and Josie in particular. In it he uses the words 'amazing' and 'inspired concept' and talks about an occasion when Josie had seen six patients in A&E, and she had recounted to colleagues what she had done for two of these patients in detail. She had summed up her work by saying 'there is only so much you can do' and Dr Robson comments that he and the others listening to her were thinking that she had gone way beyond what is expected as normal (see www.pathway.org.uk/video-links/ to view).

At Pathway, we are all proud at the way Josie has developed as a care navigator and of the work she carries out on Pathway's behalf both in the hospital and with outreach. She is an example of how people with lived experience of homelessness can, with help, turn their lives around. We hope to be able to find more suitable people to help in the future.

Services beyond UCH

We have used the success of our service in UCH to persuade other acute hospitals to introduce or consider introducing a Pathway service. These include: the RCT funded by NIHR at the Royal

London and Brighton and Sussex hospitals – the last patients were admitted to the trial in June 2013. However, we won't know the results until the end of the calendar year. Meanwhile we are negotiating for services to continue in both hospitals funded by a combination of unspent research funding topped up as necessary by the relevant NHS trusts, at least until the results of the trial are published, after which the decision will be taken whether to continue the service permanently. Ongoing funding for both services will involve the addition of an extra nurse, because the randomised element of the service will be removed, and therefore twice as many patients – possibly – will be seen.

A one-year pilot at the Royal Free was introduced in November 2012, funded through the Royal Free's QIPP programme. Something we have already learned from this service is that it is vital to gather sufficient 'soft research' as well as collecting comprehensive hard data for the needs assessment – this work should be done simultaneously. The 'soft research' would involve lots of talking to hospital staff at all levels to find out the level of need and to garner support prior to the introduction of the service. Insufficient 'soft research' was done for the Royal Free needs assessment and this has caused some difficulties for the pilot. We will make sure that this learning is taken forward when undertaking all future needs assessments.

Work on a needs assessment for Guy's and St Thomas', King's College and South London and Maudsley hospitals has proved the need for the service within these trusts. The needs assessment was presented to a meeting of managers from the three trusts and the recommendations were accepted. They are now working with us to introduce the service in 2013, and we are currently preparing applications to the hospital charities for funding for the service at the Maudsley and for the ongoing support from Pathway.

We have secured two years funding from the Department of Health Innovation Fund to support the introduction of a Pathway service in Bradford, to include not only homeless patients but other socially excluded groups of people, and work to introduce this began in April 2013. This work will be done in partnership with Bevan Healthcare, a specialist GP practice in Bradford that focuses on people who are homeless, live in unstable accommodation, refugees and asylum seekers, and other people who find it hard to access healthcare.

We are also talking in detail to other hospitals about carrying out needs assessments, including in London, the North Middlesex, Mayday Hospital in Croydon and St Mary's, and further afield in Manchester and Birmingham.

It is our ambition and intention to broaden the activities of the Pathway team to include A&E, particularly in Brighton and Sussex and the Royal London after the RCT finishes and when additional staffing is in place. However, experience at UCH suggests that it is necessary to get the model embedded within the in-patient service before attempting to undertake a responsive service at A&E, because the amount of time needed to support patients attending emergency services can be substantial. A Pathway team with one nurse and three or four half-day sessions of a GP would be insufficiently resourced to be able to extend the service into A&E. Ideally, a care navigator would also be added to the team to assist with work in A&E and to be able to follow up patients in the community.

The future service at UCH

A business case asking UCH NHS Foundation Trust to fund three full-time nurse posts and four sessions a week of GP input from April 2013 was submitted. This was shared with various colleagues within the trust and we are delighted to report the funding has been approved. This agreement means that we will have an additional nurse added to our service at UCH. The

business case showed the Pathway team to be significantly cost positive for the Trust. Alongside the business case we have developed a short partnership agreement to be signed by the trust and Pathway, setting out the terms of our relationship and committing the hospital to our model – this is likely to turn into a memorandum of understanding with the hospital. We intend this kind of arrangement to be put in place with each hospital trust with a Pathway service. In addition, UCH’s new medical director is interested in taking forward our medical respite concept and is talking to us about this.

Wider outcomes for homeless health

To support independent advocacy for the healthcare needs of homeless people we set up a new charity – Pathway (www.pathway.org.uk). This charity, in turn, supports the Faculty for Homeless and Inclusion Health which is gaining influence nationally and has led to our support being sought for the National Inclusion Health Board, and funding for various projects including the next iteration of our Faculty Homeless Health Standards document which is due for publication later this summer.

Pathway and the Faculty for Homeless and Inclusion Health held the first international conference on Homelessness, Health and Inclusion on 27 and 28 February 2013 (Appendix v). The conference brought together for the first time in London a range of people (more than 150) who work in the areas of healthcare or homelessness. There were speakers from the UK, Europe and USA, and the keynote speech was delivered by Anna Soubry MP, parliamentary Under Secretary of State at the Department of Health. She told the conference that she expected to be in a position to shortly be able to make an announcement on funding for respite care for homeless people. Professor Steve Field, then the assistant director at the NHS Commissioning Board and Chair of the National Inclusion Health Board, highlighted Pathway as an example of an excellent service and Duncan Selbie, Chief Executive of Public Health England, spoke at the conference and raised the issue of homelessness in his weekly newsletter (Appendix vi). *The Lancet* was represented at the conference and wrote an editorial pledging a series of papers on Inclusion Health (Appendix vii) that it has subsequently asked Dr Nigel Hewett to collate. Delegates described the conference as ‘inspirational’ and ‘moving’.

Following her indication of an announcement at the conference, Anna Soubry MP visited the Pathway service at UCH on 13 May, where she announced £10m funding for a new Homeless Hospital Discharge Fund which is to be linked to the newly published Medical Respite for Homeless People – outline service specification published in May 2013 jointly by DoH Inclusion Health and Pathway (Appendix xviii).

