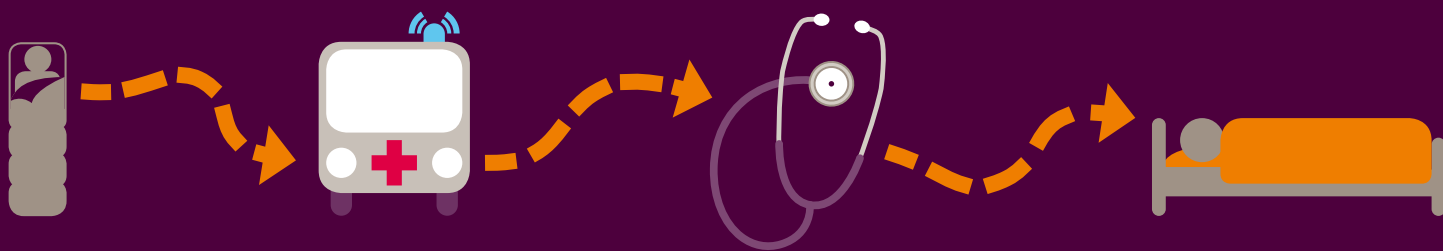


IMPROVING HOSPITAL ADMISSION AND DISCHARGE FOR PEOPLE WHO ARE HOMELESS



They just came to my room, and said **“you can go now”**. I said, “no. I’m homeless, I’ve got no clothes. And basically **they kicked me out**. I didn’t want to go. I was ill, in pain, just had an operation, and they should have kept me longer, or done **more to help.**”

FOREWORD

This report was commissioned by the Department of Health to support the delivery of the commitment made by the Ministerial Working Group on Homelessness in their 'Vision to End Rough Sleeping' report, published in July 2011:

“The National Inclusion Health Board will work with the NHS, local government and others to identify what more must be done to prevent people at risk of rough sleeping being discharged from hospital without accommodation.”

Acknowledgements

Stakeholder interviews undertaken by Homeless Link and St Mungo's Peer Researchers.

Report produced by Homeless Link and St Mungo's.

The authors would like to thank all the clients, homelessness agency staff, Local Authorities and NHS staff who took part in the research and advised us on the report.

Economic evaluation undertaken by the Centre for Health Service Economics and Organisation.

CONTENTS

Executive Summary	4
1. Analysis of Current Provision	6
a. Introduction	6
b. Identification of homelessness	8
c. Responding to housing need	10
i. Case study 1: a joined up approach	10
ii. Case Study 2: sub regional protocol	12
iii. Case Study 3: award winning specialist protocol	12
iv. Case Study 4: putting in a response with a lower homeless population	13
v. Case study 5: intermediate care pilot	14
d. Safe Discharge	19
e. Continuous Improvement: Monitoring and Quality	24
f. Additional Findings	25
g. Conclusion	
2. The Cost Benefits of effective admission and discharge practice	28
a. London Pathway, UCH	29
b. Arrowe Park, the Wirral	29
3. Recommendations	31
4. Appendices:	35
a. Review of guidance	35
b. Good practice template	38
c. Profile of client participants	42

EXECUTIVE SUMMARY

This report draws together the direct experiences of clients and staff to provide an updated national picture of hospital admission and discharge practice for people who are homeless.

It identifies examples of effective working, as well as where improvements still need to be made. It builds on existing guidance on hospital admission and discharge to propose a set of standards which can be applied regardless of the specific models of practice in place.

Our findings reveal that while some areas have introduced effective measures to help address homeless patients' accommodation needs when they access hospital, this is not widespread. Only a third of homeless people interviewed in our study had received any support around their homelessness. Many homeless patients were discharged straight back to the streets; often without their housing or underlying health problems addressed.

Where effective processes were reported, housing was viewed by local partners as a key part of a 'safe discharge' from hospital. However there is a lack of accountability for ensuring this happens. Homeless patients repeatedly flagged up prejudice of staff and this was seen as contributing to the poor level of care and support being offered both on admission and in relation to early discharge.

The lack of appropriate accommodation options is a challenge in many areas and can lead to an assumption that it is too difficult to ensure everybody has somewhere safe to go when they leave hospital. We believe this assumption needs to be tackled: the localities which have put measures in place demonstrate it can be achieved.

Many clients we spoke to were readmitted shortly after leaving hospital: preventing this through more co-ordinated discharge practice can reduce costs for the NHS, as well as improve the health and wider outcomes for homeless people. Analysis included in this report demonstrates the cost savings to the NHS and wider partners which can be made when effective practice is put in place.

Although national guidance on hospital admission and discharge for homeless people has played a role in improving practice, it is not enough to drive up standards in every local area. We urge national and local agencies to take stronger action and outline below a number of recommendations to take this forwards. These include:

At a national level:

- The Department of Health should set a clear agenda for the NHS Commissioning Board to improve accountability within health services so that nobody is discharged to the streets. This should be monitored through NHS indicators including reducing emergency readmissions within 30 days and unplanned A&E use within 7 days¹. Ambitious improvement levels for homeless people should be set against these indicators.
- The NHS Commissioning Board should introduce new standards to improve the recording of homeless patients, revising the NFA code to more accurate indicators of someone's housing status.
- The proposed NHS Outcomes Framework indicators on Patient Experience (Domain 4) should be used to set improvement levels for homeless people's experience of using hospital and accident and emergency services.

¹ The NHS Outcomes Framework published in December 2011 includes 'Emergency readmission within 30 days from hospital' as an overarching indicator under domain 3 and should be used to monitor this.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131724.pdf

- The Care Quality Commission should review whether these targets and standards are being achieved as part of its inspection of hospitals.
- The Inclusion Health Board should task the NHS Commissioning Board to review progress of discharge outcomes on an annual basis as part of its commitment to reduce health inequalities.

At a local level:

- Hospitals, local authority housing teams and voluntary sector organisations should work together to agree a clear process from admission through to discharge to ensure homeless patients are discharged with somewhere to go and with support in place for their on-going care. This process should start on admission to hospital. The local Health and Wellbeing Board's new functions could provide oversight for this process.
- NHS Trusts should promote a definition of 'fit for discharge' which takes into account if every patient has somewhere suitable to go with plans in place for on-going care as required.
- NHS Trusts, working with local partners, should promote a cultural change in the way homeless people are viewed and treated in the NHS through strong leadership and training for staff.
- Hospitals and Local Authorities should undertake routine monitoring and reporting of the discharge outcomes for homeless people within their performance frameworks.
- NHS Trusts, Local Authorities and providers should explore how intermediate care between hostels and hospitals can be developed, for example through joint funding between health and local government
- All sectors should take a greater responsibility for maintaining links, sharing expertise and offering advice to others involved in the discharge pathway. The Health and Wellbeing Board's new functions could support this process.

1. ANALYSIS OF CURRENT SERVICE PROVISION

INTRODUCTION

In its 2003 guidance, 'Discharge from hospital: pathway, process and practice', the Department of Health stated that all acute hospitals should have formal admission and discharge policies to ensure that homeless people are identified on admission and that their pending discharge be notified to relevant primary health care and homelessness services². Subsequent guidance in 2006 set a clearer expectation that it is the joint responsibility of hospitals, Primary Care Trusts (PCTs), local authorities and the voluntary sector to ensure a protocol is in place so that no one is discharged from hospital to the streets or inappropriate accommodation³.

A survey in 2010 of all Local Authorities in England indicated that implementation of such policies is far from widespread, with only 39% reporting that they had an admission and discharge protocol for homeless people⁴.

This picture is reflected by a national audit of homeless people which showed that only 27% of clients had received any help with their housing before being discharged from their most recent admission to hospital⁵.

In 2011, the Government committed to ending rough sleeping in their strategy Vision to End Rough Sleeping: No Second Night Out Nationwide⁶. To achieve this vision, local areas need to focus on meeting four simple pledges:

1. No one new to the streets should spend a second night out
2. No one should live on the streets
3. No one should return to the streets once they have been helped off them, and ultimately
4. No one should arrive on the streets.

Preventing someone becoming homeless when they leave hospital will contribute to meeting these aims, and one of the first commitments of the Ministerial Working Group on Homelessness is to identify what else needs to happen to make sure nobody is discharged to the streets.

It is against this backdrop that we undertook this current scoping work. Our findings reflect a similar variation in both coverage and approaches being taken.

For this report we gathered the first-hand experience of homeless people and organisations involved in different stages of the hospital admission and discharge pathway. We sought to understand what models have been developed; what effective practice looks like; as well as the challenges in implementing these measures. In doing this we have drawn on previous reports and case studies that have looked at this issue (see appendix B).

