# Hackney Needs Assessment

## Homerton University Hospital NHS Trust &

## City & Hackney Centre for Mental Health

## Needs Assessment for Patients Who are Homeless

## December 2019-March 2020

## Executive Summary

The Better Care Fund of NHS City and Hackney Clinical Commissioning Group and London Borough of Hackney commissioned Pathway to complete a needs assessment regarding patients who are homeless attending the Homerton University Hospital and the City and Hackney Centre for Mental Health.

This was completed between December 2019 and March 2020. Quantitative and qualitative data was gathered and analysed, including 26 interviews with relevant staff.

The main findings are that across the two sites, 800 people who are homeless are admitted each year, and the readmission rate within 30 days is just under 30% at HUH.

In the period March 2019 to January 2020 there were 1168 A+E attendances with a 14% reattendance rate within 7 days.

Themes were developed from the interviews and needs identified. In order to address these needs, the following recommendations were made:

1) Set up a Pathway in-reach team
2) Implement a multidisciplinary homelessness team meeting
3) Set up outreach provision to enhance community support
4) Explore options for a step-up/step-down facility
5) Design and implement a staff education programme

**Pathway Needs Assessment Team March 2020**

## Table of Contents


..... 1

1. Introduction ..... 4
2. Summary of Needs Assessment Findings and Recommendations ..... 4
3. Proposal for A Pathway Homeless Team ..... 7
4. The Pathway Approach and Network ..... 8
5. Pathway Social Franchise Package ..... 10
6. Evidence Summary for Pathway Approach ..... 10
7. Research on Pathway teams ..... 12
8. How this needs assessment and recommendations were produced ..... 13
9. Statistical information ..... 14
10. Interpretation of Statistical Information ..... 17
11. Interpretation of Qualitative Data ..... 19
12. Benefits of a Pathway Team ..... 26
13. Case studies ..... 27
14. Benefits of a Pathway Team ..... 28
15. Appendices ..... 29

# 1. Introduction

This needs assessment reviews the care, management and discharge of people who are homeless at the Homerton University Hospital NHS Trust (HUH) and City and Hackney Centre for Mental Health (CHCMH) run by the East London Foundation Trust (ELFT). The needs assessment was commissioned by the Better Care Fund of NHS City and Hackney CCG and London Borough of Hackney, and supported by the Integrated Discharge Planning Group.

The agreed plan and timetable for the completion of this piece of work is included as appendix 2.

The steps involved were to:

a) Interview, and gather experience and views from, a wide range of relevant people from within hospitals and community services regarding the current system.
b) Analyse statistics on hospital usage by people who are homeless.
c) Identify the current recording, monitoring and discharge procedures for people who are homeless in the HUH NHS Trust and CHCMH.
d) Identify areas for improvement and make recommendations to achieve these.

# 2. Summary of Needs Assessment Findings and Recommendations

Drawing together the information generated from interviews and the statistical data available, the following themes have been defined, and five main recommendations made for improvement.

**Theme 1: Need for improved management and discharge planning for people who are homeless across the two sites**

The current numbers of people attending the hospitals mean that the discharge system is overstretched and there is a large variability in response, which needs to be addressed and standardised. There are delays to discharges, particularly among patients from outside the area, or who are not eligible for local housing. There is a high readmission rate to HUH at 29%.Areas of good practice (in-reach housing worker for City and Hackney patients from HUH) need additional clinical support to improve management of patients in hospital, increase the involvement of local services, and extend provision to all patients who are experiencing homelessness, from both sites.

There is an opportunity to improve input to A&E and ACU areas such as early identification of people who are homeless prior to admission, or when attending A+E, to provide up to date information and to intervene with frequent attenders.

**Recommendation 1 - Set Up a Pathway In-reach Team**

The primary recommendation is that a Pathway Homeless In-reach Team is commissioned to work across both hospital sites, and to outreach to the community (recommendation 3).

The suggested team design (discussed in the next section) is of a multidisciplinary team with GP, nurse, housing and advocacy worker, social worker and OT input.

**Theme 2: Need for improved co-ordination and communication between hospital and community services.**

There are many different relevant services within the area, but poor awareness and co-ordination, particularly between the hospital and community services. There were multiple examples of inappropriate referrals from hospital to the wrong service, discharges out to the street, and a need for increased co-ordination around discharges of vulnerable patients such as those with complex needs and/or substance misuse issues.

**Recommendation 2 - Implement a Multidisciplinary Homelessness Team Meeting**

Commission a weekly, clinically focussed and led multidisciplinary meeting to discuss people who are homeless who have attended A+E or been admitted to the hospital, and those recently discharged, to begin to bring the expertise of community services into the hospitals and create more robust and sustainable discharge and follow up plans. This meeting should also discuss deteriorating patients in order to formulate plans to avoid hospital admission. The meeting should also ensure regular and systematic communication with support services in the community to inform the relevant agencies of discharge plans.

**Theme 3: Need for increased clinical and non-clinical work beyond hospital**

Currently patients who are homeless are not accompanied to community appointments and do not benefit from advocacy or follow up from the team, meaning outcomes are unknown. Additional support is needed for people being discharged from hospital to be able to attend and successfully complete the relevant appointments, make use of community services' follow up, particularly to enable them to attend housing services, continue with mental health, drug and alcohol treatment, and register with a GP.

There is also a need identified for clinical staff to support, and work alongside community teams who are working with people who are homeless in the community, and who are unable to access services, and are therefore at risk of admission.

**Recommendation 3 - Set up Outreach Provision to enhance community support**

The commissioned Pathway Team should include an outreach element to address the issues above, in particular to support and follow up patients on discharge and to work alongside community services to find and assess patients in community.

This would also facilitate the bringing of cases to the MDT meeting, promote liaison with Primary Care and community services, and ensure that follow-up of patients takes place.

**Theme 4: Need to avoid delayed discharges and inappropriate admissions**

There was a strong theme in the needs assessment of patients being clinically ready to be discharged from hospital, particularly while recovering from serious illness but with nowhere suitable to be discharged to, or while suitable accommodation was being found. Similarly, patients are being admitted to hospital because of the need for safe accommodation rather than a medical or mental health need.
If a Pathway team had access to a step up/step down facility, unnecessary admissions could be averted and patients could be discharged pending housing decision or accommodation being located, and so free up a costly hospital bed.

**Recommendation 4- Explore Options for a Step-Up/Step-down facility**

Commissioners should look into options available for a suitable Step-up/Step-down facility to allow people who are homeless to continue to recover while accommodation issues being addressed, or avoid admission/re-admission to hospital.