We take every opportunity presented to us to lobby healthcare commissioners and policy makers to try to raise awareness of the need to improve healthcare for homeless and vulnerable people. We also promote Pathway’s service model and the Faculty of Homeless and Inclusion Health’s published standards of care for homeless and vulnerable people as widely as possible in order to try to drive up the quality of care and services provided for our patients.

Later in the summer, we intend to convene an inaugural meeting of a Research and Scientific Advisory Board to help us develop a research agenda for Pathway. The membership of this board includes five leading medical research professors: Prof Sir Michael Marmot, Prof Graham Foster, Prof Adrian Renton, Dr Andrew Hayward, Prof Barry McCormick and Prof Aidan Halligan. We have also invited Sir Muir Gray to join the board. We want to use research to drive up the quality of care and services provided to homeless and other vulnerable and marginalised groups of people.

During the past two years of the Pathway service at UCH, we have had more than five medical students who have chosen our service as part of their elective placements. All have told us that they have found the work of Pathway fascinating and inspirational, and some have had their desire for training in medicine reinvigorated. A report written by Emily Dobell, the most recent medical student, is attached as Appendix xix. In the report she summarises how she spent her time with Pathway and her impression of how Pathway improves the 'usual' planning for discharge service provided to homeless patients.

Pathway has been asked to support the merger of two specialist homeless primary care services in East London: Health E1 in Tower Hamlets and the Greenhouse practice in Hackney. The merger has resulted in an independent social enterprise, and they wish to use the merger as an opportunity to model more integrated service responses into primary care provided to homeless patients. We are talking to them about how we can support them, including the possibility of their being accredited as working to Pathway standards by the Faculty of Homeless and Inclusion Health.

In March and April we started a research project, funded by the London Housing Foundation, into the state of dental health in homeless people, its impact on their lives and their ability to access affordable dental treatment. So far, the results have highlighted a high prevalence of dental ill health and significant misconceptions around what the NHS will fund in terms of dentistry amongst homeless people. We have undertaken a survey of around 150 hostel dwellers about their experience of dentistry and access to restorative dental health interventions, and 15 homeless and formerly homeless people have had a detailed dental health and orthodontic assessment undertaken at the Eastman Dental Hospital. Next steps are to complete the analysis of the survey and to support the 15 individuals into treatment. As part of this work, we have been asked to feed any lessons about future commissioning of dental services to the National Commissioning Board.

Pathway's nurses ask homeless patients treated by them in hospitals about how they access primary care. Where a patient is not registered with a GP our staff encourage and help the patient to do so. We do not have data on how many patients have been helped, nor information about the quality of the care from GPs, but enabling the access to GP care for some patients can be counted as an improvement in itself.

The Pathway model recognised and rewarded

Our Pathway model was awarded the 2012 *HSJ* award for patient centred care, and we think this rewards the compassionate and dedicated approach our staff have towards our patients. We were also one of ten runners up for the 2013 GSK Impact Awards.

3.3 Economic impact of the Pathway model

A draft economic impact report of the Pathway model was produced by OPM early in June 2013, but this was based only on data collected by Pathway and does not cover all admissions of homeless patients in the hospital. We do not consider it to be sufficiently robust to prove the economic impact of the service, and have decided not to include it with this report. Instead we consider that the article *A general practitioner and nurse led approach to improving hospital care for homeless people* published in the *BMJ* (Appendix iv) contains a better economic justification of the Pathway model, although it is not a detailed economic assessment.

3.4 What was the quality and robustness of the data that we used to assess progress and impact of the Pathway model?

Our data

Our data was accepted and published by the *BMJ*, an international peer reviewed journal. See Appendix iv for the full article.

A separate note explaining our data collection for Pathway patients is attached at Appendix viii.

As explained in section 3.2, most of our data relates to the homeless patients referred to the Pathway team in UCH, and this is recorded by our homeless health nurse practitioners. Therefore, to evaluate the overall impact of our project at UCH we used data obtained from UCH's management information system, which includes data on all patients classified as homeless, whether or not they were referred to the Pathway service, and which includes patient admissions where the address was recorded as NFA, the patient was registered with a known homeless GP practice, or gave an address matching one of the known local homeless hostels.

Also, to further evaluate the effectiveness of our model, we are running the two-site RCT at the Royal London and Brighton and Sussex hospitals.

What problems have we encountered in collecting data, and how are we trying to overcome them?

The data for repeat admissions may also be incomplete, because if a patient is discharged to stable housing and is readmitted to hospital, then they would not be referred to the Pathway team, as they would not be considered homeless. We have no way of knowing the impact of this on our data. Similarly, if a patient is readmitted to another hospital, whether or not it has a Pathway service, the UCH team would not know of this readmission. The analysis planned for our RCT will include an attempt to match all consented patients' NHS numbers against national HES datasets. This will enable us to see all subsequent health service use for patients within the research trial, not just when they are seen by a Pathway team.

We have found it very difficult to gather evidence to assess patient satisfaction at discharge and changes in clinical attitudes to homeless people. We trialled surveys for both elements of this measure, asking homeless patients a set of standard questions when they were discharged from hospital, and asking junior doctors a set of standard questions using Survey Monkey at the start and end of their placements at UCH. Both surveys proved unsatisfactory because of the small number of results that we were achieving. Therefore, during the project we decided to rely on qualitative data being obtained through capturing stories, including patients' stories. Examples of these are set out in Appendix ii, and we have captured video stories which can be viewed on our website (www.pathway.org.uk/video-links/). We asked the person filming the videos to ask three key questions to a number of people: to find out the impact having Pathway staff in the hospital has had on them, their work and the homeless patients; to get examples of specific cases where Pathway has had an effect either on a patient, a member of the hospital staff or more widely; and to get examples of specific impacts on staff and patients from having Josie, as care navigator, as part of the Pathway Team – as part of this we wanted to try to explore the differences in relationships and services provided with and without care navigators.

It has been impossible to collect full cost data for our patients at UCH, or even to obtain an agreed average cost per bed day, because each unit uses a different basis to calculate this and there is not a single agreed figure.