Who we spoke to

All regions in England were included in the interviews, and efforts were made to ensure a reasonable spread in terms of rural and urban areas.

² Discharge from hospital: pathway, process and practice, *DH* (2003)

³ Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation, *DH, CLG, Homeless Link and London Network of Midwives and Nurses*, (2006)

⁴ Homeless Link 2010. The survey was sent to all Local Authority Housing Leads as well as Public Health Directors. Results based on 141 responses.

⁵ The Health Needs of Homeless People, findings of a national audit, Homeless Link 2010

⁶ Vision to End Rough sleeping: No Second Night Out Nationwide, HM Government, 2011
<http://www.communities.gov.uk/publications/housing/visionendroughsleeping>

St Mungo's undertook a series of peer led interviews with homeless people from across the country: - 57 men and women were interviewed from London, Bristol, Birmingham and Leeds. People were living on the streets, in hostels or in unstable and temporary accommodation (such as squats).

Homeless Link received input from 38 members of staff from homelessness organisations, Local Authorities and hospital trusts (28 in depth telephone interviews and 10 written case studies or feedback). In addition, we attended a regional event on Hospital Admission and Discharge in Greater Manchester. We also held a meeting with experts involved in hospital admission and discharge of homeless people across England to gather their experiences and recommendations for change.

Overall picture of provision

A number of areas felt there had been an improvement in the way homeless people are discharged over the past few years. This was usually evidenced by a reduction in the number of homeless people presenting at the local authority straight from hospital, and improved interagency working. Few had recorded formal data on these outcomes so much of this information was largely anecdotal.

The development of formal protocols was seen as an important driver for these improvements. Where there were arrangements in place, these tended to fall into three broad groups:

- Formal protocol involving a specialist post or service – funded either by the local authority or co-funded with the NHS.
- Formal protocol, without specialist provision, but a clear process in place with the hospital- often using agreed referral forms. These protocols exist both at a local authority and sub-regional level.
- No formal policy, but good links between hospital staff, the local authority and community based agencies which usually led to the involvement of appropriate agencies in the discharge process.

However, a few areas we spoke to had little or no agreement in place, or felt their protocol was not effective. Several areas also mentioned that funding for specialist liaison or 'link worker' posts had been cut in recent years which had negatively impacted on provision.

The lack of provision was highlighted by our interviews with clients. Only a third had received any help with their housing prior to being discharged: cases where homeless people had been discharged to the streets were common, and we heard examples where clients had even been denied access to services. However, some clients did have a more positive experience. Although this had occurred in a range of settings and areas, a large proportion of clients had experienced these in specialist homelessness services within hospitals- such as at University College Hospital (UCH) in London.

For the purpose of this report we present a summary of issues people shared beneath the following headings, representing key stages of the hospital discharge pathway:

- Identification of homelessness (point of admission)
- Responding to housing need (during admission/treatment)
- Ensuring a safe discharge (taking into account housing, on-going support, and practicalities of the discharge itself)
- Continuous Improvement: quality and monitoring

I. IDENTIFICATION OF HOMELESSNESS – THE POINT OF ADMISSION

On admission: identifying homelessness

Any discharge process for homeless people must start on admission to hospital. Early identification of a housing need is essential to trigger the appropriate responses, both within the hospital and with external agencies who are likely to play a key role in ensuring the housing and health needs of the patient can be properly met during and after their stay in hospital. This was uniformly raised by interviewees.

The timely identification of an individual's homelessness or risk of homelessness was raised as a key challenge by many of the hospital staff we spoke to: often clients do not disclose this information; staff do not always ask the right questions to elicit the information; and even if it identified it is not always recorded in an accurate or useful way– for example the NFA (no fixed abode) code is used when in fact the client might have a bed, for example in a homeless hostel.

“We do find that a lot slip through the net because they give a friend's address, so a lot of times unfortunately it's found on discharge when they're ready to be sent home, they say “I haven't got anywhere to go”.” Nurse

A few areas we spoke to had developed specific methods to improve disclosure of housing need. This included training staff to ask questions to help elicit more accurate information from clients, developing standard forms which would include probes about the patients housing and potential risks to the tenancy, and using hospital recording systems to log housing status. However, practice was varied.

Few of the clients we spoke to mentioned discussing their housing on admission. Some told us that staff did not ask about their housing, and so they didn't raise it until the last minute.

“...the only time that they really knew I was homeless was when they said, “Right, you can go home now.” And I said “No I can't, I'm homeless. You can't just kick me out”. Plus, they kicked me out in just a pair of pyjamas, with nothing on my feet.”
Client

Where it was discussed early on, this was attributed by some clients to there being a specialist service for homeless people which meant it was picked up as part of the routine procedure. One client who was admitted to UCH mentioned how his circumstances were flagged up through their process:

“The hospital staff knew I was in a hostel as I filled out a form on admission.” Client

For others it came up in conversation.

“They asked me for my address – at the time I was homeless. So I told them “nowhere”. So they gave me a number to ring.” Client

The reaction many clients received on mentioning their homelessness is likely to make many unwilling to flag up their homelessness for fear of being discriminated against. There were countless examples given where the mention of homelessness on admission had triggered prejudice among hospital staff:

“Nurses could be much more supportive – because they can be really unsupportive when they find out your homeless. Initially they're saying “Oh, do you want some

water? Do you want a paper?’ And then, as soon as they find out your homeless they want you out of the door.” Client

“They said “he’s a tramp”, and whispered about me, pointing.” Client

It is important here to also consider that several clients did not even get seen by hospital staff. Some respondents felt they had been denied treatment as a result of the prejudice of medical or security staff even before any medical examination had been made:

“The year before I was coughing up blood, and I went to the hospital – but the security guards at the hospital wouldn’t let me in – so I collapsed down the road - and the attitude was that I was trying to get a bed for the night because I’m homeless.” Client

“[I was] referred by... health centre... I had a serious lung infection – Pleurisy. They wrote a letter to the hospital and I went to the A&E and said to the nurse on desk, that I needed to see someone and have an X-ray... I didn’t think at the time and just told her I was homeless. Within 3 minutes two security guards came over and said ‘We’ve seen you on the camera, and you look ok’. There was a camera on the wall and that was my examination! They literally escorted me out of the building and over a white line... I had to come back and get the doctor... to take me back up there. She was fuming!” Client

On admission: identifying support agencies

In addition to housing need, interviewees discussed the importance of identifying the support agencies a homeless person might be engaged with at the earliest opportunity- including substance misuse services, GPs, and outreach projects. Traditionally, one of the key challenges from members who manage accommodation based projects has been that they are not notified if their clients present at A&E or are admitted to hospital. This can not only lead to tenancies being terminated (as staff assume the client has abandoned) but can prevent necessary measures being put in place to support a client when they leave hospital.

In many areas, staff in all settings felt this process has generally improved over the past few years, with stronger local links and partnership developing often as a result of setting up protocols. However, this does not always happen. Several agencies felt they still have to ‘do the chasing’ to find out if their client has been admitted and to keep updated of their progress during their admission.

II. RESPONDING TO HOUSING NEED

“In the past there were disasters, there were people who were inappropriately sent in a taxi to the housing options department...we do admit that. Now we liaise through housing options, with the local housing trust and accommodation shelters throughout the borough, throughout [the region] now, we can do that rather than just be restricted.” Ward nurse

The interviews revealed a varied picture of how local partners respond to a patient's homelessness once this has been identified. We included some areas in our study which are known to have developed protocols to secure accommodation solutions for homeless patients. However we also came across examples where no measures were in place: in these cases few clients received any support with their housing and many were simply discharged back to the streets. We present a summary of the issues clients and staff shared below.

2.1 WHERE IT WORKS

Typically, effective practice meant having an agreed process between the hospital teams, local authority and wider voluntary sector agencies about how and when the relevant agency would be notified to make a housing assessment and referral if necessary; and how discharge would be co-ordinated to take into account any ongoing needs including medical care. The importance of early intervention to trigger this process was stressed by all those we spoke to.

Case study 1: a joined up approach

In York, there is a protocol between the Hospital and the Salvation Army who run the Early Intervention and Prevention Team (EIPT). In the past, many clients were regularly discharged to the streets, so the Salvation Army set up an agreement with the hospital where they would contact the EIPT if a homeless person presented. The team go in to assess the client and make a referral into a local hostel where possible, or to the area where the client has a local connection. For clients in priority need, the team would contact the council and arrange for an appointment, sending information in advance. Once the patient has been discharged, they ensure the hostel receives a full report of the individual's needs, so they can ensure there is an appropriate service- such as the local nurse led team- in place to help with aftercare.