This approach is known to known to reduce A+E use when used in addition to Pathway team, and similar schemes run successfully at nearby Trusts such as the Royal London Hospital, utilising beds in a designated supported accommodation unit.

**Theme 5: Need for improved education for staff regarding homelessness**

Respondents from both within and outside the trusts highlighted the low level of knowledge and understanding of issues affecting people who are homeless, including the management of drug and alcohol issues, mental capacity assessments, Care Act assessments and 'duty to refer' legal requirements.

As noted above there is also poor knowledge regarding local services available for people who are homeless, and lack of up-to-date advice and information for patients which could enable their engagement with community services and prevent re-attendance and re-admission.

**Recommendation 5 - Design and implement a Staff Education Programme**

Both hospital sites should instigate a joint education programme for both new and existing staff regarding homelessness and health. This could form part of preparation for new team set up initially, and

subsequently become part of induction training or annual training requirement.

Community services could be invited come to the hospitals to take part in a 'Grand Round' or similar clinical meeting, once the Pathway team has started to see patients.

A senior board level champion should be identified within the hospitals to take this work forward and be responsible for the successful launch of the team.

## 3. Proposal for A Pathway Homeless Team

A Pathway Team in a hospital provides 'end to end' support for patients who are homeless. It involves not only medical staff, but a range of multidisciplinary professionals with expertise in social care, housing law and benefits issues, ensuring that a patient's full range of needs are supported.


Many patients who are homeless at HUH and CHCMH are currently being discharged to sleep rough. This severely hampers their recovery e.g. wounds dressings cannot be hygienically maintained, medication cannot be kept dry and may be stolen, and mental health conditions often deteriorate.

In this situation, many patients will rapidly become ill again and will be readmitted to hospital. In effect, the cost of the previous health intervention has been lost because the care needs could not be maintained.

Pathway teams intervene in that cycle of homelessness and illness. This model of intervention is the only evidence-based approach to homeless in-patients which has been shown to improve patient housing status and quality of life after discharge from hospital. Evidence has been generated through a published randomised controlled clinical trial of the Pathway approach, published results of the work of the Pathway team at King's Health Partnership (KHP) in 2016 and other evidence which is summarised below.

The Pathway approach is recommended in the NHS Long Term Plan 2019 and the NHSE Menu of Evidence Based Interventions to Reduce Health Inequalities 2019

The Pathway approach is tailored to meet the needs of the local homeless population. For Homerton University Hospital NHS Trust and City and Hackney Centre for Mental Health we would recommend that the team comprise of:

- a hospital nurse (Band 7) with knowledge of the hospital system, for example a current discharge co-ordinator. This role should be full time.  the position should be complemented by
- a part-time Pathway GP to provide clinical leadership and guidance (3 days per week)

- advocacy and housing worker, full time
- Adult Social Care social worker, full time
- Occupational Therapist, full time
- input from existing and planned additional Housing In-reach service for patients with ‘local connection’ to Hackney.

The team’s work would include:

- case work for all patients who are homeless
- a weekly ward round to see all current in-patients in order to plan and monitor progress
- a weekly multidisciplinary team meeting to which hospital and community services are invited to discuss recent or current cases and formulate discharge plans.

Other work may include:

- education sessions for hospital staff on identifying and supporting homeless patients,
- supporting student teaching and elective placements,
- overseeing any step up / step down beds.

The multidisciplinary meeting would be open to the local community services such as community support, Housing Options, adult social care, day centre, voluntary sector, supported housing, legal advisors, substance misuse and alcohol service workers plus hospital discharge co-ordinators, adult social care, medical and nursing staff, to attend and meet with the clinically-led team. The aim would be to plan the discharge and follow up of homeless people being treated at the hospital, discuss any recent discharge issues, and develop stronger, more co-ordinated and more robust working relationships for patient benefit.

All Pathway teams are given access to the charity’s research and ongoing guidance, reduced priced tickets to conferences and events run by the charity, and opportunity to join The Faculty for Homeless and Inclusion Health, a network of professionals working in the arena.

## 4. The Pathway Approach and Network

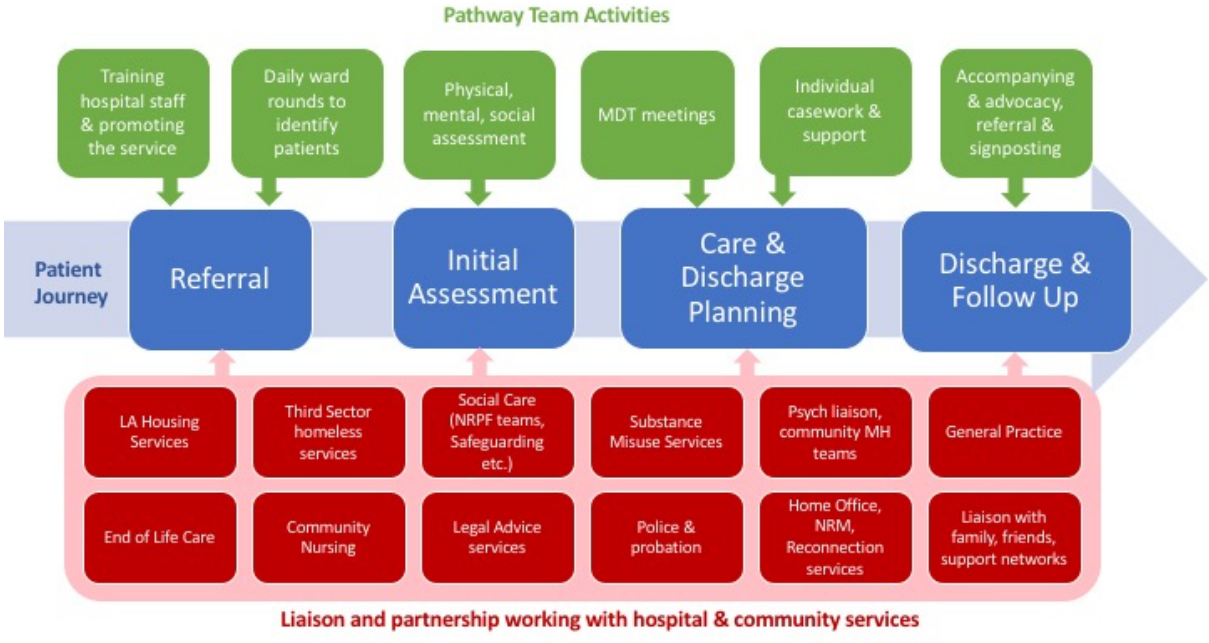
The Pathway approach involves a multidisciplinary team, including part-time GP with experience in homeless health, full time nurse, and housing/engagement worker, identifying, supporting and planning discharge of patients who are homeless by interventions such as early application for housing on discharge, GP registration, benefits, plus connection with community support, mental health and substance misuse services when needed.