4. Discussion/learning

4.1 Summary of the major successes of the Pathway project

- Enabling an infant charity, Pathway, to run a pilot service to improve healthcare for homeless patients in UCH for the duration of the Health Foundation funding, which has enabled us to go a long way to proving the model.
- Sharing our learning from UCH with other hospitals considering the introduction of a Pathway service, and to make sure that they avoid some of the problems that we encountered at UCH. This includes making sure that stakeholders from all areas that would be involved in the new Pathway service are consulted from the inception of the proposal, so that, as far as possible, everyone is supportive.
- Ensuring that the Pathway approach has a national profile with a robust evidence base, so that we are increasingly sought out to help hospitals meet their new Health Inequalities Duties under the 2012 Health and Social Care Act.
- Recruiting and training a care navigator, a person with personal experience of homelessness who is employed to befriend, mentor and support homeless patients in hospital and post discharge and to support Pathway clinical staff. Her presence has, at times, challenged other clinicians' opinions of homeless people and their ability to turn round their lives, as she is a clear example that this is possible.

Main challenges that the Pathway project faced

- To produce sufficient and robust evidence to convince corporate managers at UCH to continue the service by providing funding for the GP and specialist nurses from April 2013. Approval has been confirmed, but we are waiting for formal confirmation of the details and for a memorandum of understanding to be drawn up and signed.
- To recruit and train a number of care navigators – we have not progressed with this element of the project as we had planned, and therefore have not been able to measure the changes in relationships as a result of routinely having care navigators as part of the team.
- With fewer care navigators than planned, we have not been able to follow up as many patients following discharge from hospital as originally envisaged. However, with one trained care navigator we are now following up a few more patients, but this in turn is bringing forward more challenges as those patients followed up can become dependent on the support and it is proving difficult to fully hand them over to community support services.

What has been most difficult, and what we concluded

We have found demonstrating how we change relationships to be one of the most difficult aspects of this project, and have tried various mechanisms including surveys with no real success. We ran surveys with patients at the time of discharge and also with cohorts of junior doctors at the start and end of their placement to try to evidence how we were changing relationships of homeless patients with clinicians and vice versa, as well as hospital clinicians' view of a specialist GP intervening in their work with homeless patients. The surveys did not generate any meaningful findings, and therefore we are relying on storytelling, both written stories and video stories, to evidence this change.

We have formed the view that in healthcare changing relationships does not necessarily mean an improvement in care quality, but rather that improving the quality of care is the impetus to change and improve relationships.

Dr Chris Sargeant, Pathway's GP at Brighton and Sussex Hospital, gave the following feedback from one of our quarterly team meetings: *'Here are a few things that struck me. The first is the amount of strength that we can all get from being with supportive and like-minded people. It is a great relief to not have to convince people that homeless people are entitled to good healthcare etc etc like we do the rest of the time! The second is in how many ways things have changed because of Pathway – for the patients of course, but also the knock-on effect to attitudes of other staff, the way things have changed for people working in the organisation, and how Pathway can act as a link or catalyst to bring other services together. The third is the potential to do even more – starting with the conference and the reflective practice groups, but then going on they act as a resource for people working with the homeless population, the potential to have staff available to give advice by phone to clinicians or homeless people with a health problem and expanding the remit to cover dentistry etc.'*

4.2 Pathway's achievements, challenges and the things that didn't work out quite as we planned

What we hoped to achieve

Our overall aim was, and continues to be, to transform the dynamic of the interactions between health workers and homeless people, leading to a measurable increase in the quality of healthcare and resulting in improved life chances and life expectancy. For this project the three specific aims were as follows.

1. Over the life of the project and beyond to transform homeless patients' experience of being in hospital and being discharged from it through transforming the quality of patient–staff relationships, and changing staff behaviours, attitudes and practice.
2. To test, enhance and prove during the project that the Pathway model is both replicable and transferable to other acute trusts with significant numbers of homeless patients.
3. To improve connections around patient care between primary and secondary care, leading to long-term reductions in admissions and repeat admissions to hospital.

How far we achieved our aims

Aim 1: Over the life of the project and beyond to transform homeless patients' experience of being in hospital and being discharged from it through transforming the quality of patient–staff relationships, and changing staff behaviours, attitudes and practice

So far, over the life of the Health Foundation funded project, 545 homeless patients, over 578 admissions, received care from Pathway staff at UCH and we responded to 231 calls to A&E to see homeless patients.

The following quotes from colleagues and patients exemplify how our work has transformed experiences of patients in hospital and relationships between hospital and Pathway staff; Pathway and hospital staff and patients; and staff, patients and staff from other support services.

'The change in the service for homeless people has been tangible. The patients' views are sought, and there is a joint solution to the issue. Having witnessed the open dialogue that occurs with the homeless people and the homelessness team, I am impressed with the empathy, trust, and openness of the relationship.' **Senior colleague at University College Hospital**

Our patients told us:

'You were the only ones that felt my life was worth saving. I am now back with my family. A family I have not seen for 10 years.'

'Why do you want to help me? No one has wanted to help our kind before. You have saved me, thank you so much.'

'I've never stayed in hospital as long as this [two weeks] but I know you are really going to help me, I trust you, that's why I'm staying.'

'With me being so ill I was grateful there was someone to speak on my behalf when sorting out my housing; you always went that extra mile.'

'I very rarely talk to people about my situation but I can talk to you. You give the time and you don't judge so it is a relief to be able to unburden some of my problems without a feeling of shame.'

