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

1. Purpose

The aim of the evaluation is to evaluate the homeless support team against the objectives set for the service and impact on the following key areas; trust activity, patient experience and outcomes, staff and stakeholder experience and integration, value for money and model. The pilot is due to end in July 2018, so a decision needs to be made by BNSSG CCG to inform future commissioning.

2. Background

The Impact of Homelessness

Studies suggest that people who are homeless attend A&E six times more than the housed population; are admitted four times as often; and stay three times as long[1]. Outcomes for the homeless population are significantly worse than for those of the housed population. The average age of death of homeless people is 47 and 43 years for men and women respectively compared to 77 years of age in the general population.

Drug and alcohol abuse account for over a third of deaths[2] and in BNSSG this group make up 54% of our total admissions.

The NHS England needs assessment[3] highlights Bristol as having one of the highest numbers of rough sleepers in England's core cities[4]. More recently Bristol's annual rough sleepers count has shown a 14% increase since 2016, which is recognised as a large underestimate of the real problem[5]. Also, Bristol has one of the highest rates of families who are statutorily homeless in the U.K, with 1 in every 197 households becoming homeless in 2017. This is twice as high as the national average[6].

A recent report by Crisis[7] has shown that for each one person sleeping rough, there are 4 in hostels, 8 'sofa surfing' and 3 in other accommodation whilst homeless. This study also predicts a rise of 176% in homelessness by 2026.

The Queen's Nursing Institute reported[8] from a community nurse perspective, homeless people report poor experiences and outcomes at hospital discharge. The reasons for these include; poor communications around discharge planning and joint working between organisations, inappropriate/unsafe discharge for vulnerable patients and lack of access to appropriate accommodation/step down care.

Why did we fund this pilot?

In 2016 Bristol had a visit from the Pathway Team[9]. Pathway was set up by clinicians at University College Hospitals in London to develop a model of care to support and change the lives of homeless people. It was founded to show that homelessness is a healthcare problem - good health services have a vital part to play in helping people with their health but can also help patients address the problems that led them to the street. Through their integrated healthcare model, they reduced bed days for this group by 11%. They have supported 11 hospitals across the UK, including the Bristol team, to implement the model.

The model provides:

- Housing and benefits advice
- Help to recover important documents such as birth certificates, passports etc.
- Links to community services

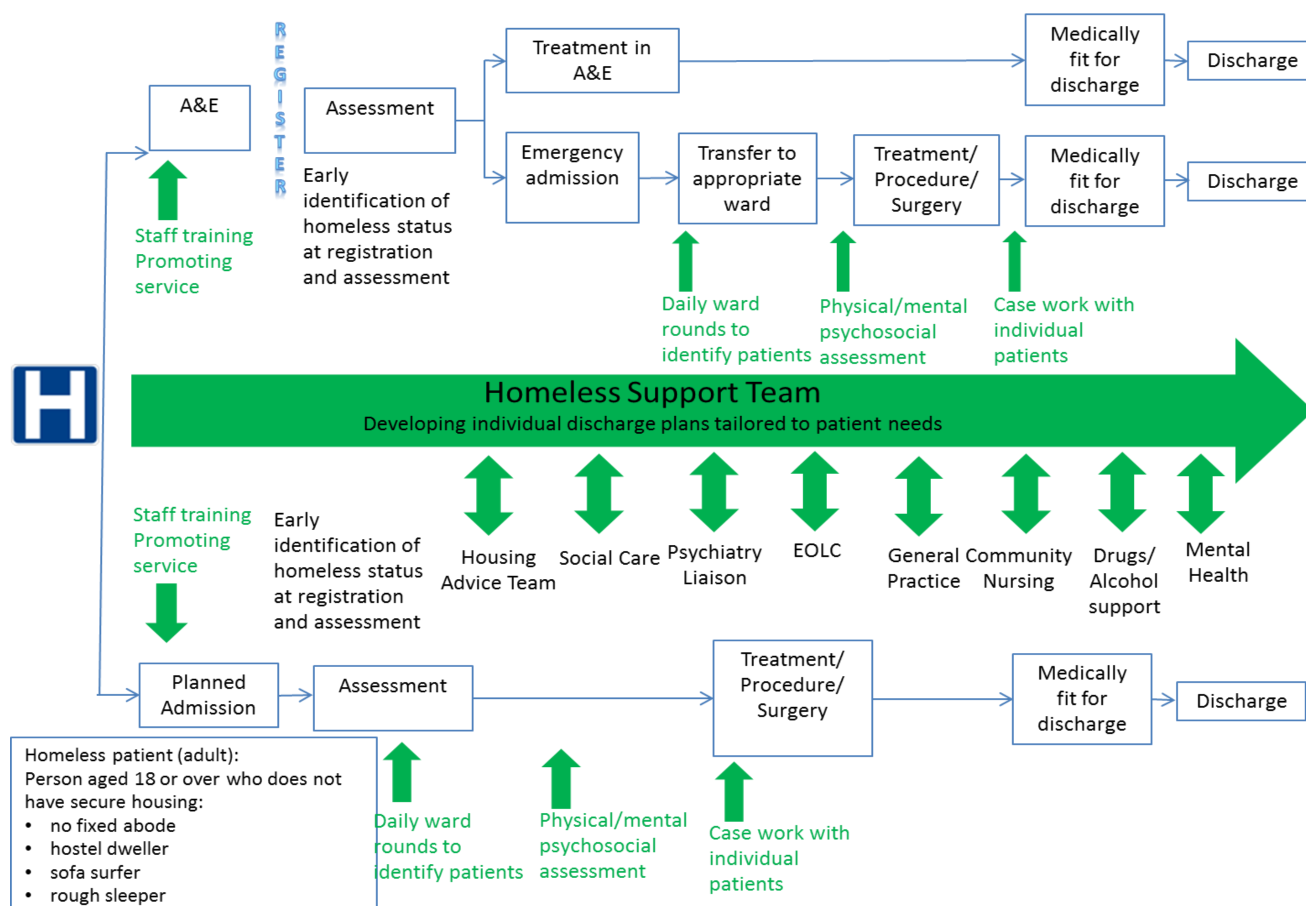
- Support and collaboration with other clinicians e.g. advice on drug interactions, addictions, personality issues etc.
- Complex care planning and discharge liaison
- Referral for addictions support
- Help with GP registration
- Fresh clothes, shoes and other basics (for example where these have been destroyed because of infection/infestation)
- Help to reconnect with loved ones