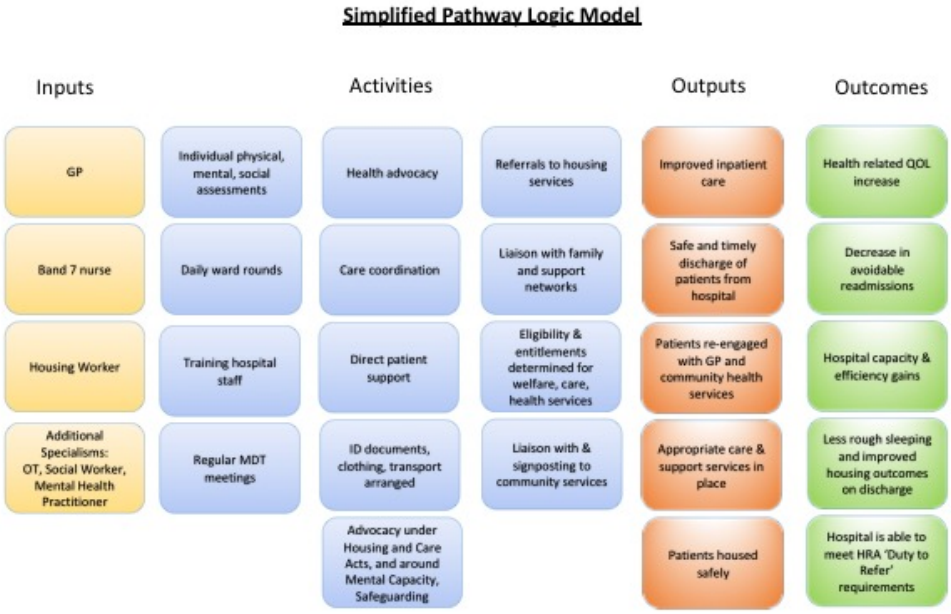
Ten UK teams currently exist, and Pathway has worked over the last two years to design and create a social franchise package of materials to guide, train and monitor new services from the initial stages of development, to recruitment and go live, through to creating an established team.

Pathway teams hold regular multi-disciplinary planning meetings involving community and hospital services improving joint working and co-operation and instigate a change in culture regarding the treatment people who are homeless, improving collaborative working across Primary, Secondary and Community care services, and large reductions in the number of people discharged to sleep on the street.

The Pathway model of GP-led hospital management homeless patients has been shown in a peer-reviewed published clinical trial to provide cost-effective improvement in patient outcomes, quality of life and housing status on discharge from hospital. Subsequent studies have also shown cost savings that vary depending on locality and study method.

Health inequalities are reduced by improving the experience of hospital admission and treatment completion, planning ongoing community service follow up and support, registration with GP in the community, improved housing status, linking with alcohol and drug dependence services, mental health services, and in some cases help with returning to family or friends in other areas for increased social support.






## 5. Pathway Social Franchise Package

Pathway now offer a Social Franchise Package which includes:

- all materials needed to set up, run and monitor progress of a new Pathway Service,
- full training and support package
- membership of the national Pathway support network
- attendance at annual international conference

Cost of the package is £20,000 per year for the first two years of operation.

More details can be found on Pathway's Social Franchise Website.

## 6. Evidence Summary for Pathway Approach

The first Pathway team was launched in 2009 with rigorous evaluation built into each subsequent pilot, so that all current Pathway teams are now recurrently funded. The positive outcomes from these evaluations culminated in the Pathway approach being cited as best practice in a case study in the 2019 NHS long term plan, (p42), and the NHSE Menu of Evidence Based Interventions to Reduce Health Inequalities.

The evaluations and outcome studies were all published. The citation list at the end of this section presents these studies chronologically, with the key findings. The wealth of published data supports three key benefits of providing a Pathway team.

- **Pathway improves outcomes for homeless patients.** Better health 90 days after discharge[3], less rough sleeping[3] and improved housing outcomes on discharge[4,5,6], particularly effective when combined with a step-up/step-down facility.1[0]

- **Pathway improves capacity in a busy hospital** by reducing the average duration of admissions for homeless patients[1,2,5,6,7], and by reducing subsequent A&E attendance[2,5,8,10], and the number and duration of subsequent unplanned admissions expressed as total bed days[1,2,5,7,8].
- **Pathway is cost effective.** This has been calculated using Quality Adjusted Life Years[3], and also by comparing the costs of the team to the reduction in secondary care activity for involved patients[7,9,10]

## 7. Research on Pathway teams

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

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

Hewett N et al. Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'). Clin Med 2016;16(3):223-9. A two centre NIHR funded randomised controlled trial, at Royal London and Brighton and Sussex University Hospital. Quality of life scores (EQ-5D-5L) improved significantly in the intervention arm and quality-of-life cost per quality-adjusted life-year was £26,000. Street homelessness was reduced, the proportion of people sleeping on the streets after discharge was 14.6% in the standard care arm and 3.8% in the enhanced care arm.

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

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

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

Bristol Service Evaluation of Homeless Support Team (HST) Pilot in Bristol Royal Infirmary. Internal evaluation presented at Faculty for Homeless and Inclusion Health Conference March 2019. This evaluation compared outcomes for a control group of homeless patients identified from hospital records during the needs assessment, with the outcomes for patients seen by the Pathway team during the

first 12 months. Results showed a 74.5% reduction in average duration of stay (11 to 2.8 days), 35.7% reduction in self-discharge, 62% reduction in re-admission within 28 days (132 to 50). Estimates of savings in secondary care costs were £921,300. Taking into account the costs associated with the team this equates to an overall saving of £766,300 annually.

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

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

Cornes, M, Aldridge, R, Tinelli, M, Whiteford, M, Hewett, N, Clark, M, et al (2019), 'Transforming out-of-hospital care for people who are homeless. Support Tool & Briefing Notes: complementing the High Impact Change Model for transfers between hospital and home'. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London, London. https://doi.org/10.18742/pub01-007 This work examines the role of in-hospital homeless teams on outcomes for patients and reports improved outcomes and cost-effectiveness when the Pathway model of clinically-led in-reach is utilised, particularly when used in conjunction with step down facility.

## 8. How this needs assessment and recommendations were produced

Statistical information was kindly provided by:

Neela Tirumala for HUH A+E and hospital admissions

Rebecca Lingard and Tim Stevens for ELFT for CHCMH.