The scheme has a visible presence in the hospital. The social workers come to meet the team as part of the induction, and they've also delivered training to hospital ward staff. The EIPT team felt this has helped create a shared understanding of the need to prioritise discharge and the mutual benefits of this. *‘The hospital won't release the patient until we've found them somewhere to go. On one occasion a patient was discharged to us late in the day, and when we told the hospital he would be rough sleeping they actually re-admitted him. They understood that otherwise patients can end up back in hospital.’*

Other agencies in York felt the agreement had improved information sharing and joint planning for clients while in hospital, leading to far better planned discharges for homeless people. *‘We have a multi-agency partnership, we're all signed up together...There's an agreement that homeless patients need to be brought out in planned way.’*

Protocols varied in how housing need would be assessed: in some areas Local Authority staff would visit patients on the ward to make an assessment, start the referral process to an accommodation providers, and offer advice. The extent to which hospital staff stayed engaged in this process varied: some saw that once they had alerted the housing options

team this was effectively the end of their involvement. In others they stayed involved with the referral and followed up action with the housing options service where needed – for example hosting a case conference or joint panel meeting.

In many areas discharge staff pursued a number of options until a solution was found. One nurse described a case when the hospital paid for a patient to be put up in a hotel to prevent them being discharged onto the streets. Others said that sometimes the only option was keeping the patient in the ward to prevent them leaving to the street.

‘Our trust doesn’t have any short term accommodation for people who are homeless, so that’s a restraint on us. We tend to keep patients in longer than maybe if there was a bed in a hostel [nearby]’ Nurse

Where models were seen as effective, there were a number of factors which were central to this:

a) Strategic buy-in

“You need a driver in housing and in the PCT. You need people who will push things forward and pull rank.” Hospital manager

Where formal protocols had helped drive improvements, this had been dependent on having a wide buy-in from the full range of stakeholders, from a senior to frontline level. This also required efforts to keep the protocol ‘live’- either through steering groups, or other joint meetings to oversee the continued implementation of the policy or review of discharge cases.

b) Information sharing

“[We] need to check local connection as soon as possible. The referral comes via email or fax to us with as much information about the patient as possible, including their immediate medical history.” Local Authority

Local Authority staff in particular talked about how critical it was to have sufficient information about the patient’s housing status, local connection, and medical history, in order to put an appropriate response in place. Where this is outlined in the protocol, it was far more likely that this information would be received because medical staff were more aware of the local authority’s needs and requirements.

c) Training

“The housing manager and liaison officer train staff in the hospital once a month and this is part of the induction for new staff...we cover the relevant parts of the homelessness act and also aim to dispel myths [about what’s available].” Housing Options Manager

Good information sharing needed to be underpinned by an awareness within the hospital of how local housing referrals and allocations work, and the type and range of accommodation options which are in place. Training and advice for ward staff had helped to overcome this in some places. Equally, local authority and voluntary sector staff had welcomed informal opportunities to meet with hospital staff to improve their knowledge of how discharge practice can work.

d) Joint working

“The key to getting things right is personal relationships, you have to be open, work closely and be aware of the constraints each team has...[local authority] staff need to

get into the hospital to understand who does what, and who is best to speak to.”
Discharge team

As has been found in previous work on hospital admission and discharge, the importance of multi-agency approaches was seen as critical to effective practice. Agencies talked about the need to be proactive at forming local links and maintaining these, through regular meetings, phone calls or personal contacts.

e) Community based support

In areas where hospitals did not necessarily have in place protocols to support homeless people specialist community based support could make a difference to a person's health outcome. For example, one client who was turned away at A&E was supported to access hospital by a specialist community service and then supported in hospital and on discharge to access accommodation.

Case Study 2

Greater Manchester: shared responsibility from the sub-regional to local level

The Greater Manchester Hospital Discharge (Prevention of Homelessness) Protocol was launched in October 2011.

Following the publication in December 2006 of national guidance on this issue, agencies in the North West held an event to look at how homeless patients were being discharged in the area and consider the requirements of a protocol for hospital trusts and PCTs. This 2007 meeting created the momentum for subsequent events involving hospital trusts and local authorities within the Greater Manchester sub-region, at which a framework for a sub-regional protocol was agreed. At this meeting a steering group was formed to take the draft protocol forward through regular meetings.

Initially the group sought a single protocol for the whole area but this proved too inflexible to local conditions and a more adaptable model was chosen. This model, launched in 2011, consists of two sections. Part one is a single overarching framework which sets out the principles that all participating bodies will adhere to. Part Two is locally developed by each local authority and hospital trust and sets out simple steps for all agencies to take which will help to prevent homelessness. This enables the protocol to take into account local variations in each of the 10 Greater Manchester housing authorities.

Staff we spoke to from Greater Manchester during the course of this research stressed how important it was for the protocol to clarify responsibility among different sectors and agencies at a broader level, with more localised policies to guide staff through the practical steps. *'We feel this protocol will help plug the gap in feedback and communication. It's now down to our regional areas, but it's also individual to our type of patients that we get through our trust.'*
(Nurse)

For Part 1 of the protocol see:

www.gmphnetwork.org.uk/writedir/128bHospital%20Discharge%20Protocol.%20Part%201%20GM%20Framework.pdf

Case Study 3

Liverpool: award winning protocol for homeless patients

As winners of National Nursing Time Award, the specialist nurse team at Liverpool Royal Hospital and its local partners are well known for its protocol on discharge of homeless patients. As a city centre hospital it houses the largest Adult A&E department in the country.

The protocol places multi agency working at its heart and involves the local authority, the hospitals, voluntary sector agencies and the Brownlow Group Practice, a specialist GP service.

A Homeless outreach worker is based in the hospital. If a patient presents with a homelessness issue, this is picked up on admission. Staff are trained to ask certain questions which might reveal that the patient is homeless or living in a local housing project. Not all patients are prepared to say that they are NFA, and this extra training of staff is essential in ensuring that homeless patients are identified as early as possible.

The hospital outreach worker contacts patients and, in association with local agencies including the Basement, and the Whitechapel, works to find housing on discharge. Whitechapel have access to ring-fenced beds which can then be accessed. Follow up healthcare is enhanced by a new treatment room, funded by the PCT, at the Basement which ensures that people can access health services in an environment and time they are comfortable with.

The support of the senior management in the Trust has proved key. This has ensured that safe discharge is a priority throughout the Hospital and allows consistency. The support of the Safeguarding Lead has also proved important in working with those who may need to approach the council for housing and in delaying discharge if necessary.

Local services have also reported improved outcomes for their clients, not only for housing but because the protocol ensures appropriate referral are made to rehab, ongoing health services, and other community based projects, such as the Basement's peer mentoring programme

Case Study 4

Conquest Hospital, Hastings: putting in a response with a smaller homeless population

Targeted approaches to homeless people's discharges have traditionally been linked to larger urban areas. However the Conquest Hospital in Hastings offers an interesting example of how an area with a lower homeless population has put measures in place to improve discharge practice.

In Hastings, St John Ambulance Homeless Service (SJAHS) has a partnership with the Conquest Hospital so that all homeless patients attending A&E and inpatients are referred both to the Local Authority Housing Services and to SJAHS.

The SJAHS receives referrals from the discharge nurses as soon after admission as possible— usually within 1-2 working days – to assist with discharge planning, to ensure the client receives all the necessary support and care on discharge, and if possible is rehoused. Their role is primarily one of support and advocacy, and linking the patient and the hospital staff (including Adult Social Care) with community agencies. They usually visit the patient on the ward several times before their discharge, depending on how long they're on the ward and what the needs are. Some of this work is done by a SJAHS volunteer, but the assessment and most of the advocacy is done by a nurse on the SJAHS team.

Support might include accompanying clients to the housing office in order to make an application for housing, referring to other agencies- for example substance misuse- and ensuring clients attend follow up appointments with their GP.

Since an initial pilot in 2009, the service has developed. Referrals are frequent and although it can be very time-consuming, the process works very well, especially because the SJAHS has close working links with other community agencies with which the hospital and social

care staff may not be so familiar. They are also able to be assertive advocates for clients during and after the discharge planning process.

Sometimes the system breaks down and there have been some isolated cases of poor discharges. However, where these have occurred it has led to positive changes, with closer inter-agency working and further development of communication channels to prevent the same problems recurring.

Contact: roger.nuttall@sussex.sja.org.uk

Case Study 5

The Intermediate Care Pilot St Mungo's and Lambeth PCT

In response to the high levels of mortality and morbidity among rough sleepers and those at risk of rough sleeping, St Mungo's and Three Boroughs Services launched a pilot project at Cedars Road in January 2009. The project located health services in a hostel providing access to intermediate care to those most at risk of death or disability. The pilot was staffed by a full time nurse and a full time Health Support Worker and was supported by a visiting GP. Staff were funded jointly by the local NHS and St Mungo's. In addition the rest of the hostel had access to services, funded by local GP commissioners, of three nurse sessions and one GP session each week. These were provided prior to the start of the pilot.