To understand our local population need we undertook an initial audit which showed the potential for reducing re-admission and re-attendance rates for those who are classed as homeless or vulnerably housed, following the pathway model. Kate Rush, a Bristol CCG GP clinical lead at the time, then presented a business case to Bristol CCG who agreed to fund the pilot team for 18 months from January 2017-July 2018. Over 18 months the pilot has cost £180,000 in salaries for the staff and initial I.T setup.

The Homeless Support team is a multi-disciplinary team comprising the following staff that are all based in the Bristol Royal Infirmary discharge hub:

- 1 x WTE Clinical Co-ordinator (nurse lead)
- 0.5 x WTE Social Worker
- 1 x WTE Housing Support/Outreach Worker
- 1 x four-hour session/week GP from Homeless Health Service providing clinical leadership

The model works within the hospital and other agencies as below:



3. What age groups are affected by this proposal?

This proposal affects adult patients (18 or over) who are homeless and/or vulnerably housed and who are:

- An inpatient at the Bristol Royal Infirmary
- Identified as a frequent attender at Bristol Royal Infirmary A&E

4. Aim and Objectives of the pilot

The aim of the pilot was to improve the experience and outcomes for homeless patients attending A&E and admitted to Bristol Royal Infirmary whilst also addressing important system issues.

The following objectives have been developed to inform the aim of the evaluation:

1. To review the service delivered against performance and quality standards
    - Performance targets
        a) Reduce rates of admission and re-admission (within 28 days)
        b) Reduce attendance and re-attendance in A&E (within 28 days)
        c) Increase the number of homeless A&E frequent attenders with a care plan
        d) Reduce number of patients discharged with no housing provision in place
    - Quality standards
        a) Improve health outcomes for homeless patients
        b) Improve the experience of hospital discharge for homeless patients
        c) Improve quantity/quality of information available on discharge
        d) Increase engagement with primary care (e.g. increase GP registrations)
2. To understand the overall level of satisfaction the patients have of the service provided by The Homeless Support Team
3. To understand the overall level of satisfaction the healthcare professionals have of the service provided
4. To identify what works well and any opportunities to further improve the service provided

5. Method/approach of evaluation

In order to demonstrate whether or not the objectives have been achieved, specific measures have been identified for each objective with data sources and tools to support this.

Stakeholders have been identified and sense checked with the Homeless Support Team, BNSSG CCG Clinical and Managerial Leads for the project, and the Discharge Co-ordinator for UH Bristol. They have included service users, healthcare professionals in secondary and primary care, third sector organisations such as St. Mungo's, Bristol Drugs Project and The Homeless Support Team Staff.

A variety of methods have been used to collect the required information

- Data from Medway and Emis
- Previous reports and meeting notes
- Questionnaires
- Face to face interviews

6. Results/feedback

The details in Table 1 below summarises the data sources, approach and numbers involved.