Additional quotes are included in paragraph 3.2 above

Attendees of the MDT told us:

'The joint working relationship between Camden Council's Housing Options Team and UCH [University College Hospital] has greatly improved the customer care experienced by homeless clients by providing them with a prompt and individually tailored service. Early notifications of a potential hospital discharge and our joint working protocols have enabled the Housing Options Team to quickly identify suitable accommodation, preventing both delayed discharge and a return to the street.' **Housing Options Team, at the local authority housing department**

'The homeless team provide the vital link between the hospital ward and community client support workers. This has supported completion of medical treatment, provided consistent management of opiate dependent clients, and ensured better communication with support services. Joint working and information sharing with the weekly meetings have helped support completion of treatment and reduce recurrent readmissions.' **CRI Camden, a health and social care charity**

We think the above quotes help to illustrate how we have improved homeless patients' experience of attending A&E or being admitted into hospital at UCH.

Previously, UCH along with other hospitals would have given the 'normal' service to homeless patients, no better (but possibly worse) than that given to 'housed' patients. However, because Pathway takes the time to help patients more by planning their discharge, including addressing their housing need in particular, we hope to break the cycle of them returning to hospital as frequent flyers to A&E. Also, the Pathway team are aware that mental health and personality disorder issues are common in our cohort of patients and of the likely impact of these. So, by

their behaviour and actions, Pathway staff are able to help the patient get a more positive experience in hospital. Having a Pathway team in the hospital helps to de-stress other staff, by showing different ways of modelling patient-centred care but also because they know there is a specialist team that can be called on to deal with difficult homeless patients. In the video clip titled *Gosh. Why?*, Pathway's nurse Florence Cumberbatch shares her experience of this, and Dr Tim Robson also shares his experiences at UCH in video clips titled *Pathway Team Profile* and *Discharge Lounge Record* – see www.pathway.org.uk/video-links/ to view.

Many more hospitals with a significant homeless population want to introduce a Pathway service, and this suggests that we have been successful in raising the profile of the need and benefits of such specialist, compassionate services. On its own, this does not illustrate a change in relationships as the potential economic benefits of the service to a hospital cannot be ignored, but it does go some way to evidencing that staff attitudes to the treatment of this difficult and vulnerable patient group are changing.

Aim 2: To test, enhance and prove during the project that the Pathway model is both replicable and transferable to other acute trusts with significant numbers of homeless patients.

We have collected data, analysed and reviewed it over the life of the project, and have enhanced it with wider data obtained from UCH databases. Through this data, and by sharing our ethics of our model of compassionate care with others, we have shown it is possible to replicate our model and have convinced other NHS trusts to introduce it. So far, this has been the Royal Free using QIPP funding; the RCT at the Royal London and Brighton and Sussex hospitals paid for with NIHR funding; and in 2013, we will introduce services in Guy's, St Thomas's, King's and the Maudsley hospitals in South London, funded by their trusts, and a pilot service in Bradford with funding from the Department of Health Innovation Fund. We are working with Manchester to introduce a service using local funding, and Birmingham, the North Middlesex and Mayday Hospital, Croydon have all contacted us recently with a view to introducing a Pathway service.

Aim 3: To improve connections around patient care between primary and secondary care, leading to long-term reductions in admissions and repeat admissions to hospital.

Improving connections around our patients is integral to our model of care, and we try to ensure that no patient is discharged without somewhere to go. When a patient is referred to our team, our nurses immediately start to work to find out and address their housing and benefits status. They and the care navigator support the patient every step of the way during their hospital admission; they lobby with housing teams, hostels and outreach teams to achieve solutions to the patient's immediate needs. Where appropriate, the team will talk and persuade the patient to consider detox treatment. The team will also find out whether the patient is registered with a GP, and will encourage and help them to do this if they are not. At discharge, the patient will be given new clothes and will be accompanied to their new home or hostel place to make sure that they can be settled in. Our nurses contact key workers, community health and other outreach workers to confirm the patient's discharge, and will follow up the patient for a few days to make sure that the services that have been arranged prior to discharge are being provided and that the patient is engaging with them. For some patients, one of the nurses or the care navigator will continue to accompany them to medical appointments for some time after discharge to make sure that they access the ongoing treatment required. Where a patient is classed as having 'no recourse to public funds', usually foreign nationals who have not been in England long enough to qualify, then we will try to

secure them a place in a charitable night shelter which also provides breakfast and evening meals so as to ensure they are not sleeping rough.

What we haven't achieved that has impacted on our achievements

Our programme to recruit and train care navigators has not been as successful as we had expected. We have only managed to train one care navigator fully, and provided training to another for one day a week over six months, when it was decided that the role was not suitable for him. The reasons for our lack of success include: it has proved difficult to identify suitable candidates who are work ready; the role of care navigator is very challenging for an individual because they are likely to encounter patients who are having similar experiences to their own, which can bring back disturbing memories for them; and it has proved difficult to secure honorary contracts with UCH prior to being able to work in the hospital.

There are two main reasons why it is difficult to secure honorary contracts for care navigators at the hospital. These are:

- selected candidates need to undergo Criminal Record Bureau checks to satisfy Pathway's and UCH's stringent requirements for an honorary contract. It is usual for former homeless people to have a criminal history, usually minor offences, and they often fear the consequences of this coming to light, and therefore delay the process of completing the necessary forms. It is also challenging to the hospital's management to 'take a chance' on employing someone with a history of criminal activity, however trivial the offences.
- Pathway is asking the hospital to issue honorary contracts to people who would not fit in with its usual recruitment profile, ie former homeless people who may have a criminal record, and who are employed by a charity working within the hospital. This means that we need to try to find ways of working together to overcome the delays that the hospital procedures inherently introduce to the recruitment of trainees.

We plan to develop closer links with key staff in UCH's Human Resources Department so that they better understand the issues that we face and what we are trying to achieve, and to work with the candidates and reassure them that minor offences will not jeopardise their employment as apprentices.

When we have recruited suitable candidates we will ensure that where additional support, eg one-to-one counselling, is required, then we will endeavour to provide this. However, it is our plan to introduce regular reflective practice sessions in July 2013 for all our hospital staff and the care navigators should benefit from this too.