Additional statistical information was kindly provided by Damani Goldstein, Consultant in Public Health, London Borough of Hackney.

26 face to face interviews and telephone interviews were undertaken between December 2019 and March 2020, with a nominated team member or service manager from a range of services, both from within the hospitals and from the community services in the Hackney area. These provided information about the way that services currently work at the HUH NHS Trust and CHCMH, how discharge of patients who are homeless is managed and ways in which this can be improved.

Each interview was analysed to generate themes which were then collated and in addition to the data gathered, form the needs assessment which in turn informed the recommendations given above

The themes generated are collated and provided in section 11. Interpretation of Qualitative Information

## 9. Statistical information

Summary of how information provided

The 'Data request – proforma' is provided as appendix 2 at the end of this report.

We requested data on the numbers of homeless patient A&E attendances and admissions at the HUH and the City and Hackney Centre for Mental Health. We received data from the HUH, but not the CHCMH, at the time of producing this report (20th March 2020). Similarly we are awaiting information regarding the cost of an A+E attendance and day of hospital admission to HUH which would allow financial calculations to be made.

Homeless patients were identified on hospital systems if they had no address, or an address known to be used by individuals experiencing homelessness. This list of known addresses is included in the table below, which also includes known omissions. Some of these are due to lack of access to a more comprehensive list. Therefore it is expected that the numbers identified are a significant underestimate.

We were given access to a full list of 'temporary accommodation' addresses used by Hackney Housing to house residents approaching the local authority for emergency assistance. However, we opted not to include these addresses in our data request as it would include too many 'false positives' – for example, families placed in temporary accommodation, and other groups without chronic health issues or support needs which are likely to affect their health care and discharge from hospital.

Data request includes patients with:

- NFA (no fixed abode) or other known variants
- No address listed
- Addresses known to be used by homeless:
  - 14 Hackney hostel and supported housing addresses
  - 2 Hackney temporary accommodation addresses
  - 4 Hackney day centre addresses
  - 1 Hackney homeless GP address
  - 1 Tower Hamlets homeless GP address
  - 2 Tower Hamlets day centre service addresses

Data does not include:

- Homeless patients that are using a friend's address
- Homeless patients with their last settled address still listed
- Most Hackney temporary accommodation addresses
- Several hostels and supported accommodation projects, (for example, women's hostel addresses were not disclosed)
- Anyone living in temporary accommodation or hostels provided by neighbouring boroughs

## A&E attendances

| Count of A&E attendances March 2019 to Jan 2020 | | | |
|---|---|---|---|
| **Disposal Method** | No subsequent attendance or next attendance in more than 7 days | Had subsequent attendance in less than 7 days | Total |
| **Admitted to hospital bed/became a LODGED PATIENT of the same Health Care Provider** | 67 | 15 | 82 |
| **Died in Department** | 0 | 0 | 0 |
| **Discharged – did not require any follow up treatment** | 437 | 65 | 502 |
| **Discharged – follow up treatment to be provided by General Practitioner** | 201 | 27 | 228 |
| **Left Department before being treated** | 49 | 18 | 67 |
| **Left Department having refused treatment** | 0 | 0 | 0 |
| **Referred to A&E Clinic** | 9 | 1 | 10 |
| **Referred to Fracture Clinic** | 25 | 2 | 27 |
| **Referred to other health care professional** | 62 | 11 | 73 |
| **Referred to other Out-Patient Clinic** | 18 | 2 | 20 |
| **Transferred to other Health Care Provider** | 12 | 2 | 14 |
| **Other** | 0 | 0 | 0 |
| **Unknown** | 121 | 24 | 145 |
| **Total** | **1001** | **167** | **1168** |

## Hospital Admissions

| Count of admissions to the HUH for calendar year 2019 | | | |
|---|---|---|---|
| **Admission Method** | No subsequent admission or next admission in more than 28 days | Had subsequent attendance in less than 28 days | Total |
| **Emergency (via A&E)** | 182 | 44 | 226 |
| **Emergency (not A&E)** | 8 | 2 | 10 |
| **Elective** | 165 | 103 | 268 |
| **Maternity** | 35 | 15 | 50 |
| **Birth** | 20 | 0 | 20 |
| **Transfer** | 0 | 0 | 0 |
| **Total** | **410** | **164** | **574** |

## Admissions to CHCMH

The following data was extracted from the CHCMH database for 2019 and 2020 to 31st August. The destinations for the known 'non-settled' patients are recorded in the lower table.

| Row Labels | Non-Settled | Not applicable | Not known | Settled | (blank) | Grand Total |
|---|---|---|---|---|---|---|
| **2019** | **48** | **1** | **4** | **528** | **675** | **1256** |
| **2020** | **43** | | **2** | **319** | **383** | **747** |
| **Grand Total** | **91** | **1** | **6** | **847** | **1058** | **2003** |

| Row Labels | 2019 |
|---|---|
| Bail/Probation hostel | |
| Homeless | 9 |
| Mainstream Housing | |
| Mental Health Registered Care Home | 3 |
| Night shelter/emergency hostel/Direct access hostel | 2 |
| Other homeless | 1 |
| Placed in temporary accommodation by Local Authority | 19 |
| Rough sleeper | |
| Settled mainstream housing with family/friends | 1 |
| Sofa surfing (sleeps on different friends floor each night) | 2 |
| Squatting | 1 |
| Staying with friends/family as a short term guest | |
| Supported accommodation | |
| Tenant-Housing Association | |
| Tenant-Local Authority/Arms Length Management Organisation/Registered Landlord | |
| Tenant-Private landlord | |

### Estimates from staff

- The Housing Needs Team Manager estimated that the Hospital Housing worker hospital housing worker sees around:
- 3-5 patients per week at the Homerton
- 2-6 at the Centre for Mental Health
- This equates to between 260 - 572 homeless patients a year.
- A member of the Homerton's Mental Health Liaison team estimated that they see at least one homeless patient every day.
- The High Intensity User group stated that there are a small number of people who are homeless attending hospital very frequently- a few times a week.

## 10. Interpretation of Statistical Information

The data suggests that the Homerton is seeing 574 homelessness admissions per year, and 1168 A&E attendances in the March-January period. The number of unique individuals will be lower.

29% of admitted homeless patients were readmitted to hospital within 28 days
14% of homeless patients attending A&E reattended within 7 days

The re-admissions rate is particularly high and could, at least in part, relate to adequate discharge plans not being in place. We also do not know the figures for patients re-admitted to other hospitals nearby, or the number of patients who self - discharge.

At CHCMH, there is a low rate of admissions recorded as 'non-settled' at 48 per year in 2019. However, 675 admissions had no data regarding accommodation recorded, many of which could represent people who fall into the relevant homeless groups in which we are interested.