Table 1:

Data sources and tools	Approach	Numbers involved
Medway data for all patients with an NFA/hostel postcode	Electronic data	Referrals for the last 12 months =384
Emis data using a tailored HST Emis template	Electronic data	Referrals for the last 12 months=384
Case studies of individual patients - including details of interventions made and outcomes	Collated by Homeless Support Team	See Appendix A
Patient experience questionnaires	Hard copies	13 Hard copies
Semi-structured interviews with patients post discharge	Face to face	Two conducted by Patient Public Involvement Lead
Patient filmed feedback	Face to face	Two patients
Health professional and stakeholder filmed feedback	Face to face	Three staff members
Health professional and stakeholder questionnaires	Hard copies	71
Steering group meeting notes	Electronic copies	See Appendix B
Monthly written commentary report from the Homeless Support Team	Electronic copies	See Appendix C

6.1: Evidence to support objective 1 - To review the service delivered against performance and quality standards

The data obtained to support this objective has been from the following

- Medway data
- Emis HST template
- Monthly HST reports

6.11 Delivery of Performance Targets

Table 2 – evidence for delivery of performance target a): Reduce rates of admission and re-admission (within 28 days)

UHB Admissions for NFA (No Fixed Abode) or Hostel	Initial Audit April 2014-2015	With HST January 2017-2018	% change
Number admitted	238	180	↓ -24.3
Average Length of Stay	11 days	2.8 days	↓ -74.5
Number self-discharged	28	18	↓ -35.7
Number re-admitted within 28 days	132	50	↓ -62

By reducing length of stay, if you assumed each patient cost the average NICE cost of £222 per day, we would have saved £439,308 with the HST in place. As this group of patients often present with complex health needs, looking at the HRG codes and trim points for each admission means that we have actually saved £921,300. Taking into account the costs associated with the team this equates to an overall saving of £766,300.

Table 3 – evidence of delivery target b): Reduce attendance and re-attendance in A&E (within 28 days)

UHB A&E Attendances for NFA (No Fixed Abode) or Hostel	Initial Audit April 2014-2015	With HST January 2017-2018	% change
Total number of A&E Attendances	324	252	↓ -22
Number re-attended within 28 days	152	78	↓48.7
Number self-discharged	Not known	62	N/A
Number admitted	238	180	↓ -24.3

Evidence for delivery of performance target c): Increase the number of homeless A&E frequent attenders with a care plan

Evidence of this comes from the joint work undertaken by the High Impact User (HIU) Group and the HST.
All the HIU work and personal support plans are conducted jointly with the HIU coordinator. This is a role that has started since the team commenced in Feb 2017. The HST team is actively involved with the ED HIU group and they attend the monthly meetings and undertake any actions around this which involves homelessness. HST also support the HIU/ mental health CQUIN.
The HST have developed care plans for people who are homeless and are considered a high impact user of A&E – you can see an anonymised version of this plan in Appendix D. All patients who are a high impact user and homeless/vulnerably housed have one.

Table 5 – evidence for delivery of performance target d): Reduce number of patients discharged with no housing provision in place

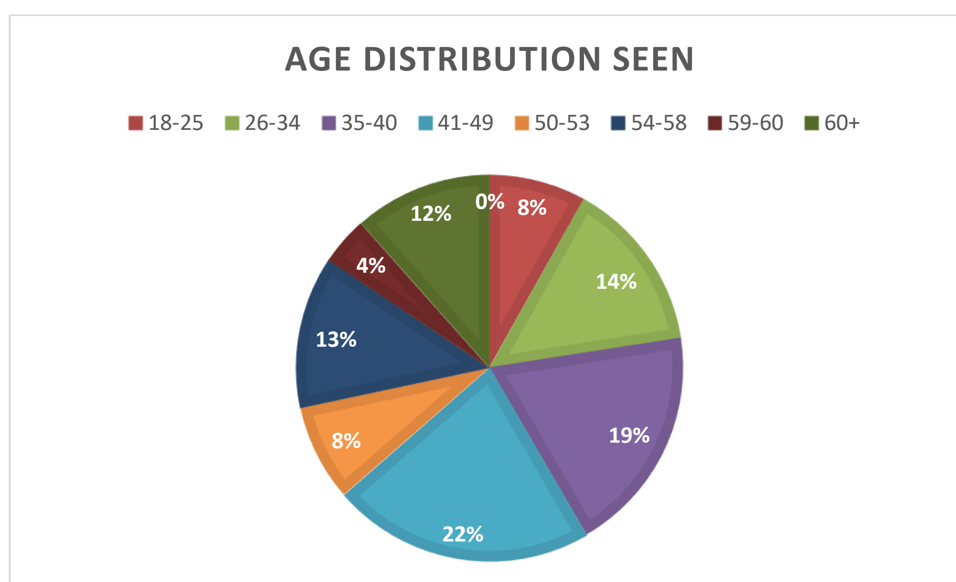
Housing on Admission	Number	%	Housing on discharge	Number	%
Evicted	2	1	Care Home	6	3
Hostel	29	17	Hostel	12	7
Housed	28	16	Family / friend	6	3
Rough sleeping	93	53	Rough Sleeping	6	3
Sofa surfing	11	6	Crash pad	9	5
			Reconnec-tion	7	4
			Returned to original housing	105	60
			St Mungo's shelters	6	3
Unknown	1		Unknown	1	1
Other	11	6	Other	17	10