In 2013, we are planning to offer a few one-year paid apprenticeships to former homeless people to train to become care navigators. This training will be a combination of hands-on and academic training. The hands-on training will be led by Trudy Boyce at UCH, and the academic training will be supported and assessed by the London Learning Consortium. Additional support will be provided at the start of the training if the trainee needs help to attain the minimum literacy and numeracy levels required by the course. It has been essential to include an academic element to the training to be able to offer a recognised, accredited and transferable qualification.

At the end of the apprenticeship trainees will have achieved a level 2 Diploma in Health and Social Care. We hope that we will be able to offer opportunities for successful apprentices to follow up with an advanced level 3 diploma. Josie, our trained care navigator, started the advanced diploma in April 2013. We hope that offering formal apprenticeships that lead to accredited and recognised qualifications will make it easier for us to identify suitable trainees.

We recently interviewed two prospective care navigator trainees, but unfortunately neither was acceptable for the scheme at this time, although we have suggested that one of them tries again in a year's time when we hope his life is more stable. Meanwhile we have encouraged him to continue to volunteer with our research and admin officer on service user projects.

We are exploring more ways to recruit trainee care navigators – through networks we work with, including Crisis's Homeless Employability Network, who have offered to circulate a job pack to suitable teams and contacts, and by placing an open advertisement in the Big Issue.

Fewer care navigators has led to less resources being available to follow up our patients on discharge, and therefore this aspect of the service is less developed and evaluated than we had expected at this stage of the project.

4.3 Interpretation

Why was the Pathway intervention successful?

This intervention has been more successful and has spread more rapidly than we expected. The published link between a quality improvement intervention and reduced bed days was key. This was only possible because we devised a research-based methodology which allowed us to compare data before and during the intervention by using existing hospital data to identify homeless patients.

It is hard to analyse what it is that makes our service 'work'. There is no magic recipe, but there may be magic ingredients including: a small team of staff who work with the patients every day and who follow through the arrangements for discharge, getting all the necessary component parts in place – this is constant and never changing. Also, there is a team culture which is very patient-centred, as can be seen from a number of the video clips that we have included on our website (see Appendix xx). We also have a compassionate and specialist team of staff who take time to do what they can for patients. Sometimes they 'win', and achieve a significant improvement to a patient's life, but sometimes they 'lose' and make little difference to the patient's life beyond helping them over the crisis that brought them to hospital in the first place. However, personal qualities that our staff have which must contribute to our success include endless patience, resilience, perseverance and infinite compassion. (See www.pathway.org.uk/video-links/ to view the clips.)

In all hospitals where there is a Pathway service, it has been recognised that the MDT is absolutely key to the success of the model, and that this also contributes to changing the cultures within services. The person leading the MDT, usually the nurse, has to establish the correct culture from the start, and that culture has to be one of collaboration with the patient at the centre of their own care pathway. The team must include parties from all aspects of the patient's care and all parties must be made to feel integral to achieving the best outcome for the patient. In the video clip *Pathway MDT*, Dr Tim Robson describes the how the local housing officer acknowledges the role of the MDT in eradicating erratic unplanned discharges – see www.pathway.org.uk/video-links/ to view.

Why have our plans for care navigators not been as successful as envisaged?

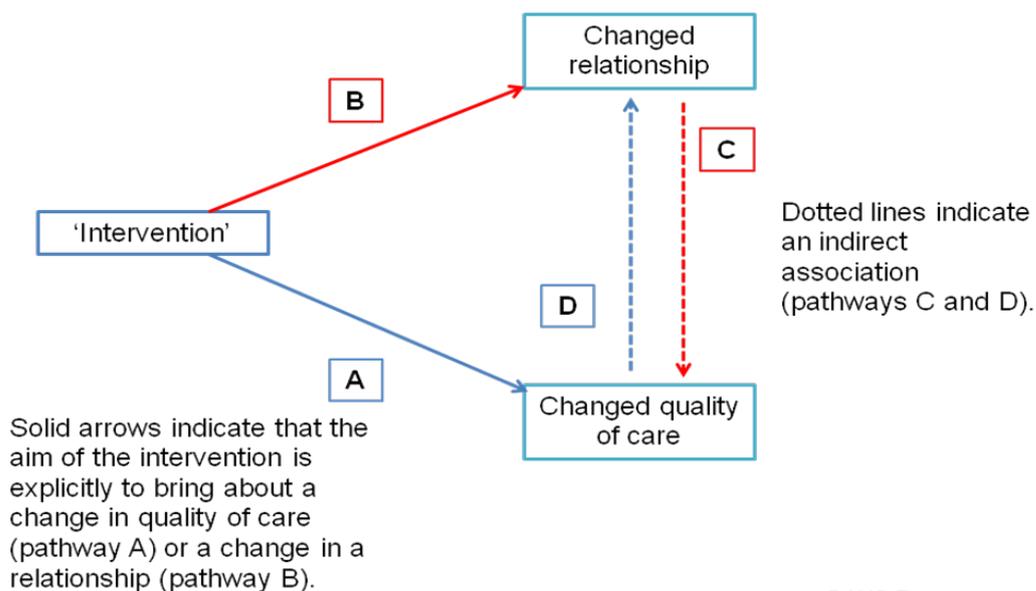
The outcome in which we failed to achieve our objective was recruitment and training of care navigators. This is because we had underestimated the step we were expecting formerly homeless people to make – from episodic volunteering to regular employment in the very formal and hierarchical setting of a hospital. We plan a more gradual and stepped approach to

support formerly homeless people into this work. We also need to make sure that we improve our working relationship with the hospital’s human resources team, so that the bureaucracy and procedures do not put unnecessary obstacles in the path of achieving our objectives for care navigators.

We are also aware that a majority of people with lived experience of homelessness are male, and wonder whether many of these would not consider training to be a care navigator as a suitable career choice. If that proves to be the case, the pool of possible candidates will be much reduced.

Similarly, the three former homeless people we have successfully worked with, in the roles of care navigators, and also as service user researcher/administrator, have all had several years of settled and established life before joining us. Therefore, we are considering seeking potential candidates with an historical rather than recent personal experience of homelessness as part of our recruitment requirements.