The team gathering this data commented on the difficulty extracting it from the current system, and the high number of cases where no details are recorded on discharge destination, making interpretation difficult. They believe that many of the admissions which have no data relate to people who are experiencing homelessness.

Under-recording of the use of health facilities by homeless people is widespread, as the systems used often do not allow for homelessness or housing status to be captured accurately and staff do not see the priority of recording housing status if they do not believe this alters patient's management nor leads to any additional intervention. We were told that for coding purposes in the CHCMH 'last known address' is recorded routinely even if the patient is known to be homeless when seen. Even when they are asked about their accommodation status, homeless patients may give a 'care of' address such as a friend's address, or that of a day centre, or other facility out of embarrassment, or fear of discrimination. This will mean that they show on the system as having an address, when in reality they do not.

Accurate identification of homeless people in hospital is important because it is the first, vital step in being able to address longstanding health, housing and social problems, start or re-start benefit claims and engage patients with community follow up services including General Practice services. All of these interventions reduce the likelihood of re-presentation and re-admission to hospital.

The experience of the other Pathway hospital teams is that homelessness is not identified or recorded routinely by hospital staff and is not volunteered by patients unless specifically requested. Where Pathway teams become involved in paitent management, there is improvement in detection and recording of homeless people in the hospital, and increased referral rates to the Pathway teams over time. For example, in the first year of Pathway involvement at Brighton and Sussex University Hospitals in 2012-13, 100 patients were referred and seen by the team, whereas in 2018-19 it was over 500 patients.

The Faculty of Homeless and Inclusion Health published 'Homeless and Inclusion Health Service Standards for Commissioners and Service Providers' recommends that hospitals with more than 200 homeless patients presenting each year require a full, clinically led, Pathway team. A core Pathway team comprises a GP, Band 7 nurse and a housing worker. The experience of Pathway's existing teams is that every additional 100 homeless presentations over this number is likely to require an additional FTE member of staff.

Therefore, given that we do not have accurate figures for CHCMH but can estimate that at least another 3-4 patients per week would be referred from there, a final figure of approximately 800 admissions of people who are homeless per year across both sites can be assumed.

# 11. Interpretation of Qualitative Data

Stakeholders were interviewed to hear their views on the current hospital discharge process for homeless patients. This was from both the acute and mental health service perspective. Interviews were held with representatives covering clinical and non-clinical positions in the hospitals as well as a variety of community support services. The views of Hackney Council and the CCG representatives were also covered in this stakeholder interview phase.

Each interviewee was asking about their involvement in the care and discharges of people who are homeless. The structure of the interview is included in appendix 4. Interviews explored current practice and experience, including examples of good practice and priority areas for improvement. Conversations also considered practical suggestions for how improvements could be achieved.

Interviews have helped to identify some common themes arising from the assessment. The findings, along with the data analysis, have also informed the final recommendations in this report. A full list of interviewees is provided in Appendix 1.

The following section summarises the themes and main findings from the stakeholder consultation.

## Emerging Themes

Stakeholder interviews have helped to identify a number of common messages and themes occurring in both clinical and community settings. There is a level of overlap between themes; a well thought out response to the challenges posed is likely to address the identified themes on multiple fronts.

Findings from the various discussions broadly fall under the following categories:

- Effectiveness of the hospital discharge process
- Links with other services/co-ordinating responses
- Housing, hostels and accommodation
- Education & training
- Benefits of a Pathway team

Before covering these themes in more detail, it is worth pointing out there is a great deal of positive activity evident in all aspects of homeless patient support. Many interviewees cited examples of things that are working well including, for example, the in-reach housing support service, housing assessment support at the Greenhouse and mental health outreach services. Many services are managing to support homeless patients despite extremely limited or significantly reduced resources. Whilst there is much to commend, it is also clear there is work to do to improve the consistency of support and to ensure more joined up working across and between primary and secondary care and with community support services and the housing sector.

## Effectiveness of current hospital discharge service

Whilst there is acknowledged good practice in how homeless patient discharges are dealt with, this good practice is not applied in a consistent manner. Responses can vary from ward to ward and are very dependent on the approach of individual consultants, the speciality concerned and the level of complexity being dealt with. It is felt that discharges from A&E are less secure than those from other wards at the Homerton. By contrast, there is less pressure on mental health beds, meaning patients may remain in hospital longer until appropriate accommodation is found.

The presence of Tony McDonald (specialist housing worker from London Borough of Hackney Housing Service) has made a noticeable difference to discharge proceedings. The proposed introduction of a part-time satellite service located within the hospital discharge team will help improve this even further. Housing workers will now be in a position to conduct housing assessments at the hospital rather than requiring homeless patients to make appointments at the Greenhouse immediately post discharge. However, the caseload numbers for this service is challenging and only covers those patients with an evidenced local connection to Hackney. Not all patients will be 'on the radar' and so, not all patients will be receiving support that might be eligible for it. Tony does support mental health discharges currently, but this is on an unofficial basis and is stretching an already oversubscribed resource even further. Many stakeholders acknowledged that patients with No Recourse to Public Funds (NRPF), particularly those with health needs, are grossly underserved.

The appropriateness of referrals was raised several times during consultation. There are frequent examples of inappropriate referrals (e.g. to Drug & Alcohol Services for primarily physical health needs, patients with multiple complex needs to temporary, unsupported accommodation), ill-timed referrals (e.g. Friday evening discharges with little information or no discharge plan) and a general lack of communication between services (e.g. Street Outreach Team (SORT) not informed of patient discharges or admissions, disputes between physical and mental health Adult Social Care teams, substance misuse and mental health not conferring enough on specific patients). There is clearly work to do to improve the operational links and communications among and between services to ensure homeless patients are receiving the right advice, the right care and the right follow-up support post discharge. Having a Pathway team is viewed as the central component to a more joined up and co-ordinated approach.

A Pathway team could also bring more discipline to identifying all 'categories' of homeless patients via hospital attendances and/or admissions. This could include street homeless patients but also sofa surfers, those who are insecurely housed or even those who are unwilling or reluctant to reveal their homelessness due to 'fear of authority.'

Patients presenting with physical and mental health problems alongside substance misuse issues presented many challenges to current services. Individuals with the most complex needs are likely to attend A&E and/or be admitted to hospital more frequently. They are also more inclined to self-discharge. This could be due to the inadequate methadone prescribing or the requirement to undergo detoxification whilst on the ward. Homeless patients also struggle to become or remain engaged with services or follow-up appointments once discharged. Individuals with chaotic lifestyles and dealing with multiple complex physical and mental health needs require

a great deal of support to engage with follow-up services. The problem is exacerbated if patients are discharged to the street or unknown destinations.