The increase in healthcare on site has made a dramatic difference to the health outcomes. In the year prior to the pilot there were 7 deaths on site whilst during the first year of the pilot there was one death. Client feedback was highly positive.

A report of Intermediate Care Pilot gives information on emergency usage (A&E visits). This shows that A&E visits dropped by half (8.4 per month to 4 per month 2008-2009) whilst inpatient admissions dropped from 10 per month in 2008 to 2.33 in 2009⁷. These striking improvements are further validated by comparisons with other local hostels, including some provided by St Mungo's, which show no similar improvement (hence the results can reliably be attributed to the ICP rather than, for example improved hospital practices).

It is estimated that St Mungo's saved £100,000 as a result. Taking into account the costs of running the project, it has been demonstrated to be cost neutral overall and results in reduced mortality and morbidity as well as improving clients' health outcomes.

2.2 WHERE IT DOESN'T WORK

Although the above section highlights some of the practice in place, many of the clients we interviewed had not received support with their housing. It is important to note that the client interviewees did not necessarily come from the same geographical area as the local authority and hospital staff we spoke to.

Only 19 out of 57 clients said they had been offered support with their housing whilst in hospital. This represents just under a third of those we spoke to. Our findings also suggested that those who came to hospital directly from the streets were even less likely to receive help with their housing:

- Clients living in hostels were more likely to have had their housing discussed; however this still represents under half (41%) of those living in hostels who were offered support with their housing
- Of the 12 people who were discharged to the streets, only one had been offered housing support.
- Of the 18 people those who accessed hospital from the streets or a squat, only four were offered housing support (three of which resulted in them avoiding street

⁷ www.mungos.org/services/recovery_from_homelessness/homeless_intermediate_care_pilot_project

homelessness after hospital, suggesting this type of intervention can make a real difference).

- Clients who received help with their housing were more likely to have had a positive experience of hospital. 14 of the 19 who had received such help rated their experience in this way.

While this is only a snapshot of experiences, this information arguably suggests that those in the greatest housing need are not being offered the support they need.

The impact of this was clearly felt by the clients we spoke to. Not getting good advice and support to access housing clearly undermines some people's recovery and as a result leaves them falling between services without their issues being addressed:

"I've also got hep C – had it for about 13 years, but I can't get any treatment for that whilst I'm still drinking and using. I've been in detox several times, and stayed at the Sally Army, but now I'm hoping my mate's going to put me up. Or the night shelter in St Pauls. Or hospital, because of the diabetes." Client

CHALLENGES FOR AGENCIES

There were a number of barriers to effective practice, a summary of which is provided below.

a) Who is responsible for addressing housing need?

"If they don't have a medical reason as to why they would need housing, I don't think it would be seen as a responsibility...if it was just a straightforward homeless admission they would be discharged as homeless." Discharge nurse

There was a clear lack of consensus about who is responsible for ensuring homeless people have somewhere to go on discharge. Within hospital settings, some staff perceived that the NHS does have clear responsibility for making sure a patient's housing need was taken into account and addressed while they were being treated.

"That's really difficult isn't it, because of all the other priorities that hospital staff are having to deal with...I'm not saying that we don't have responsibility because I think we do and you need to see the whole picture, and that's part of it." Hospital vulnerable adult lead

However for others, this was an area which lay beyond the hospitals' remit. While some of this variation is likely to be affected by the individual nature of the staff role, it is also indicative of the lack of clear understanding about where the involvement of each sector or agency should start and end. There was little agreement about how far hospital staff should be expected to proactively seek accommodation, and how far this was the role of the local authority:

"It's a grey area, from a legal perspective we only have responsibility to highlight the case to the housing team." Nurse

"It's the hospital's job to make sure everyone with an acute need is taken care of, then make a smooth transition and handover to the appropriate agency. I don't think it's our job to make sure someone has a home, it's our job to conform to the homelessness legislation." Nurse

Because lines of responsibility are not clear, a perceived clash of priorities emerged as a key stumbling block to joint working to address hospital discharge. Some local authorities felt they had to push hospitals to see it as their priority. They felt hospitals were only concerned

with the period of the hospital stay itself and do not see beyond this, unless bed blocking occurs. They would like to see a shift in the way hospitals view housing as an important element of their patient's recovery.

"There's a sense they are only here for health issues and not anything else...its clear we're singing from different hymn sheets, their main interest is in making beds available as quickly as possible". Housing Options Manager

"Housing is often an afterthought, it's not flagged up on admission rather it's considered at the point where staff want to free up the bed." Local Authority

Where it is not viewed as a priority, this often led to a late notification to the local authority or housing agency of a homeless person's discharge (although it was stressed this can still be the case even where good protocols are in place). They felt this placed them under an unreasonable amount of pressure to find accommodation options at short notice. This was particularly difficult in some areas with limited emergency or temporary accommodation or where they received referrals from clients outside the local authority area (meaning they had no local connection). There was a sense that hospital staff did not appreciate how difficult it can be to find accommodation, and how long this can take.

"The pressure to reduce bed blocking is a real issue. There needs to be flexibility so that hospitals' partners can provide enough support for the homeless person. Hospitals need to understand the constraints that housing options work under- they have few options to house people." Local Authority Housing team

"The hospital was phoning us every day to complain that a patient was bed blocking and that we are irresponsible for not providing them with accommodation." Local Authority Housing team

b) Lack of accommodation options

"You can't get past the fact that there aren't enough houses out there for people so regardless of process you'd be stuck waiting for accommodation at the end of it."
Discharge nurse

This is symptomatic of the wider frustration felt across the sectors that accommodation is simply not available for patients who are being discharged. Many of the homeless patients do not fall into priority need, even if a protocol worked well to secure an assessment, it did not mean there was any duty to accommodate the patient. In some cases once this process had ended there was limited action taken beyond this point.

Local authority staff told us about cases where they have had to use B&B accommodation which was unsuitable for homeless patients in lieu of any suitable alternative. Others said that all they can realistically do is give information about local hostels or day centres to clients:- *'if there is no need for social service involvement, patients are given a list of hostels to contact'*. There was still an assumption that if accommodation is hard to find or not available at the time of discharge, signposting was an adequate response. An outreach worker expressed frustration that their service was often seen as a 'fallback' option and was expected to intervene if no housing had been secured in time. With prevention of homelessness and rough sleeping high on the agenda for local areas, this assumption needs to be challenged.

Hospital staff also voiced this concern and many felt powerless to know where to turn to. There were particular concerns raised about Out of Hours provision (i.e after day centres or Housing Options services had closed). Some felt the lack of options sometimes left the hospital few options but to discharge back to the streets. Some also said the Local Authority

do not always act quickly enough, and don't appreciate the quick patient turnaround hospitals are expected to work within.

"The council don't even offer B&B. The biggest problem is where there are ongoing medical issues. The council won't house those who we feel are vulnerable." Nurse

The lack of options was seen to undermine the success of the protocol in some areas as staff simply did not have faith that it can find what is needed:

"It's possibly failing because stakeholders feel demoralised, staff can't offer what they would like to patients...maybe they feel there is little point if the patient will end up rough sleeping anyway." Outreach manager

c) Building and maintaining relationships

'It feels like we have to force them to work with us.' Local Authority Housing Options

Good relationships were not shared across the board. In some areas agencies felt there was a poor attitude towards joint working meaning it was rarely a priority. Even where relationships did exist, there was concern about how easily they could be lost with the high turnover of staff, and variation between wards within the same hospital. *'There are so many staff changes and a high turnover of staff...we've told them about good practice but once staff changes started to be so frequent it's got harder for the message to get through.'* Hospital link worker

In some areas agencies continued to feel isolated and would welcome the opportunity to extend communication links, particularly within hospital settings. *'We would like a higher presence in hospital, like a drop-in. We do this at a mental health hospital, giving advice on wards so we can offer help if any clients are likely to be homeless. It has been good having this access, we need to make those involved see the benefit of the protocol, it helps to get the ball rolling even if they can't be housed immediately.'* Outreach Manager

Spotlight on Discharge from A&E

The majority of staff we spoke to were linked to inpatient wards, however we spoke to a number of A&E staff who stressed the additional challenges of putting measures in place if the client was being discharged from A&E, due to the tight 4 hour turnaround time. *'It's very different to inpatient wards, there's very little time to do anything and a lot of pressure'*.