4.4 Link between interventions, changed relationships and quality of care



As stated in 4.1 above, we have concluded that in healthcare, changing relationships does not necessarily lead to an improvement in care quality, but rather that improving the quality of care is the impetus to change and improve relationships.

When we first introduced our model into UCH, we encountered resistance from many quarters, including a strong pocket of scepticism in A&E. It is only through working alongside other colleagues, helping them and sometimes remonstrating with and challenging them that we have changed attitudes and relationships towards our staff and our patients, and improved the quality of care given to our patients. One example is that now staff in A&E call us to help with homeless patients, where before they would have just turned them away having ‘patched them up’, as they recognise that having Pathway staff spending time helping the patient with things other than the immediate medical issue can result in the patient not presenting the following day or in the near future.

We also find that now ward staff take pride in managing some homeless patients themselves, without feeling they need to involve the specialist skills of the homelessness team.

Our view that improving quality of care leads to changed and improved relationships is further enforced by our experience at the Royal London and Brighton and Sussex hospitals. At the start of these services we were aware of resistance and wariness to their introduction from the housing staff in the local authorities (Tower Hamlets and Brighton and Hove) although less so with the hospitals' staff because we had done a lot of groundwork with them during the needs assessment process. However, soon after the service began, officers from both councils saw its value and that there are reciprocal benefits. Housing staff attend MDT meetings and now love the service and are keen for it to continue beyond the end of the RCT.

5. Resources to share

Appendix No.	Title
i	London Pathway Improvement Plan
ii	Patient stories
iii	Training activities, events and visits
iv	<i>BMJ</i> 2012 article 'A general practitioner and nurse-led approach to improving hospital care for homeless people' <i>BMJ</i> 2012;345:e5999 doi: 10.1136/bmj.e5999 (Published 28 September 2012)
v	International conference brochure
vi	Duncan Selbie, PHE newsletter
vii	<i>Lancet</i> Inclusion Health editorial March 13
viii	Data collection: How we measured our progress and impact
ix	Brighton and Sussex University Hospital Needs Assessment
x	Poster produced by James Smith, medical student on placement with Pathway, and submitted to his medical school in Newcastle
xi	An audit report: Borough of Origin and Primary Specialty of 2011 UCH Homeless Team Admissions produced by James Smith, medical student on placement with Pathway, and submitted to his medical school in Newcastle
xii	Article from UCH's internal newsletter June 2012, focusing on Pathway's service and featuring our senior care navigator
xiii	Article from Vital , Annual Report of the Director of Public Health Brighton and Hove 2011 – highlighting the introduction of the NIHR funded controlled trial of a Pathway service into Brighton Hospital
xiv	Pathway's poster for the International Forum on Quality and Safety in Healthcare in Paris
xv	Pathway prospectus for medical care
xvi	<i>HSJ</i> Award paper
xvii	Operational guide – produced with the help of the Quality Improvement Adviser, supported by the Health Foundation Grant (zipped file – The Pathway v1)
xviii	Medical Respite for Homeless People – outline service specification http://www.pathway.org.uk/publications/pathway-research-and-service-development-publications/
xix	Report of Emily Dobell, fifth year medical student, University of Nottingham, about her experience with the Pathway team
xx	List of and introduction to video clips that can be found on www.pathway.org.uk/video-links/

Other links of interest	
xxi	Harvard Business School Professor Michael Porter commends Pathway approach after leading the UCL Partners/Monitor sponsored 'Value in Healthcare Delivery' leadership seminar. He said, ' ... is an excellent example of how a value-based approach can better serve patients, reduce inequalities, and deliver better outcomes that matter to patients per pound spent'. The Pathway service was selected as one of four examples of value-based innovation in UK healthcare delivery, for presentation and discussion at the two-day conference with UK health leaders in London. The following is a copy of the Harvard Business School short 'case paper' describing the service at UCH and prepared for the seminar. http://www.londonpathway.org.uk/uploads/UCH_Homeless_Care_(FINAL).pdf
xxii	Pathway featured as one of eight UK and US case studies in New Philanthropy Capital's report 'A journey to greater impact', published on 16 November (http://www.philanthropycapital.org/publications/improving_the_sector/improving_charities/journey_to_impact.aspx),
xxiii	Article from UCH's website featuring the visit of Paul Burstow, Minister of State for Social Care http://www.UCH.nhs.uk/News/Pages/28Helpingthehomeless5.aspx
xxiv	BBC item reporting on publication of report <i>Improving hospital admission and discharge for people who are homeless</i> produced by Homeless Link and St Mungo's, but featuring Pathway's service at UCH http://www.bbc.co.uk/news/health-18210825
xxv	BBC London report on the RCT we are supporting at Barts Health and in Brighton and Sussex University Hospital. http://www.bbc.co.uk/news/uk-england-london-21258498

6. Sustainability

Proving the Pathway model

Proving our model is effective and economically viable has been a significant challenge in sustaining our work. We have overcome this by gathering, reviewing and analysing our own and UCH-wide data on homeless patients over three years. We have worked with independent experts to help us prove that we have a model that improves the healthcare experience for homeless people in hospital but is also economically beneficial for a hospital. The publication by the *BMJ* of a quality improvement report of the Pathway model has been instrumental in getting our work recognised, as has winning the 2012 *HSJ* Award for Patient-Centred Care.

At UCH, our team works as part of the discharge team, and at times our nurses cover for staff absence. It is our ambition for the Pathway service to be integrated into the hospital services and to become the norm rather than the exception. We are not there yet, but are finding that other staff are modelling their style of care on ours.