Interview participants agreed there were many strong examples of good practice and effective joint working. However, there is undoubtedly room to make improvements to the discharge process. There is also general consensus around the pivotal role a Pathway team could play in making such improvements. Overall, stakeholders believe there is more work needed to:

- identify homeless patients early during attendance/admission
- have a more consistent approach across all wards
- provide clear and transparent onward pathways to accommodation and support services
- consider not just street homeless, but 'hidden' homeless, those in housing crisis and at risk of becoming homeless
- take more proactive stance for the most complex & chaotic patients (although acknowledge the resource constraints)
- identify people at risk of re-admission and create MDT to plan interventions

### Links with other services & co-ordinating responses

The stakeholder consultation has revealed a wide variety of services in both the Homerton Hospital, Mental Health Centre and community services. This does not mean all bases are covered when dealing with homeless hospital discharge. There is widespread recognition of the loss of certain services (e.g. hospital step-down/assessment beds in local hostels) or significant reductions in key services such as the Hackney Drugs and Alcohol Team. Dealing with such budget cuts has proved to be a significant challenge for discharge planning.

It is important that all stakeholders are aware of the range or services available and how they can assist patients as part of the hospital discharge process and afterwards. In such a crowded landscape, it is essential that stakeholders feel adequately informed, understand how to get best use from relevant services and for there to be clear co-ordination of and between services to meet individual patient needs.

A simple mapping of services to reflect both hospital and community services would be a good starting point and is planned. This mapping would need to include any new Pathway team and show the relationship with other services.

Having strong links between hospital and community-based services is a vital component of an effective referral mechanism. There were differing views on just how effective the referral process is in the borough. Some are happening systematically while others are more ad hoc and highly dependent on the individuals working in specific services. Overall, there was agreement that improvements could be made to bring a more joined up approach to how services work together. Strong communication, giving and receiving advice and checking the appropriateness of referrals should be a systematic process, not a 'nice to have.' This will help to overcome some of the more unrealistic expectations of complex and chaotic patients and the difficulties they face in engaging with referral or follow-up appointments without additional support. One stakeholder described the solution as a 'wraparound

approach' to joining up all relevant services within both clinical and community settings.

There is also scope for improved internal communication within the hospital to help identify homeless or insecurely housed patients. Interviewees flagged up the opportunity to do more via A&E and the ACU; a more concerted effort to engage here would help with early identification prior to admission, could reduce instances of self-discharge and provide a platform to intervene with frequent attenders.

### Strengthening Current Systems

It was also noted that there are a number of existing services with forums, meetings, or working practices which serve homeless patients. It is important that a Pathway team is represented at meetings and co-working with relevant colleagues to ensure smooth communication and consistent discharge planning across all relevant hospital and community teams:

**Daily Delayed Transfers of Care (DTOC) calls**: The Head of the Integrated Discharge Service, Simon Cole, holds a daily DTOC phone call with Jo Bennett (Improving Emergency Care Project and Operational Manager) as well as other hospital staff. A Pathway Team would add capacity and expertise to problem solving cases that are complex discharges due to their homelessness and housing issues (as well as working with complex or delayed discharges that do not fall under the Integrated Discharge service: homeless patients that do not require social services input).

**The SUOM (Street Users Operational Meeting)**: a representative of a Pathway Team would be able to attend this meeting. At SUOM observed for this report it was noted that there were 3 or 4 on the caseload who were or had recently been in hospital. A Pathway Team member at this meeting could contribute expertise in managing risks associated with poor health, and could support working to multi-agency support plans for vulnerable patients who are likely to (re-)attend hospital.

**The High Intensity Users Service**: It was reported that a small number of the 200 HIU that this team works with are homeless. A Pathway Team could add value through added knowledge of homelessness services a providing expert multi-disciplinary input.

**Hospital Discharge Worker:** the importance of the existing Hospital Discharge worker was noted by many interviewed for the needs assessment, as well as the limited capacity and large caseload. Working with the Hospital Discharge Worker, a Pathway team could supplement this role through:

- Pathway clinicians would provide independent clinical input and advocacy to identify and coordinate the most suitable routes into housing, whether through social services, housing department, or voluntary sector services.
- Additional Pathway housing workers could accompany a greater number of homeless patients to housing assessments, in Hackney and at other local authorities. In Pathway's experience, this ensures vulnerable patients are supported, and that transport between hospital, housing offices, and accommodation is managed smoothly.

- A larger, multi-disciplinary team adds capacity to advocate and coordinate with external services that can support NRPF and ineligible EEA patients (supporting Care Act/human rights assessments, liaising with legal specialists, and organisations such as Routes Home etc).

**Hackney Housing Joint Working Protocol:** The current Hackney Housing Joint Working Protocol (included as appendix 6) provides a useful starting point for ensuring a more joined up approach between the Benefits and Housing Service, Adult Social Care and Mental Health Support. It covers a wide range of support provision including how to deal with people with No Recourse to Public Funds and administering the National Referral Mechanism, Duty to Refer and other duties under the Homelessness Reduction Act. The principles and objectives of effective joint working set out in the protocol could be used as the basis for creating an MDT for case managing homeless patients in hospital. This approach can ensure the right people are represented at MDTs and that they are clear on their responsibilities. The protocol can be expanded to add clinical input to the housing, mental health and social care elements of case management. A hospital-based Pathway team would not only provide such clinical opinion, but also an independent, patient-centred view on what is best for the patient. With so many existing services stretched to capacity, and reports of poor communication, inappropriate referrals and a general lack of joining up, the addition of a Pathway team could provide the necessary checks and balances to the discharge process and ensure all the right support services are engaged. A Pathway team would not have any vested interest in other support agencies and therefore would be best placed to provide an independent view to MDTs and be focused on how best to deploy the wraparound support which stakeholders seek. In addition, a Pathway team with the ability to outreach into the community would be able to provide additional guidance and clinical support to the current existing teams.

### Housing, hostels and accommodation

For many of those consulted, housing is viewed as the cornerstone issue for successful management of homeless patients' health, wellbeing and substance misuse problems. Finding more secure and appropriate accommodation, temporary or otherwise, forms an important piece of the recovery jigsaw.