One discharge nurse relied on close personal links with the local day centre who she usually phoned up to alert them that the client had been admitted, but there was often no other steps she could take and some clients were still discharged to the streets. If it was late in the day, sometimes clients would be admitted over night to avoid this, but this was depending on who was on duty. *'They [the hospital] are pretty flexible here but it is also dependent on the doctor. If it's first thing in the morning they'll have to go'*. Several nurses stressed the additional challenge of finding out of hours provision- often the best they were able to offer was a list of local services they could access.

Spotlight on Mental health

We did not look specifically at admission and discharge to psychiatric hospitals. However, when clients talked specifically about mental health wards, people seemed to have strikingly different experiences. Only one person interviewed who had spent time in a psychiatric hospital had a positive move into accommodation afterwards. For others there were a mixture of problems. Some felt they didn't get support with substance use issues while others felt their physical health problems were ignored.

However, during several of the staff interviews, separate protocols for mental health wards were flagged up. On the whole, staff felt these tended to work more effectively as generally there was longer to put measures in place prior to discharge. However, many of the challenges were similar to those experienced on general wards: lack of suitable accommodation for those requiring on-going support was a particular challenge.

There is separate guidance for discharge from mental health hospitals, produced by NHS London and Homeless Link in 2010⁸. More focussed research into how this is working is probably needed to better understand specific improvements needed within these settings.

⁸ <http://www.homeless.org.uk/hospitals>

III. ENSURING A SAFE DISCHARGE

During our interviews, clients were asked about the illnesses they had when they came to hospital. Although we did not ask people to list all their conditions, 61% mentioned multiple health problems, with 6 people listing over 4 conditions. Problems with heart, lungs and liver, and injuries caused by being attacked or falling over were common. Communicable diseases such as hepatitis were mentioned by more than one person. Substance use and mental health problems were also cited by many.

This illustrates that, as the analysis conducted by the Office of the Chief Analyst in 2010 also concluded, many homeless people enter hospital with multiple health problems in addition to their housing need⁹. Our findings suggest that many clients are still being discharged before these wider health needs are being met, and without consideration of the likely conditions people are returning to.

a) Fit for discharge?

“There is often a lack of understanding about the nature of the service at the hostel – and the assumption is that we provide care, therefore some clients are released way too early.” Hostel Manager

Our findings also suggest that too many patients are being found as ‘fit for discharge’ without their wider support needs being taken into account.

Many clients reported leaving hospital in a poor state of health. Many people said they did not get support with wider needs, particularly mental health and substance misuse, even if their ‘primary’ injury had been treated:

“[I was asked about my substance use and mental health], but they didn’t do anything about it. They got the alcohol liaison nurse to see me. She said that I’m fit to be discharged as soon as possible. But I was still shaking like a leaf! So how can someone be fit to be discharged when they’re shaking? The psychiatric nurse ‘held’ that I was fit to be discharged, when I have mental health issues.” Client

In total, 17 clients felt they had been discharged too early which is almost a third of those we spoke to. Many were street homeless when they came in and had been discharged back to the streets. This could indicate that people are being discharged too early when they are street homeless or that people who are street homeless feel they need longer in hospital. Indeed, the lack of intermediate or rehabilitation beds was seen as a gap in provision by staff in all sectors.

Some clients attributed this to the prejudice of staff. Others felt they had not received the right level of support in the first place. After being discharged with a heart condition this respondent then talked about being bought back in by a member of the public:

“And it was only because a gentleman... helped me up to the hospital and basically shouted at the staff “This lad is seriously ill, you’ve got to do something about it”, before they’d even look at me, and they found out that I had a severe viral infection, which is probably what I had when I first went in, but it got worse because nobody treated me.” Client

⁹ Healthcare for single homeless people, Office of the Chief Analyst, DH, 2010

b) Re-admission

“I’m going back to hospital for an X-ray and echo. I’ve got worse, not better.” Client

Many clients linked their early discharge to worsening health and readmission to hospital. 19 clients said that they had been quickly readmitted after discharge or that they regularly attend hospital. Nine people said they had been in hospital over five times in the last year with three clients stating they had been in hospital over ten times.

“I’ve been in hospital over the past four months but recently the past fortnight, and for a heart attack – in for 7 days, with drips and cannulas, then kicked onto the street straight after. Then I went back into hospital last week, for an accidental overdose of tramadol to kill then pain of my liver which has sclerosis. Then they kicked me out again a few days later. They knew I was homeless, but they didn’t come and speak to me about this.” Client

It is unacceptable that people are discharged without being properly fit, with unmet health problems which will often require them to return to acute services once these have met crisis point.

Readmission is also highly inefficient and represents a considerable burden to the NHS which is avoidable if more effective support is put in place for their discharge. One local authority housing manager told us about a client who had been admitted over 50 times in one year. Several felt that more needs to be done to flag up repeat admissions – or the ‘frequent flyers’ so that more intense packages of support can be put in place. *“It costs money failing to have a good system. Health is exacerbated if people are not referred properly – it just ends up costing the NHS more money”*. Co-ordinator of Homeless Shelter

One of the central aims for the NHS QIPP (Quality, Innovation, Productivity and Prevention) workstream on urgent care is to reduce admissions to A&E by 10%. Given our findings, this represents an even greater incentive to improve discharge practice for homeless people if these standards are to be met.

c) Self-discharge

“But the biggest problem I find with hospitals is that - I was a drug user – and if I get admitted into hospital, I need them to supply me methadone immediately, otherwise I’ll start withdrawing...Usually, if you’re admitted in the late afternoon or early evening...they’re not able to give you any methadone that night until the next day. So with most people, even if they’re really, really ill, they’d rather not stay and get treated, they would rather leave the hospital.” Client

Ten clients reported that they had left hospital before being formally discharged, and failure to take wider needs – particularly relating to substance misuse- was seen as a major contributor to this.

Just under half (four of ten) of those who self-discharged felt they had left hospital too early but didn’t feel they could stay at the time. Of those, three had substance use and/or mental health problems.

Self-discharge was also a major concern for agencies. One service manager told us that many of their clients with substance misuse needs self-discharge because hospitals fail to arrange a methadone script in time. In another area, an outreach worker told us that her clients with alcohol dependency often leave without being properly treated because they are unable to drink on the ward. Another felt their clients leave because of the poor experience

of using hospital services, often stemming from the negative attitude of hospital staff, something which was repeatedly highlighted by the clients we interviewed.

‘Sometimes when nurses find out the client is homeless or on a methadone script they can treat them very poorly, they can be quite dismissive and patronising to them...I have had to intervene on a few occasions. It’s not all nurses, but it happens more than it should.’

Outreach worker

“Our clients’ health is often debilitated, but bad experiences from local GPs or other health professionals means they are reluctant to stay in hospital.” Hostel manager

It would be useful to look in more detail at the circumstances around self-discharge to see how services can intervene more effectively around an individual’s mental health and substance misuse needs to prevent them leaving early. Addressing some of the attitudinal issues raised here is also an important step to reduce cases of self-discharge.

d) Joined up support during and after discharge

“Sometimes they need a higher support partly for their healthcare needs but also to give them an opportunity to get stable. If they’re released to the same lifestyle again, their health can deteriorate again.” Resettlement Manager

Even if discharge was not seen as premature, there were still a number of concerns that not enough support is put in place to ensure clients can have their on-going medical needs met.

Several clients were unable to attend follow up care due to their homelessness or severity of health problems – for example attending appointments, storing medication, or dressing wounds can be difficult if living on the streets or in a chaotic environment:

“The staff were very good, polite. The staff didn’t talk to me about being homeless. I was in there about a month. They discharged me, and gave me medication and organised a registered nurse to look after the wound – which never happened. They came twice and said because I was mobile I could come down to... hospital – but I had a big hole in my abdomen the size of my fist and it was quite difficult to walk long distances.” Client

Several of the homelessness agencies we spoke to felt far more needs to be done to involve them in the post-discharge care or follow up of the patient. We heard examples of clients being discharged without medication, or with discharge notes which couldn’t be understood. Others felt that hospital staff have a poor understanding about the nature of support they, as a housing provider, can offer the client. This related both to logistics on the day of discharge, as well as on-going medical supervision or care:

“We are often not informed of discharge (leaving us management and preparation problems), hospital staff assuming that we can pay for taxis and spare staff to go and pick clients up and bring them home, unrealistic expectations of the care we can provide (such as close monitoring overnight) and a general lack of communication about planned discharge dates.” Hostel manager

Case Study: where co-ordination is not in place

This case study was provided by a London based agency, and shows the impact that poorly co-ordinated discharge can have on a vulnerable rough sleeper and the agency seeking to support them through this process:

‘A client was taken to Hospital X after she had a fit. Our local outreach service was contacted and the worker liaised with the hospital. The discharge team were really

uncooperative, they didn't appreciate he was working to a tight schedule with trying to get her emergency accommodation so that she wouldn't lose her place. There was no joint working at all. The outreach worker kept getting conflicting reports from the hospital staff, saying that she was ready to be discharged today and then saying she couldn't be discharged until next week, there was poor joint working even within the hospital team. When she was discharged, her medication wasn't ready so the worker had to return to the hospital to pick up her medication afterwards. Also, she didn't get a copy of her discharge papers, they couldn't find them, and he had to collect them for her. This delayed the process of her getting on benefits.'