The key challenge is obtaining mainstream and permanent NHS funding for our work at a time when commissioning arrangements are in transition. So far, we have been successful in doing this at UCH where the trust has agreed to fund three nurses and four sessions per week of the GP – this is an increase of one nurse. The nurses will be based in the discharge team. This

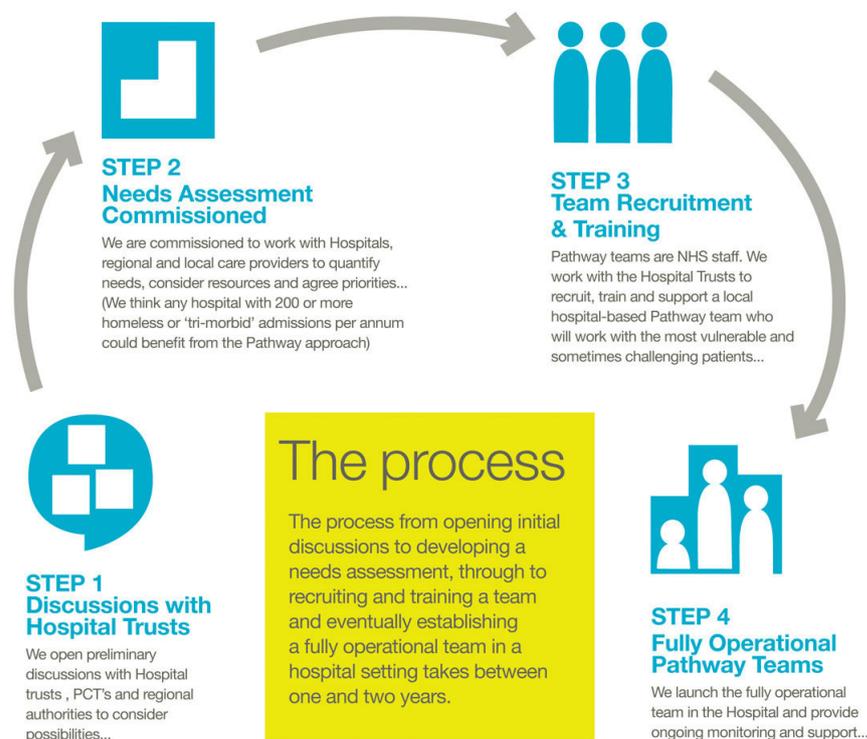
funding has been agreed in perpetuity. Pathway will continue to provide care navigators funded by charitable funding.

We anticipate that Barts Health and Brighton and Sussex University NHS Foundation Trust will fund services at the Royal London and Brighton and Sussex hospitals if the results of the RCTs prove the service to be beneficial. Meanwhile, the service will continue funded by a combination of unspent research funding in the first instance and topped up as necessary by the respective trusts.

7. Spread

7.1 Pathway's model for spread

Our model for spreading the service is outlined in the following picture.



What do we need to do to spread the Pathway model?

The spread of our service model (quality improvement activity) will be dependent on convincing commissioners and other funders that our model really works and not only improves outcomes for patients but also makes economic sense. We have already been using our experience and data from this project and the services at UCH, the Royal London and Brighton and Sussex to evidence this, and are working with Guys, St Thomas', King's and the Maudsley in South London, and Bradford and Manchester to develop pilot services. At the same time we are trying to secure funding to run pilots in other hospitals, eg North Middlesex, Birmingham, Mayday in Croydon and St Mary's, where there are significant numbers of homeless patients. We are also in the early stages of talks with contacts in Liverpool about expanding to their hospitals.

How are we trying to improve healthcare for the most vulnerable?

We lead work for the Faculty for Homeless and Inclusion Health, which consists of a broad range of people involved with or interested in a multitude of aspects of healthcare for these groups. We will use their meetings as a mechanism for spreading our learning from Pathway services, but also to gather and spread additional learning and understanding of broader health issues for homeless people.

How will we ensure our model stays true to our ethos?

As we spread the Pathway model to other sites, we intend to ensure that appropriate statistical information is collected and evaluated to show that the model improves health services for homeless patients at each site, and to share this data widely.

We will continue to use formal quarterly meetings of Pathway's wider team, as well as informal support networks, for staff to share their experiences of beneficial interventions on any Pathway site, and thereby encourage their introduction and implementation on the other sites. The formal quarterly meetings of the wider team are our main mechanism for sharing, and maintaining, the culture and values of Pathway. We ensure that a session for telling patient stories is built into each meeting for this purpose.

We will also encourage staff to share any negative experiences and issues from which the wider team can learn.

7.2 How we are promoting our innovation and convincing others of its value

What are we doing to promote Pathway's model of care?

We use every opportunity to promote our model of care. We seek out meetings with key people in the NHS, Department of Health and community service providers to talk about and explain our model of care. Currently, we are trying to add a further component to our service – medical respite – and talking about this concept and garnering support for it means that we are meeting many influential people to whom we promote our model of care.

We have developed a particularly useful relationship with the National Inclusion Health Board, with our chair and our medical director chairing two of the four working groups that report to the Board.

We use meetings of the Faculty of Homeless and Inclusion Health to promote our model, and the recent international conference is an example of how we do this. We were integral in drawing up the agenda for the two days, used it as an opportunity to launch our first annual report, and had a stand displaying our publications and plans for medical respite for the duration of the conference.

Our ambitions for Pathway's service model

Eventually we would like our service model to be spread to all acute hospitals in England where there is a sufficient need for it, and will support it by developing a system of annual accreditation (similar to the Macmillan Cancer Support model) where all Pathway sites will be inspected and reviewed to ensure they meet Pathway's core standards. Formal partnership arrangements will be secured with each site/trust hosting a Pathway service, which would also give the staff of the Pathway service access to support networks and events and mechanisms for sharing information and learning.

7.3 Advice we would give to someone wanting to replicate a Pathway model

We would encourage an organisation trying to replicate our work to follow our model set out in 7.1 above.

Consultation is key

It is important to consult widely ahead of agreeing to commence a service, in order to secure the support of as many key stakeholders as possible. These will include the clinicians and staff of the hospital, the specialist GP practices, local healthcare commissioners, community-based services and specialist third sector organisations for homeless and vulnerable people, and former and current homeless people.