Many concerns were raised about the serious shortage of all types of accommodation in the borough from social housing and hostel beds to supported and temporary accommodation options. The loss of assessment and high support hostel beds have had an impact as has the reduction in supported and temporary accommodation places. For the latter, this has led to more and more people being accommodated out of borough, not always an ideal scenario for patients with high support needs. It is perhaps no surprise that this lack of accommodation is resulting in increased instances of inappropriate referral. The pressure to find places for people leaving hospital alongside reduced hostel or temporary accommodation options to deal with the capacity to deal with complex needs can lead to a scenario of finding 'the least worst option.' Stakeholders working in the community also report increasing instances of people in housing crisis or with insecure tenancies. This is of particular concern for those dealing with mental health issues.

It is not within the scope of this needs assessment to solve the shortage of accommodation. Clearly, reductions in the availability of suitable accommodation to deal with the needs of individuals being discharged from hospital are detrimental to both recovery and the ongoing wellbeing of patients. However, the additional resource of a Pathway team alongside the instigation of multi-agency MDTs would help to make best use of the available services, including housing and accommodation options.

Several stakeholders mentioned the very difficult challenges faced by NRPF patients. Whilst the borough provides support where it can e.g. conducting human rights assessments or assisting with repatriation, there is a limit to what can be done for some individuals. It is understood some people with no recourse actively avoid attending hospital when they are unwell due to concerns over the Charging Act. The borough's Joint Working Protocol sets out what support can be provided and in what circumstances. For people with NRPF with serious health need to address, accommodation and support should be provided. However, concerns were raised during consultation that there was a gap in provision to support this and that some individuals were being 'moved around from pillar to post.'

The shortage of appropriate housing is of even more concern given the potentially high instances of 'hidden homelessness' in the borough. There is no systematic handle on the extent of this; there could be large numbers of people living in chaotic circumstances or impending housing crisis. These situations are often very difficult to identify. There is a strong likelihood that many such people are attending hospital without coming to the attention of homeless services.

A number of hostel managers were consulted for the needs assessment. They supported the view that there is a real variance in the hospital discharge process. Discharge summaries were not always provided as a matter of course and relied on hostels being proactive in tracking them down. Not all hostels are set up to handle dual diagnosis which limits the type of patient who can be discharged to hostel services. Staff also reported instances of hostel residents avoiding A&E due to concerns about waiting times or the need to detox, this can lead to people becoming very unwell during their hostel stay.

The loss of assessment beds for mental health and the former hospital discharge beds in St Mungo's Mare Street hostel was unfortunate. Discussions with various stakeholders suggest there is still demand for step-down provision to accommodate the needs of homeless patients as part of the discharge process. The ability to provide continued recovery time for individuals whilst also co-ordinating plans for their housing and ongoing support needs could help alleviate some of the pressures inherent in the current system. Recent research shows that having a hospital Pathway team with access to step down beds gives the best overall outcomes for patients, (see reference 10 in 'Evidence on Pathway Teams' box above).

Stakeholders are keen to understand what scale and scope of step-down provision might work in Hackney, albeit in a scenario where there is a severe shortage of beds available anywhere in the borough. Pathway teams at UCLH and the Royal London have been successfully utilising step down beds in either local hostel or social housing providers settings for a number of years. Both are valid models which could potentially be applied in Hackney. Finding the right model for homeless patients would require some more detailed work to understand the exact requirements, levels

of demand and the type of provision needed i.e. low support/self managing or recovery focused provision for more complex cases. A useful guide is available from Pathway at https://www.pathway.org.uk/wp-content/uploads/How-to-do-a-needs-assessment-for-a-medical-respite-service-July-2018-v2.pdf

This idea could be explored in more detail if there is an appetite to pursue step-down provision. Evaluations of both services have been carried out; Pathway to Home (UCLH Service at Olallo House hostel) and Gloria House (collaboration between Peabody Housing, Royal London Pathway team and Tower Hamlets CCG). Details of these evaluations can be found at:

https://www.pathway.org.uk/wp-content/uploads/2013/05/Pathway-To-Home-Summary.pdf

Hackney is already providing housing support to the hospital discharge service via a dedicated housing support worker post. This arrangement is working well; Tony McDonald (the support officer) is highly regarded and is doing an excellent job despite significant capacity constraints. He is able to offer support to both the acute and mental health hospitals, although he is not officially contracted to deal with the latter currently. Tony is also only able to deal with Hackney connected patients who are referred to appointments at the Greenhouse GP surgery. Other housing cases are referred to appointments at the Hackney Service Centre. Both services are deemed to be operating well despite these capacity issues. However, it is acknowledged there is a significant amount of time needed to confirm housing eligibility and complete the necessary paperwork to support applications. This puts further pressure on services to complete all background work prior to discharge. As mentioned earlier in this report, it is likely that a significant proportion of homeless patients are falling through the net and are not being picked up by any housing support service. Increasing the capacity to identify patients within the hospital will have a knock-on effect on potential caseloads.

The Greenhouse proposal to relocate their in-reach housing support to a hospital-based satellite service (for two days per week) is a welcome move. The presence of a Pathway team would provide an additional level of support and help improve the level of co-ordination and communication between the hospital, housing and community services.

### Education and training

There is a widespread consensus of the benefits of a bespoke homelessness training programme for the borough. This would be helpful for clinical staff, housing teams and support service professionals. The needs assessment uncovered a range of views on the awareness of homelessness issues and staff attitudes towards the homeless. Some say there is no discrimination associated with homeless patients while others report more negative attitudes. All do agree that a formal approach to education and training on this subject would be welcome in both hospital and community settings.

The main focus would be on helping staff to understand homelessness and the health and social impact and risks associated with early or inappropriate discharge. In addition, the mapping referred to in the previous section would be a useful aide memoire of the wider support service network.

A number of suggested training topics were put forward by stakeholders during consultation, including:

- Understanding multiple complex needs and substance misuse
- Identifying safeguarding concerns and self-neglect
- Assessing capacity
- Information on current legislation e.g. Homelessness Reduction Act, Duty to Refer, housing eligibility

Some pre-existing training sessions (e.g. those mentioned in the Joint Working Protocol) could be incorporated into a homelessness training programme. Pathway can provide other modules to suit requirements.

In practical terms, training could be delivered as part of the set-up of a new Pathway team. The initial focus would be in hospital staff with sessions opened up to community based services later. This could be offered as a 'Grand Round' where community services attend training as part of a clinical meeting. Once established, homelessness training should form part of induction training for hospital staff and/or be a mandatory annual training requirement. Whichever approach is taken, it will require a senior champion within the hospital to make it happen and maintain momentum over time.

## 12. Benefits of a Pathway Team

Interviewees noted several benefits to having a Pathway team to support care co-ordination and hospital discharge process. Ideally, a team would cover both the HUH and CHCMHT. First and foremost, a Pathway team is viewed as an additional resource to complement current services; but is also a resource which could take on leadership and/or co-ordination roles to enhance and improve current approaches.