HST intervention has increased the range of housing options accessed by the patients they have seen. Although the majority have returned to their original housing, the number of rough sleepers has greatly reduced with more use of temporary housing options offered by the council and intensive support given to aid reconnection.

6.12 Delivery of quality standards

Table 6 – evidence for delivery of quality standard a): Improve health outcomes for homeless patients

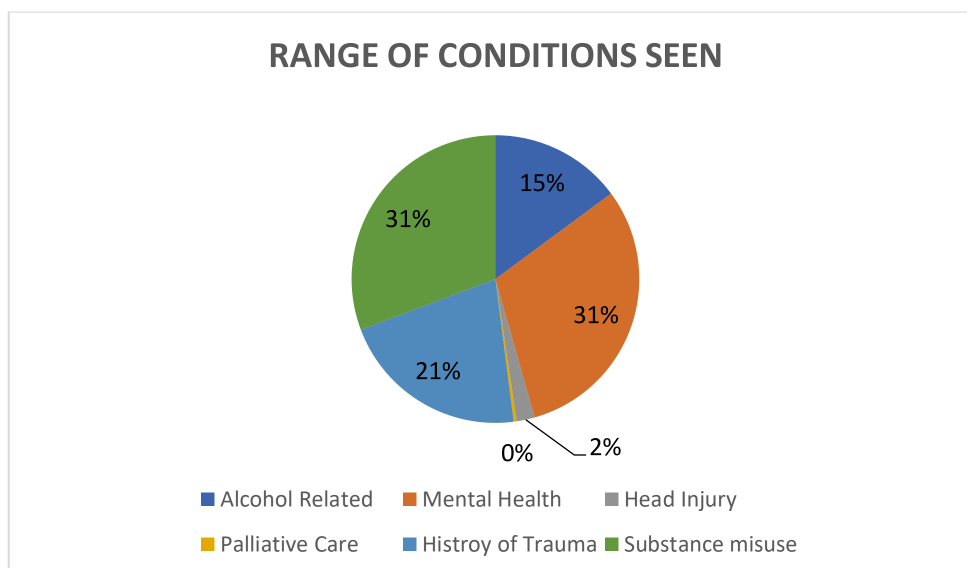
Having the HST has allowed us to understand in more detail the types of patients who present as homeless/vulnerably housed. Below shows a breakdown of the demographics and medical conditions of the HST patients:



Of these patients:

- 83% of episodes of care were for White British people
- 72% of episodes of care were for men
- 16% accepted help to register with a GP
- 28% declined support from Housing Support Team

The range of health conditions seen shows significant numbers of patients having issues with substance misuse, alcohol, mental health issues and a history of trauma. In terms of trauma this relates to patients having suffered abuse in their past, which has a direct correlation with substance misuse and mental health issues.



For mental health, 5% of patients were already known to the Mental Health Team. The team sign posted 88% of those presenting with mental health issues to mental health services, and directly referred 20%. Other high levels of referrals by the team were to the Rough Sleeper Outreach Team, Adult Safeguarding and Social Services. However, 35% were not eligible for an adult social care package as they did not have a care need.
Recording and detailing the type of trauma patients had experienced, identified that the majority related to a history of abuse, being violent towards others or having a record of imprisonment.
Substance misuse related mostly to injecting heroin and crack, an issue peculiar to Bristol.
The team also coded those patients who would have benefited from an interim solution (step-down) as opposed to a straight discharge. This was the case for 40% of all patients seen, relating to their complexity and need for ongoing health and social care support.
By supporting patients to navigate the health and social care system, the team has been able to support improvements in health outcomes. This is further detailed in the patient and staff feedback below.

Supporting this ability to improve health outcomes has been an educational programme for staff in the hospital. The Team has been running training to all hospital staff to raise awareness of homelessness in general, its effects on health and wellbeing and how best to support this patient group. Teaching is provided ad-hoc on a daily basis as well as more formal training for the Emergency Department, Liaison Psychiatry, the Liver Unit (A522) and the Admissions Unit (A300).

Evidence for delivery of quality standard b): Improve the experience of hospital discharge for homeless patients

This was evidenced through two patient interviews post-discharge conducted by the CCG Patient and Public Involvement Lead. Below is a summary of the points from the interviews:

Patient 1:

- First time the patient had the support needed to get back on track
- Attended A&E 8 times in the last 12 months.