However we also heard from a number of clients whose wider needs had been taken into account, and who had been linked into external services. This was evident in areas which had a specialist homeless liaison worker or service, as well as where it fell under the duty of a more generic post.

Case Study: Hospital without specialist homeless intervention, St James's, Leeds

The patient was admitted for ulcers as a result of alcohol use, he also had sclerosis of the liver. He went in an ambulance to A&E. He was asked about where he was living and told staff he was living in a church hostel.

Staff addressed all of his illnesses including mental health problems, offering to refer him to a psychiatrist in relation to his alcohol issues.

They gave him Librium to help him manage his alcohol withdrawal and he says he was treated well by staff. They also discussed his homelessness and found a housing solution for him: *"They arranged for me to stay with my brother. I had to stay there because of the Librium."*

On discharge he was given advice about continuing to take Librium and contacted his GP. After discharge he started to make progress cutting down his drinking: *"I didn't touch drink for a month. I'm waiting to get into a detox centre at the moment."*

At the time of interview he has not been readmitted and is receiving support from his GP and a keyworker.

Case Study: Hospital with specialist homelessness support, London, UCH

After attending A&E at one London hospital and being turned away the patient decided to attend UCH: *"I know that UCH do treat you well, coz they've got a scheme going to help homeless people..."*

He had a swollen knee cause by septic arthritis which prompted his admission but also suffers from HIV, Hep C and DVT.

He had a history of repeat attendance for his knee which UCH were able to address: *"I had to keep going back for further treatment at A&E because my knee keeps swelling up. They've given me antibiotics but it keeps coming back – probably because of the HIV. They got on top of it in the end and it's been fine ever since."*

Once in the hospital, steps were taken to ensure his care was joined up: *"When I am admitted, all the doctors involved with my illnesses are brought in, so they're all aware that I'm in there."*

They also helped to secure stable and suitable accommodation after he was discharged: *“I could have gone back to the crack house if I wanted to – that was my choice – but I didn’t want to. I wanted to sort myself out. So they kept me in there until they found somewhere for me to go... But this is the only hospital I know of that does this. I was in there about 8 weeks altogether in an ordinary ward.”*

On discharge he was given advice about medication and a district nurse was organised to come and look after his wounds: *“I’ve got to back in for another operation in two months, and I’m not bothered. Most people would be a bit thingy about it, but because I know I was treated well, it’s easy to go back.”*

“My GP is brilliant too, although I’ve only seen him a couple of times. He’s underneath Dean Street Hostel and deals with all the homeless. The hostel people were coming up to see me too. I quite enjoy going to hospital!”

e) Day of discharge:

“Give us notice, notice, notice. Hospitals discharge often late in the afternoon after the duty round so clients end up 'shuffling' into the project out of hours.” Hostel manager

Poor communication also led to late notifications of discharge, or in some cases no notification at all. The co-ordinator of a night shelter told us about examples when homeless people have turned up straight from the hospital with nowhere to go. Outreach teams and hostel managers also shared frustrations about receiving no information about their clients, or receiving it too late, leaving them unable to put in enough support for often very vulnerable clients.

Clients also stressed the lack of practical support they were given on the day of discharge. We heard many examples of where poorly planned discharge was compounded by lack of consideration for a client’s clothing, or how they would leave the hospital, many of which were a long way from town centres. Many people volunteered that they would have liked support with transport – many were told that if they had no resources they would need to walk back. This was often seen as unfair.

“The staff didn’t talk to me about my circumstances. All they saw was ‘NFA’ on the form, and they start getting abrupt with you. Sometimes I was kept in, but then I was discharged at anytime – no matter what time day or night, I was discharged onto the streets. I would explain that I was living rough, and I had no way of getting back into the town. They said it wasn’t their responsibility – walk. It’s between 5-10 miles from City Hospital back into town, I’d say. And I was doubled up in pain.” Client

“...I couldn’t walk, the security guard paid out of his own pocket for me to come back [to the hostel] or else I would have been in real trouble.” Client

IV. CONTINUOUS IMPROVEMENT: QUALITY AND MONITORING

Our findings provide a varied picture of practice, suggesting more needs to be done to drive up improvements. We explored what interviewees thought needed to happen in order to support this process.

a) Support and training for hospital staff

Within hospitals, only a few of the staff we spoke to had a specialist role with responsibility for homeless people's discharge. The majority were ward staff, generic discharge staff, and a few had explicit responsibility for safeguarding vulnerable patients. Several said their involvement had borne out of their personal interest and commitment to the issue because they had witnessed poor discharge in the past rather than because it had been driven by hospital management - although this was seen as a driver in some areas. There also were varied experiences in terms of the number of homeless patients they work with. For some it was 30 cases a month; for others 1-2 a day; others even more infrequent. .

Despite these different levels of demand, many staff would like further support and training. They also wanted processes to be simpler so that all ward staff could be confident about using them.

"Ward staff are not adequately trained, I think they're a bit lost with it...a lot of times we get the wards ringing saying 'I don't know what to do with this chap, he's just told me he's homeless, he's got nowhere to go.'" Vulnerable Person's lead.

There was also demand, particularly from the homelessness sector, for training to address some of the discriminatory attitudes which persist in health settings. The findings from our client interviews make a compelling case for this training to be prioritised:

"We need to teach them [healthcare providers] to avoid negative stereotypes, we need to change the culture and attitudes of the NHS." Voluntary sector Chief Executive

b) Monitoring

"We don't collect data because we don't report on discharge." Local Authority

To underpin this work, some staff felt that more needs to be driven at a management level. They also felt more can be done to record and collect data to enable them to routinely monitor the outcomes for their homeless patients. Some expressed that the work they do was despite, rather than because of, formal policies for homeless people.

Some areas had systems in place to monitor outcomes for homeless clients. In one, for example, homeless clients are entered onto a database. If a client is readmitted this gets highlighted so that the case can be reviewed. However on the whole, hospital staff did not monitor data about the outcomes for their clients and were not aware there were systems in place to do this. Many staff said they would welcome the system to do this.

"There needs to be a way of how we monitor, how we know that what we're doing is actually working or not. We need to look at our coding." Nurse

V. CLIENT EXPERIENCE: ADDITIONAL FINDINGS

There were a number of points which clients raised in the interviews which are important to raise in this report. While many referred more broadly to client's experience of using hospital services, these findings impact on the admission and discharge process.

Prejudice

While this has been raised in the sections above, it is important to stress how many clients felt poorly treated by hospital staff because of their homelessness, or because of substance misuse problems.

"I felt I'd been treated like an animal. A stray dog would have been treated better. I'm disgusted. I'm a human being... I took an overdose a few days ago, and when the ambulance came, I said "Fuck it; if I die, I die". I took 36 paracetamol. But I'm still alive. But I'm suffering the consequences – bleeding rectally. But I don't want to go back to hospital – the way I've been treated by the NHS like this – I don't want to bother." Client

"I have diabetes – but as soon as they find out I'm a junkie and alcoholic, they treat me differently. It's alright but not as well as the next man." Client

Others also felt that medical staff denied them access to treatment because they were homeless:

"Because I'm homeless, on nine different occasions, I've been thrown back out onto the streets in severe pain. As soon as they find out you're homeless, the staff at the hospital become abrupt. They start treating you like a drug addict even if you're not... I was meant to be constantly monitored with a heart machine – but instead they would take an echocardiograph, and take the machine away again. When I looked at my notes, the doctor asked for a three hour trace, and it was never done." Client

Three of 45 people asked had been banned from hospital, two of them twice.

Every person who had a good experience said they had been treated well or with respect by staff, while all those who had a negative experience highlighted prejudice or discriminatory behaviour. It is recognised that some clients can display more challenging behaviour. However the interviews showed how negative attitudes seem to prevent many clients getting help for their homelessness and wider support needs.