The presence of a patient-focused team working across all hospital sites (acute, mental health, A&E and ACU) is an opportunity to make a positive step-change in the co-ordination of discharge and wraparound services. Having that presence in A&E and ACU (e.g. through attendance at daily white board meetings) will help achieve a more systematic and early identification of homeless or insecurely housed patients.

The team could include a local GP with expertise in both care of people who are homeless and local community services, and a lead nurse with similar expertise and knowledge of the hospital services. The team could therefore join together these different parts of the healthcare system and create a seamless transfer of patient care between the them.

The clinical focus of a Pathway team is designed to support patients to optimise their treatment, plan for their discharge, and link them into follow up support. This approach is shown to reduce the rate of self-discharge and re-admission. From a leadership standpoint, a Pathway team can lead multi-agency meetings and MDTs to discuss individual patient cases and respond to their likely ongoing support needs in advance of their discharge date. Pathway teams can also provide a link into triage or into any step-up or step-dpwn care beds for intermediate care, and provide advocacy support for patients attending services following their discharge.

Many of those interviewed highlighted the advantage of having the Pathway team having an ability to work outside the hospital in an outreach capacity, to assist in assessing patient who could not or would not be seen at current services, who had been recently discharged or who had left the hospital against medical advice. Such a role could assist with hospital avoidance for patients who are deteriorating by instigating appropriate community treatment at an earlier stage.

Several respondents remarked on the advantages of bringing a new and independent perspective to the day-to-day running of the hospital discharge process. Moreover, a team can provide renewed focus on building relationships with outside agencies to ensure a more consistent approach from service across health, the local authority and the third sector. Many respondents also remarked on the added value of a Pathway team in terms of having better discharge planning for some of the most vulnerable patients and who are not eligible for assistance from Hackney council e.g. those with No Recourse to Public Funds.

## 13. Case studies

The following case studies describe how two people who were homeless were managed at the Homerton Hospital and were used at the Integrated Discharge Team Event on 23/3/20 to stimulate group discussion regarding the current gaps in services and how these could be addressed.

**Case study 1**

44 year old Lithuanian man, brought into ED by ambulance on 02/01/2020, following tonic clonic seizure (witnessed).

Social history: came to the UK nearly 6 years ago. Once worked as a motor mechanic, but has been homeless for the last year and a half. Is registered with a GP, but actually receives basic clinical care at a homeless project run by the Salvation Army. Has very poor English, and a marked stutter when speaking. He has no family in the UK. No address; no mobile phone; no ID. Living in an open air carpark. Drinking 6L of cider most days. Smokes tobacco but denies drug use.

Presentation: Very intoxicated. Has a cough, with green phlegm and sometimes blood, fevers and hot and cold sweats during the night for 2 months. Vomiting daily. He has a pain on right side of thorax following a recent assault. Epilepsy (but not on any medication for this); depression. Pain on the right side of his head. He leaves hospital before he can be further investigated for tuberculosis.

Brought back in by key workers the following week, and admitted. Further history taking with Lithuanian advocate reveals that he is frequently the victim of assaults. A CT scan shows an acute on chronic subdural haematoma - he spent 3 months as an in-patient after an assault with a baseball bat (Nov 2017). Also multiple old and new rib fractures. Difficulty with pain control because of head injury.

CXR: cavitating lesion in the right upper zone and a further nodule in the right mid zone. Either TB or malignancy.

OT assessment: although he is independent in terms of activities of daily living, such as washing, dressing, eating, he does not know day, month, year, where he is, and why. He does not know he is in London, and reports the year to be 2015.

Psych assessment: traumatic brain injury following the assault in 2017 (L subdural, L craniotomy, subdural, significant post-traumatic amnesia). Fluctuating orientation and memory consistent with PTA; poor sleep patterns – fear s being hurt again and has bad and intrusive memories. Cognitively impaired, especially immediate recall and orientation.

Interventions so far: started treatment for TB; hospital detox; smoking cessation. Remains in a side room because of risk of MDR TB (drug resistance).

## 14. Benefits of a Pathway Team

Interviewees noted several benefits to having a Pathway team to support care co-ordination and hospital discharge process. Ideally, a team would cover both the HUH and CHCMHT. First and foremost, a Pathway team is viewed as an additional resource to complement current services; but is also a resource which could take on leadership and/or co-ordination roles to enhance and improve current approaches.

The presence of a patient-focused team working across all hospital sites (acute, mental health, A&E and ACU) is an opportunity to make a positive step-change in the co-ordination of discharge and wraparound services. Having that presence in A&E and ACU (e.g. through attendance at daily white board meetings) will help achieve a more systematic and early identification of homeless or insecurely housed patients.

The team could include a local GP with expertise in both care of people who are homeless and local community services, and a lead nurse with similar expertise and knowledge of the hospital services. The team could therefore join together these different parts of the healthcare system and create a seamless transfer of patient care between the them.

The clinical focus of a Pathway team is designed to support patients to optimise their treatment, plan for their discharge, and link them into follow up support. This approach is shown to reduce the rate of self-discharge and re-admission. From a leadership standpoint, a Pathway team can lead multi-agency meetings and MDTs to discuss individual patient cases and respond to their likely ongoing support needs in advance of their discharge date. Pathway teams can also provide a link into triage or

into any step-up or step-dpwn care beds for intermediate care, and provide advocacy support for patients attending services following their discharge.

Many of those interviewed highlighted the advantage of having the Pathway team having an ability to work outside the hospital in an outreach capacity, to assist in assessing patient who could not or would not be seen at current services, who had been recently discharged or who had left the hospital against medical advice. Such a role could assist with hospital avoidance for patients who are deteriorating by instigating appropriate community treatment at an earlier stage.

Several respondents remarked on the advantages of bringing a new and independent perspective to the day-to-day running of the hospital discharge process. Moreover, a team can provide renewed focus on building relationships with outside agencies to ensure a more consistent approach from service across health, the local authority and the third sector. Many respondents also remarked on the added value of a Pathway team in terms of having better discharge planning for some of the most vulnerable patients and who are not eligible for assistance from Hackney council e.g. those with No Recourse to Public Funds.

Dr. Chris Sargeant

Emma Thompson

Paul Hamlin

Pathway Hackney Needs Assessment Team

23rd March 2020

## 15. Appendices

Provided as separate documents:

1) List of interviewees
2) Needs assessment timeline & specification
3) Data request - proforma
4) Interview Proforma
5) Hostels and homeless ‘Care Of’ addresses list
6) Joint working protocol