- Discharge – was a great experience. Taxi to take home, coordinated discharge – medication ready, appointments set up, put in touch with all relevant agencies, *'everything sorted'*
- The team took into account his housing and health needs on discharge – the discharge took place in a timely way to ensure hostel place was not lost
- HST service should be available at NBT
- The Homeless support worker took the patient to the hostel and introduced them to all the staff and nurses in Homeless Health. *'This made a huge difference'* and is *'a brilliant service'*
- Without the support of the HST the patient would have started drugs and the opportunities such as getting a flat and work would not be available.

Patient 2:

- Registered with GP – discussed with GP good discharge experience
- 2 attendances to A&E in last 12 months, many more prior to this over the years.
- Experience of clinical staff – paramedics, doctors, and nurses were mixed. Some were judgemental which clouded their assessment of the situation
- Felt a bit of a burden - *'shouldn't be there'*, taking up health care staff time and being talked about rather than to.
- It took time for staff to know and understand his housing situation
- Discharge planning nearly went wrong when someone tried to discharge him to somewhere other than the planned hostel. HST stepped in and altered the plans accordingly.
- Gestures of kindness and support made the patient feel very different about themselves and the future. This made a big difference. *'Not sure if I would still be here if it wasn't for them'.*

Evidence for delivery of quality standard c): Improve quantity/quality of information available on discharge

By sharing Emis records, the Homeless Health Centre and key practices who work regularly with homeless patients, can access all the information relating to an admission/attendance of a patient. In addition, the HST have created a discharge summary for all, so that key pieces of information relating to the patient and referrals and connections made can be shared, saving time and effort to those who see the patient after discharge.

Table 7 – evidence for delivery of quality standard d): Increase engagement with primary care (e.g. increase GP registrations)

For both A&E attendances and admissions we have reduced the number of patients that are not registered with a GP.

UHB Admissions for NFA (No Fixed Abode) or Hostel	Initial Audit April 2014-2015	With HST January 2017-2018	% change
Number admitted	238	180	↓ -24.3
Number registered with a GP	170	170	→
Number not registered with a GP	68	10	↓ -85.3
UHB A&E Attendances for NFA (No Fixed Abode) or Hostel	**Initial Audit April 2014-2015**	**With HST January 2017-2018**	**% change**
Total number of A&E Attendances	324	252	↓ -22
Number registered with a GP	207	231	↑ 10.3
Number not registered with a GP	117	21	↓ 82

In addition, we have targeted information to General Practices with high levels of homeless patients in their registration area to give information on how to register this group of patients and the process of doing this.
By having an Emis template used by the HST through the Homeless Health Service, we have also been able recently (as described above) to create data sharing agreements so that information on the patients stay is accessible and available in a timely manner.

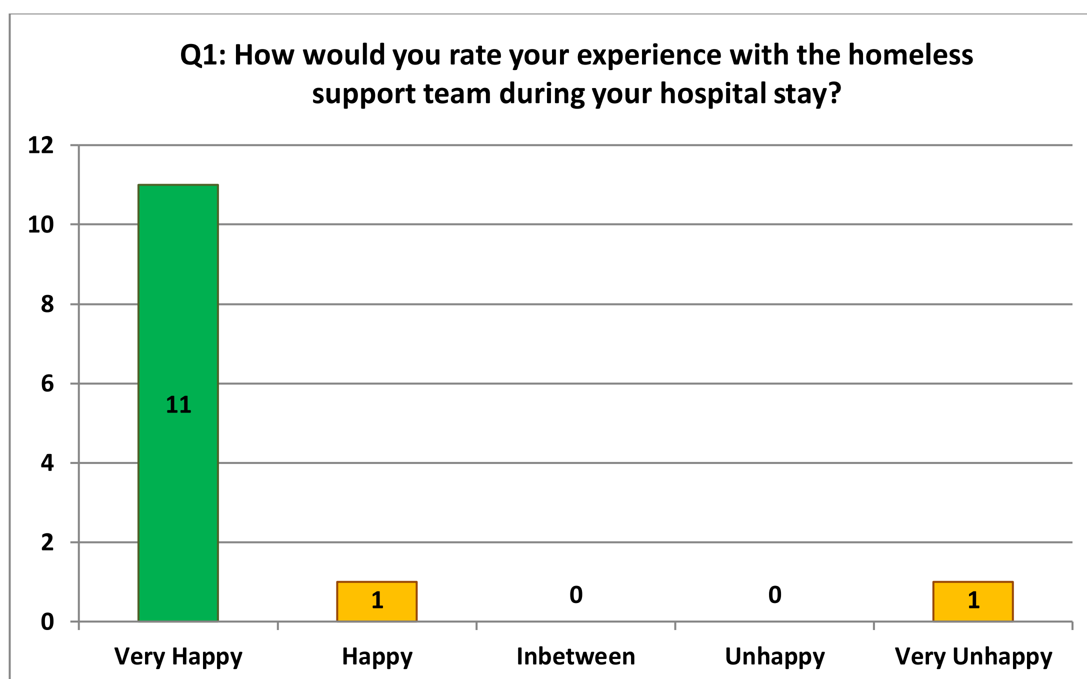
The team have begun monthly Multi-Disciplinary Team meetings with St Mungo's and the Homeless Health Service to discuss complex needs clients and deaths, hosted at the Compass Centre. Once this is established consideration will be given to inviting the hostels and other GP surgeries who see homeless patients. This is based on a model from London as a way of improving and addressing severe health & wellbeing and End of Life issues.