Low expectations

Some of those who stated that their experience of hospital was good seem to have fairly low expectations of their own health and the help which hospitals are able to provide. One man who had been admitted after being attacked and also had some problems with his kidneys as a result of substance use was very impressed by the treatment he received from staff stating:

"It was pouring down – and I was allowed to stay until it stopped raining – an extra hour and a half. Absolute diamonds." Client

However, he was discharged on to the streets and started drinking again and was still sleeping rough when he was interviewed with no real improvement in his health.

Some people were very angry about not being given better support for all their health needs while others felt that so long as they got basic treatment. Some accepted living with pain and discomfort or long term problems such as hepatitis.

Others did not feel that dealing with homelessness was something hospitals should do as *'it's not their remit'*.

One of the areas of concern for this research is that homeless people may say they have had good experience of hospital yet their expectations of what hospital can offer them are relatively low.

The role of the police

The police came up a surprising number of times in interviews. They were sometimes called in when people were disruptive in different health premises.

"I was taken by police to see a psychiatrist. He told me there was nothing wrong with me. So I went to my doctor to ask if there was any chance to have some sedatives to calm me down, as I get really hyper. So he said he'd give me a prescription, and I waited for hours it – and in the end I banged the door of the doctor's office. Police turned up and dragged me away – bang, mental health services." Client

In other cases the police brought clients into A&E. One person was followed home by police after he self-discharged following an overdose to make sure that he was ok.

While we didn't ask any specific questions about the police it seems that they are often involved in admissions, discharges and incidents in relation to homeless people and their health. This is another example of the knock on effect which can be felt if people's health is not addressed in the first place.

Variations in experiences

There were regional variations between the experiences which people had – those outside of London were much more likely to have had a bad experience than those in London. There are a number of possible reasons for this. In London there are a few specialist services which people who had good experiences often seemed to have had contact with either in the community (at their hostel or through the GP) or in the case of UCH have a dedicated team in the hospital.

Outside of London specialist services were available to people in the community and they often spoke highly of them. However, this did not seem to have impacted on their experience of hospital.

One of the other reasons for variation is a bias in the research. Many more of the people living outside London who were interviewed had been sleeping rough at the time they were admitted to hospital. It is possible that this might be a significant factor in people's experiences. Those who were sleeping rough were much more likely to report prejudice and feel they had been discharged early with ongoing illnesses.

Further investigation might be needed in order to be conclusive about whether the services in London are making the decisive difference or whether accessing hostel services rather than sleeping on the streets is the key distinction. It is possible that both play a role.

VI. CONCLUSION

Taking the findings together, there are a number of clear messages about what contributes to effective practice

CLIENTS

Being treated well: too many clients felt their homelessness had led to discriminatory treatment. Conversely, those who had been treated well tended to categorise their experience as positive even if other elements of care and support had been wanting. This might, in part, be because people have a low expectation of some statutory services.

Co-ordination of services: having an engaged GP and community based support seemed to make a big difference to people's experiences of hospital and subsequent recovery. A number of these providers seemed to be specialists involved in provision for homeless people. However more needs to be done to ensure this happens consistently, particularly for mental health and substance use needs.

Housing support: being offered support around housing often correlates to having a good experience of the hospital, but our findings showed the provision of this support is inconsistent. Hospital can act as a gateway to good housing support: it is vital this opportunity is acted on.

Fit for discharge: too many clients felt they had been discharged too early, or had self-discharged. Often this had left vulnerable clients unable to maintain appointments, or without a safe destination to return to.

AGENCIES

Intervention must start early: effective admission and discharge is dependent on timely identification of homelessness to trigger an appropriate response. Late identification and notification of relevant services led to either rushed action or no action being put in place, putting staff from all sectors under pressure.

Multi Agency Involvement: much has been stressed in previous guidance multi agency working to co-ordinate support before and after discharge. Strong links, with named contacts and regular communication, need to be in place across all areas.

Shared responsibility: while some staff were confident about where responsibilities lay for admission and discharge practice, it can still fall through the gaps. There is a need for clearer agreements between all relevant partners about how, and when, they should be involved in the pathway.

Accountability: few areas track or monitored what happens to homeless patients when they are discharged. An understanding about how outcomes can be better measured is an important step to incentivise staff and ensure it was driven by wider policy within hospital settings.

Discharge extends beyond the hospital: there is a gap between being medically fit on the day of discharge, and having the wider needs taken into account that might otherwise prevent recovery. This includes housing but also on-going support in the community.

Improving standards and expectations for staff: while there is a frustration about the lack of accommodation available, more can be done to support and train staff about how housing is allocated; challenge the negative perceptions of homeless patients; and overcome the assumption that being discharged to the streets is an inevitable outcome for some people.

2. THE COST BENEFITS OF EFFECTIVE ADMISSION AND DISCHARGE PRACTICE

There has been a strong body of evidence which has highlighted how the poorer health of people who are homeless impacts on disproportionate use of services in acute settings.

DH research in 2010 estimated homeless people use 4 times as many acute health services and 8 times as many inpatient health services as the general population at around £85.6m per year¹⁰. The same research found that homeless people have an average length of stay in hospital 3 times as long as the general population.

In addition, the poor health of homeless people has a knock on effect to housing and related support services: without good health it is difficult to address wider needs and move on to employment and independent living.

While these costs are self-evident, it has historically been difficult to attribute how improving discharge practice can directly reduce costs to hospitals and the wider community. Cost savings are based on the assumptions of:

A possible reduction in hospital resource usage:

- (i) While it could be argued that arranging appropriate discharge for some homeless patients may require them to remain in hospital, other patients may be discharged more quickly, as there is less incentive for 'bed blocking' if the patient is happier about their discharge from hospital.
- (ii) Reduced rate of emergency readmission (e.g. within 28 days). If patients are discharged at a clinically appropriate time and to suitable accommodation, they should better be able to recover from their illness, resulting in fewer readmissions to hospital.

This is in addition to the benefits to the client in terms of their health improvement, reduced homelessness, and improved patient experience.

However part of the challenge in demonstrating these savings, as discussed in our analysis, is that recording of homeless people's hospital usage is inconsistent which makes it difficult to track outcomes. Where it is used, the NFA code is most common although this can exclude some homeless people (for example those in temporary accommodation) and include others who may choose to disclose themselves as NFA for other reasons, making it an imperfect measure. This was flagged up in the DH report by the Office of the Chief Analyst into Homeless People in 2010¹¹.

Despite this, several projects have demonstrated the cost benefits of projects or models which have been implemented to improve admission and discharge practice. The majority of these involve funding for specialist posts, and all have demonstrated possible savings.

While we do not necessarily advocate that it is practical or economical for all areas to have a specialist post in place, analysis does demonstrate the improved outcomes which can be made to reducing rates of admission, and reducing bed stays. This provides a strong case for all areas to put measures in place to ensure homeless people receive the right levels of care throughout and following their stay in hospital.

¹⁰ Healthcare for Single Homeless People (March 2010) Office of the Chief Analyst, Department of Health
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114369.pdf

¹¹ *ibid*

DEMONSTRATING THE COST BENEFITS

The London Pathway is described as a model of integrated healthcare for single homeless people and rough sleepers.

The London Pathway provides a targeted service for homeless people admitted to UCH in London, and they are now hoping to extend the model and its principles to other hospitals nationally. This includes a GP led ward round for all homeless patients, supported by a specialist homeless health nurse practitioner, which visits every homeless patient admitted to the hospital to co-ordinate all aspects of care and make plans with the patient for discharge.

They liaise with medical staff across the hospital and other agencies involved with the client, working with them and the patient to plan for life after hospital. The service is also supported by Care Navigators, whose personal experience of homelessness, makes them well placed to befriend, support, challenge and mentor homeless patients in the hospital, helping them navigate the hospital environment, and supporting our homeless health nurse practitioners. They will help us follow-up patients post discharge.

An evaluation of the initial London Pathway pilot reported a number of improved outcomes, but the most significant was found to be a reduction in the average duration of stay for homeless patients.

Analysis found that:

- The average length of stay for a homeless patient was **reduced by 3.2 days** (12.7 reduced to 9.5 days)
- Over a typical year with about 250 homeless admissions at UCH this equated to a potential **reduction of 800 bed days**
- The average cost per stay £4,750 (@500 per day). The evaluation estimated that the project brought **a saving of £100,000** net after taking into account the costs of the service.
- This equate to £1,600 saving per patient on average due to lower length of stay.

In addition to the cost savings, there were considerable improvement so joint working and quality of service to clients. This was highlighted by many of the clients interviewed for this report who had reported a positive experience of the UCH service.

www.londonpathway.org.uk

Arrowe Park Hospital, the Wirral

The Hospital Discharge Project at Arrowe Park Hospital responded to a concern that homeless patients were being discharged with little support, resulting in poor health outcomes, prolonged homelessness and increased costs to the NHS. The original goal was for a hospital link worker to train staff in appropriate discharge as well as provide some direct support for patients. Funding (jointly from NHS Wirral and the Supporting People team at Wirral Borough Council) was agreed for a one-year pilot starting in early May 2010.