There will be staff in the hospital who will think it unnecessary to employ a specialist team for homeless and other vulnerable patients, who will not recognise the special needs of this group of patients, and who will consider the usual, basic discharge arrangements sufficient. There may also be some clinicians and nurses who will be reluctant to engage with and work with homeless patients beyond the minimum intervention, because they view them as 'no hopers, and a waste of time'. These are the people who have to be challenged and shown that it is possible for these patients to get better and turn their lives around.

Is the service needed?

Following the consultation and information gathering work, it is important to carry out a detailed needs assessment to consider resources, agree priorities and check that there is a sufficiently large number of service users to make the introduction of a Pathway service economically viable – we would urge them to involve us in this work.

Funding the model

After the need for a Pathway service is established, the next stage is to secure funding for a pilot service from within the relevant NHS trust or other funder. There will be hospital managers who will consider the introduction of a specialist service to be an unnecessary, additional cost. The data produced at UCH can be used to illustrate the potential cost saving of introducing a Pathway service into the hospital, and will form part of the business case to secure funding.

What staff are needed? How Pathway can help

After funding is secured, it is very important to appoint the 'right' staff – they must not just be good doctors and nurses, but must have the additional qualities of being able to show real compassion to vulnerable and challenging patients and be willing to challenge peer or senior clinicians and champion high quality services for their patients. We would want and advise the hospital to involve our experienced Pathway staff in the selection of the GP and nurse, and this may also include involving our care navigator or other service user on the appointment panel.

Initially, we would advise that when the service is introduced it should be staffed with the specialist homeless healthcare nurse(s) and GP, and then when the service has been running for about 12 months we would suggest adding one or more Pathway-trained care navigator.

The extent of the initial new service

We would also advise that the new service concentrates on the admitted patients, and when resources allow extend the service to take in A&E.

What would Pathway's role be?

When it has been decided to introduce a Pathway service, we will share our Pathway operational guide, which contains lots of detailed information that the new team will find useful, including a guide of what data should be collected to help them evidence how their service is changing and improving care for their patients. They would need to regularly analyse this data to assess improvements. We would also encourage them to enter into a formal partnership with us so that they could have their service quality assured by us annually, and join in our regular network meetings where we share information.

The role of the dignity fund

We would advise the team to negotiate access to a dignity fund with the charity associated with the hospital, so that they will reimburse the cost of new clothes and other essentials for homeless and destitute patients.

Risks to the success of a new Pathway service

The main risks to the success of the service include:

- not having done sufficient initial groundwork to get senior commitment to the service – it is good to have a senior sponsor within the hospital who can help to iron out any local issues
- resistance and prejudice of local staff in the hospital – this is why the Pathway staff need to be good and resilient negotiators
- appointment of staff who are not committed to Pathway's ethos – this is vital to the success of the service
- not understanding the hospital bureaucracy sufficiently to get their agreement to issue honorary contracts to former homeless people who may have criminal histories – Pathway staff need to be resilient in overcoming hurdles and delays and be able to persuade that the risk is minimal if any at all
- not being able to identify and recruit enough suitable former homeless people to become care navigators – these are a key component of the teams, and being able to find enough good candidates could jeopardise this aspect of the service.

7.4 What are the main challenges to the future diffusion of Pathway's work?

Funding the service

The main challenge to spreading our service model is funding, and this is because the NHS commissioning landscape remains deeply confused. We continue to meet with a range of commissioners across London to try to influence their plans towards healthcare for homeless people. In an ideal world, the commissioning landscape would be simplified and resolved, however we are using the ongoing confused situation to take opportunities to get consideration for homeless health built into new commissioning arrangements from the beginning.

Ours is an unusual model of healthcare, combining primary and secondary services in a hospital setting, so agreeing an ongoing funding model may prove difficult to achieve.

Cuts to the benefits system

The Government's wide-ranging benefits cuts will also be challenging for our future work, as it may become more and more difficult to access housing solutions for our patients. With charities finding it harder to secure funding it may be that the number of services available to homeless and vulnerable people will contract, which could have a knock-on effect on our work. We expect that the changes to housing and other benefits will increase the number of

homeless people, which over time will increase the number of people needing to access health services.

8. Conclusions – how far did the Pathway project meet the aims of Closing the Gap through Changing Relationships?

The patient at the centre of care

At the heart of the Pathway model is putting the patient at the centre of the care, and this is not to address the immediate healthcare issue but to take the time to work with other agencies to help address other issues that the patient has. For our core group of patients, this will be no home, but may also be alcohol and substance misuse or addiction, mental health problems, no access to benefits due to loss of means of identification and ability to prove entitlement, and loss of self-esteem.

The role of the multi-disciplinary team meeting

We have found that one of the most important interventions that we introduced was the MDT meeting. Pathway's GP at the Royal London reported, following one of these meetings, that a senior representative from a housing office who had attended a meeting to discuss a patient, went back to his organisation saying it was the best and most productive meeting he had ever attended and recommended that other colleagues attended to learn how services can be more joined up. This is just one example of how our staff use our model to facilitate the joining up of a range of services on behalf of an individual and advocate for that individual while remaining professional in their own discipline. It also illustrates that interventions such as ours can change mindsets and relationships with what can be a difficult group of people.

The homeless patient's relationship to hospital staff transformed

A homeless patient is usually vulnerable and often suspicious of medical staff. They are desperate for help but reluctant to trust the nurses and doctors. Our specialist team of nurses, doctors and care navigators get alongside the patient right from the start, and explain that they are there to help and advocate for them and will try to get a housing solution for when they are discharged from hospital. Having a care navigator, a person with lived experience of homelessness, on the team is often helpful in getting the patient to trust the team and to open up with problems other than the immediate health issue. This is beneficial to the clinical team, as more information can lead to more treatment and better outcomes for the patient. Often, by the time the patient is discharged they are seeing Pathway's nurses and care navigator as friends they trust. We have included some quotes from patients in section 4.2 above as evidence of these changes in relationships.