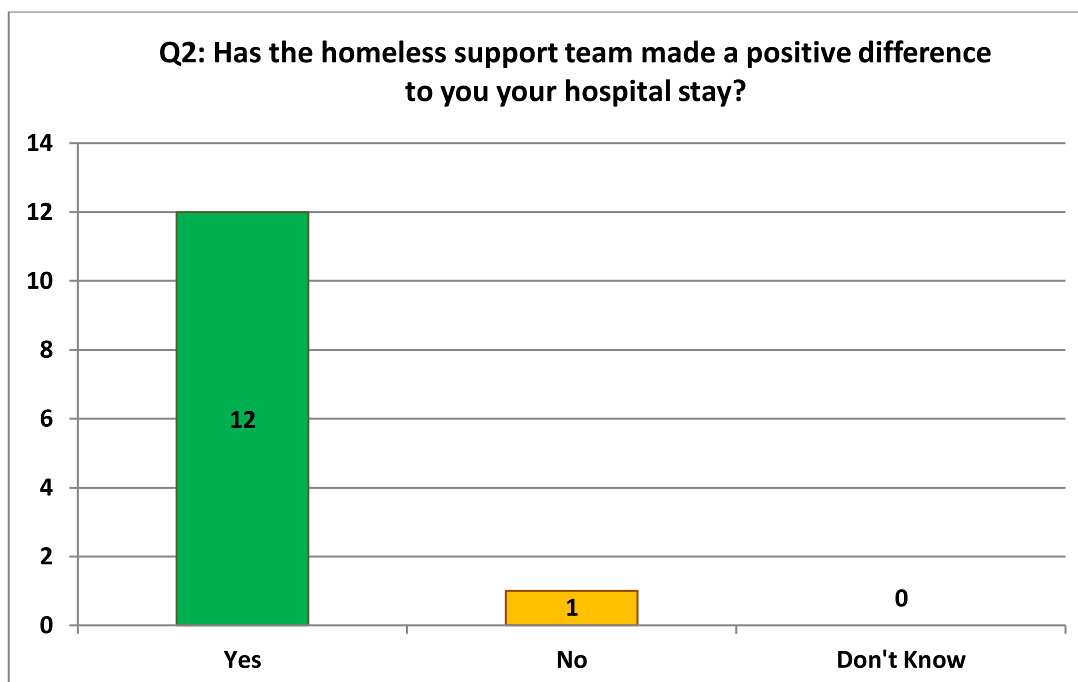
6.2: Evidence to support objective 2 - To understand the overall level of satisfaction the patients have of the service provided by The Homeless Support Team

Patient satisfaction was evidenced through a patient questionnaire and patient filmed feedback and semi-structured interviews.

Questionnaire:

Between February and October 2017 13 service users completed a patient questionnaire that was made up of three questions. The bar charts below show that most patients seen by the HST are very happy with their experience and felt it made a positive difference to their hospital stay.





Below is the feedback given to the open question: *'Is there anything we could do better?'*

- Keep doing what you did for me to others and there won't be to many complaints
- To know exactly where I will stay, not just I am going to the Council, the unknown
- I don't think so, what you did for me and my partner helped me recover faster and easier yes make sure the real people get help not just those on drugs
- If possible to have a bigger slot to see them
- Perhaps if they listened properly would be a miracle but maybe one day
- I'm not sure how the system works but they have been very reassuring as long as I'm keeping in touch
- I have no complaints. A smashing lot of people.

All but one of the comments provides evidence that the Homeless Support Team have improved the satisfaction and experience of the people who answered the survey.

<u>Patient filmed feedback:</u>

Two patients were interviewed and asked the following questions:

- Can you tell us what brought you to hospital?
- What was your housing situation before you came to hospital?
- How have the homeless support team helped while you have been in hospital?

The main themes of their feedback are as follows:

- Team provided reassurance
- Their involvement meant a great deal to the patient
- Helped me so much
- Helped manage the pressure of being homeless

The following are quotes taken from the filmed feedback:

Patient 1: '*The Homeless Support Team' was a team I could confide in, talk to; they helped me recognise the people I need to contact in the Council, so I can make a housing application'.*

Patient 2: *'I am getting my wish to spend my time back with my family. Anything I do from now on I have the team to thank for. They have helped me so much'.*

6.3: Evidence to support objective 3 - To understand the overall level of satisfaction the healthcare professionals have of the service provided

Staff satisfaction was evidenced through face to face interviews with three members of staff. The staff interviewed was the Integrated Discharge Lead, Drug Clinical Nurse Specialist and Ward Staff Nurse. They were asked the following questions:

- What has been your experience of the homeless support team?
- Do you feel having the team in the BRI has had a positive effect on the health outcomes of patients?

The main themes of their feedback are as follows:

- The presence of the HST have highlighted the little knowledge staff have about supporting homeless people and their discharge from hospital
- HST support the patient and the staff to support discharge
- If no options are available, having the HST support makes the team feel they have tried all options
- Some patients are very anxious about being discharged. Anxiety effects physical health
- The support HST gives patients has an impact of their physical health, mood and emotional wellbeing

In addition, we have had further feedback from the Care Co-ordinator of the HST:

"Having worked in the BRI for many years, in other roles (primarily the ED and as one of the alcohol specialist nurses), I have come across and cared for many homeless clients in varying states of poor health and well- being. Homelessness has always been an issue for the BRI and we have always been ill- equipped to deal with it in a practical, supportive and caring way.
The HST has been able to specifically work with this group of particularly vulnerable clients to support them in their treatments while in hospital and in trying to ensure they continue to manage their health better on discharge by ensuring they are aware of the services they need to engage with and in trying to accommodate them. If we were to lose this team, I would struggle to see how the trust would be able to continue providing the much-needed support to such a vulnerable group of individuals.
Our clients' wellbeing needs can be very challenging, and all need an individual approach to their care and support. Having such a diverse skill mix in our team has allowed us to rise to these challenges and we have found this multi -disciplinary way of working to be very successful.
Since the beginning of our pilot, we have provided advocacy to our clients and support/ teaching to staff around the trust. As a result, we have started to find a shift in attitudes toward the typical stereotypes of homelessness and noted a culture of increased empathy and compassion towards this client group beginning to develop."

6.4: Evidence to support objective 4 - To identify what works well and any opportunities to further improve the service provided

Collating the feedback and data above what works well can be defined as below:

- Reductions in attendance and re-attendance in A&E
- Reductions in admissions and re-admission to the hospital
- A significant reduction in length of stay and savings related to this
- A reduction in those patients not registered with a GP
- An increase in communication and co-ordination between services for this patient group
- Improvements in timely and accurate information relating to this patient group to aid decision making in other settings outside the hospital
- Improvement in this patient groups access to information and support
- Improvement in staff knowledge on the issues faced for this group of patients through education
- A good example of system-working for the benefit of population need

Opportunities to further improve the service provided would be:

- To expand knowledge of the service within secondary care and other settings
- To review the Homeless Housing Pathway with Bristol City Council now that the new Housing Act has been issued (Appendix E)
- The use of volunteers to support HST's work including peer support following discharge
- Improve data sharing with external organisations
- To focus on developing a BNSSG approach to homelessness from a health and social care perspective and facilitate integrated working for this vulnerable group

7. Summary

This evaluation shows that the HST has positively impacted not only admission, re-admission, attendance and re-attendance rates, but also the length of stay and a system approach to a vulnerable group of patients. The team have increased engagement and communication for patients across organisational boundaries.

Feedback from both staff and patients has been very positive and there is an opportunity to take a Bristol model and expand it across BNSSG to commission in a way that addresses local population needs.

8. Options

- To decide not to further fund the HST in Bristol Royal Infirmary

- To continue funding
  This would allow the identified benefits to continue

- To continue funding and look at a BNSSG approach
  This would allow the identified benefits to continue and give time to develop an approach with benefits those who are homeless across BNSSG.
  This would enable BNSSG CCG to fully understand what the needs are for this vulnerable group of patients across the patch and system.

The risk attached is that we may not be able to find a generic solution to BNSSG CCG's need which may be associated with an increased cost.

9. Financial Implications

The service currently costs £140,000 per year. This evaluation provides the opportunity to review options to ensure the best use of this resource moving forward.

10. Legal Implications

None identified at this stage

11. Risk implications, assessment and mitigation

Ensure which ever option is considered does not compromise the support available for this client group

12. Consultation and communication

To ensure the HST team are aware of any changes in advance of the potential end of the service in July 2018

13. Implications on equalities and health inequalities. How does this proposal fit with the Bristol Joint Strategic Needs Assessment?

This service meets the needs of a distinct vulnerable group who are subject to significant health inequalities

14. How does this fit with BNSSG CCG's Commissioning Intentions?

This service fits with BNSSG CCG's intentions to reduce health inequalities and meet the needs of BNSSG CCG's population.

15. Recommendation

BNSSG CCG is recommended to consider option 3:

To continue funding and look at a BNSSG approach

Raw data and additional information collected, including questionnaire templates available on request from Kate Rush, Associate Medical Director, BNSSG Clinical Commissioning Group.

16. References

1. https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health
2. BNSSG Urgent Care Strategy Document, 2018
3. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/692140/NHSE_Mandate__2017-18_revised.pdf
4. https://www.bristolpost.co.uk/news/bristol-news/number-rough-sleepers-bristol-revealed-916343
5. http://news.bristol.gov.uk/annual_rough_sleeping_count_figure_revealed
6. https://bristol.citizenspace.com/neighbourhoods/preventing-homelessness-accommodation-pathways/supporting_documents/Draft%20commissioning%20plan%20Nov%2016.pdf
7. https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/
8. https://www.qni.org.uk/resources/homelessness-hospital-discharge/
9. http://www.pathway.org.uk/

17. Appendices

Appendix A: Case Studies

case study KA. No local connection.doc

case study BW-NRPF.doc

Appendix B: Steering Group Minutes

Homeless Support Team Steering Group

All steering group minutes can be found at S:\T&Q\Transformation Team\Homelessness\Homeless Support Team\Steering Group

Appendix C: Monthly Reports

BRI HST monthly update Feb 2018.doc

All monthly Reports from the HST can be found via S:\T&Q\Transformation Team\Homelessness\Homeless Support Team\Performance data\Monthly reports

Appendix D: Care Plan for High Impact Users

University Hospitals Bristol
NHS Foundation Trust

NHS Working in Partnership

Avon and Wiltshire
Mental Health Partnership NHS Trust

LIAISON PSYCHIATRY SERVICE Clinical enquiries 0117 342 2777 Clinic co-ordinator bleep: 2440

Emergency Department Personal Support Plan:

Managing Distress During Hospital Attendances

Date: 5-Dec-2017

Review Date (minimum annually): 5-Dec-2018

Is it ok to share this information with next of Kin?

Name:	
T Number:	
DOB:	
Address:	
Phone number:	
Significant other/carer:	

Risks:

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University Hospitals Bristol NHS Foundation Trust | NHS Working in Partnership | Avon and Wiltshire Mental Health Partnership NHS Trust

LIAISON PSYCHIATRY SERVICE Clinical enquiries 0117 342 2777 Clinic co-ordinator bleep: 2440

Under what circumstances or with what problems are you most likely to present requesting help?

Crack smoker
Infective exacerbations COPD
Occasional spice use
Self harm and overdoses
Sexual exploitation

What is the most appropriate response to the situation?

Offer drug nurse appointment
May need medical admission for chest infections
Refer to homeless health team
Mental health referral when presents with overdoses and self harm.
Encourage to go back to [redacted] hostel to sleep. Has a room there but often doesn't use it and sleeps rough - makes her very vulnerable.

What factor/s would indicate a higher/lower risk?

Change to usual presentations
On most recent hospital admission, she self discharged after her drug dealer/pimp gained access to ward and tried to coerced her into sexual acitivity in exchange for crack cocaine.

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Avon and Wiltshire
Mental Health Partnership NHS Trust

LIAISON PSYCHIATRY SERVICE Clinical enquiries 0117 342 2777 Clinic co-ordinator bleep: 2440

Do you need to be assessed by (Y/N)?
Yes

Which specialty do you need to be assessed by?
Alcohol Nurse
Drug CNS
IDVA

Comment on assessed by;

If not, what would indicate assessment is required?

What circumstances/problems/presentation would suggest a psychiatric emergency (therefore requiring referral to the Crisis Team)?

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Mental Health Partnership NHS Trust

LIAISON PSYCHIATRY SERVICE Clinical enquiries 0117 342 2777 Clinic co-ordinator bleep: 2440

Any action plan?			
Any additional Patient/GP/care co-ordinator information?			
Please give details of professionals/others involved, e.g. GP, CPN, care co-ordinator, carer etc.			
Name:	**Role**	**Contact number**	**Copy Sent To (Y/N)?**
Do not want information shared with:			

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LIAISON PSYCHIATRY SERVICE Clinical enquiries 0117 342 2777 Clinic co-ordinator bleep: 2440

Completed by:	
Patient:	
Carer/other:	
UHB Trust staff	HIU team
Date:	5-Dec-2017

SW/DO
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Appendix E: Housing Pathway

Homeless discharge pathway.docx