The project aims to improve hospital discharge for homeless people or those at risk of homelessness by:

- Ensuring that homelessness is accounted for in discharge policy and procedure.
- Developing a discharge protocol between the hospital and the local authority.
- Raising awareness of homelessness amongst hospital staff.
- Developing links between the hospital, community support and treatment services.

- Supporting patients through discharge to appropriate accommodation.
- Contributing to the understanding of local need and access issues.

As the project has progressed, it has also encompassed elderly patients who could not easily return to their homes. The link worker's level of direct involvement is also higher than was planned, having built up his own case load. A further year's funding has since been agreed. Some of the reported improvements made to practice have been identified to include:

- Support, advice and referral service to patients, ranging from rough sleepers to disabled people who can't return to their own homes because of their health needs
- Amended hospital discharge policy and procedure to account for the needs of homeless people
- An early flagging system so that homeless patients or patients who can't return to their accommodation on discharge are identified at admission so any housing issues can be addressed by the Link Worker at the earliest opportunity
- Information resources for ward staff and A & E staff (intranet, ward manuals, posters)
- Link Worker attends ward rounds
- Link Worker attends frequent attenders meetings at Accident and Emergency Dept to provide advice to staff and support to patients identified as frequent attenders.

Homeless Link commissioned the Centre for Health Service Economics & Organisation (CHSEO) to conduct comparative analysis of the data for homeless patients, using Hospital Episode Statistics, in the year prior and during the introduction of the link worker. The analysis revealed that:

- **A reduction of approximately £26,500** (around one third; 2009/10 prices) in the total cost of No Fixed Abode episodes (as determined by the National Tariff and average Reference Costs, held fixed between the two years).
- Whilst the number of individual patients is virtually unchanged between 2009/10 and 2010/11, there are **falls in the number of episodes (26%), admissions (18%) and bed days (26%)**. These translate into similarly-sized falls in the number of episodes, admissions and bed days per patient.
- There is **a fall of one third in the number of episodes resulting in emergency readmission within less than 28 days** between 2009/10 and 2010/11.
- England-wide No Fixed Abode episode, admission and bed day totals (calculated on the same basis as the rest of the paper) are almost unchanged between 2009/10 and 2010/11, so national trends are not driving the above results
- Unexpectedly, there is a small rise in self-discharge rates between 2009/10 and 2010/11.
- Male patients and emergency care feature prominently amongst the No Fixed Abode episodes, as do substance misuse and mental health issues

This analysis is based on NFA coded patients. The project also worked with a number of homeless people living in hostels, or those at risk of homelessness, who fall outside this cohort. Hence the benefits and outcomes for these patients are additional to those above. Arrowe Park estimate they have also seen savings of £45,000, due to a reduction in delayed discharge, in 6 months between April and September 2011 for 27 patients who, because of housing/homeless issues would have stayed longer or been referred to interim care.

Full findings from the CHSEO analysis can be accessed at www.chseo.org.uk

3. RECOMMENDATIONS

OVERALL MESSAGE

Hospitals, Local Authority Housing teams and local voluntary sector agencies **in every area** should ensure there is a clear process in place so that nobody who is homeless or at risk of homelessness is discharged from hospital without having their housing and ongoing support needs planned for.

At a time the government has new ambitions to reduce inequalities and improve efficiencies in the NHS, we must grasp the opportunity to improve the way homeless people's needs are met during and after their admission to hospital.

The Inclusion Health Board is well placed to drive forward these changes.

At a national level:

- The Department of Health should set a clear agenda for the NHS Commissioning Board to improve accountability within health services so that nobody is discharged to the streets. This should be monitored through NHS indicators including reducing emergency readmissions within 30 days and unplanned A&E use within 7 days¹². Ambitious improvement levels for homeless people should be set against these indicators.
- The NHS Commissioning Board should introduce new standards to improve the recording of homeless patients, revising the NFA code to more accurate indicators of someone's housing status.
- The proposed NHS Outcomes Framework indicators on Patient Experience (Domain 4) should be used to set improvement levels for homeless people's experience of using hospital and accident and emergency services.
- The Care Quality Commission should review whether these targets and standards are being achieved as part of its inspection of hospitals.
- The Inclusion Health Board should task the NHS Commissioning Board to review progress of discharge outcomes on an annual basis as part of its commitment to reduce health inequalities.

At a local level:

- Hospitals, local authority housing teams and voluntary sector organisations should work together to agree a clear process from admission through to discharge to ensure homeless patients are discharged with somewhere to go and with support in place for their on-going care. This process should start on admission to hospital. The local Health and Wellbeing Board's new functions could provide oversight for this process.
- NHS Trusts should promote a definition of 'fit for discharge' which takes into account if every patient has somewhere suitable to go with plans in place for on-going care as required.
- NHS Trusts, working with local partners, should promote a cultural change in the way homeless people are viewed and treated in the NHS through strong leadership and training for staff.
- Hospitals and Local Authorities should undertake routine monitoring and reporting of the discharge outcomes for homeless people within their performance frameworks.
- NHS Trusts, Local Authorities and providers should explore how intermediate care between hostels and hospitals can be developed, for example through joint funding between health and local government

¹² The NHS Outcomes Framework published in December 2011 includes 'Emergency readmission within 30 days from hospital' as an overarching indicator under domain 3 and should be used to monitor this.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131724.pdf

- All sectors should take a greater responsibility for maintaining links, sharing expertise and offering advice to others involved in the discharge pathway. The Health and Wellbeing Board's new functions could support this process.
- All sectors should take a greater responsibility for maintaining links, sharing expertise and offering advice to others involved in the discharge pathway. The Health and Wellbeing Board's new functions could provide support for this process.

The following table suggests some of the activities which can help achieve these aims.

Outcome	Activity	Assured by
Hospitals have a clear understanding that appropriate housing is a crucial aspect of a safe discharge. There is a clear expectation across all staff levels that every patient should be discharged with somewhere to go and with support in place for their on-going care.	<p>Staff training</p> <p>Housing brought formally into all safe discharge processes</p> <p>Required protocol which includes LA, hospitals, community healthcare and homelessness services</p>	Penalty for hospitals/ LA where people are shown to be discharged to the streets (verified by outreach teams and other frontline staff working with homeless people)
Hospitals and Local Authority housing teams work together to ensure there is a clear process in place for identifying and responding to a patient's housing need as early into their admission as possible.	<p>Use self-assessment checklist</p> <p>Requirement for a joint protocol</p> <p>Named lead in LA and hospital</p> <p>Housing Options teams are proactive at identifying key members of staff in hospitals and offer training and support around homelessness legislation and how to make effective referrals</p> <p>Self-Assessment checklist and guidance</p> <p>The use of intermediate care and ring fenced beds should be considered as a way to improve outcomes for patients and reduce costs associated with repeat homelessness and readmissions</p>	Measured using joint outcome measure on NHS outcome framework
Hospitals accurately record homeless patients	Improve the NFA code so that housing status can be	Measured using joint outcome measure on NHS outcome

<p>on admission so that their homelessness can be flagged up across the wards, and their outcomes can be more clearly measured.</p>	<p>more accurately recorded within hospital databases/care record systems. Homeless Link is currently working on data standardisation of housing status and would be happy to work with areas on this</p> <p>Enable other agencies (including GPs, hostels, outreach, LA etc) to flag up to hospitals a person's homeless status</p>	<p>framework</p>
<p>There is greater accountability so that nobody is discharged to the streets</p>	<p>Shared protocol (as above)</p> <p>Homeless agencies can hold local authorities and trusts to account where this happens</p>	<p>CQC monitor through indicators including reducing emergency readmissions within 30 days, and unplanned A&E within 7 days</p> <p>Discharge to street recognised as 'serious untoward'</p> <p>Clear message from DH/Minister about need for accountability</p> <p>Active programme of engagement with hospitals</p>
<p>Homeless patients receive the same standard of care as other patients</p> <p>Homeless people feel and are able to complain about poor standards of care.</p>	<p>Create a targeted complaints system for homeless people (e.g. being identified as homeless triggers need for an 'exit interview' regarding standards of care)</p> <p>Module in staff training on homelessness and working with vulnerable patients</p> <p>Development of NICE standards for homeless health</p>	<p>Annual measure of homeless people's experiences through survey work in community- eg Health Needs Audit</p> <p>Measures of 'patient experience' in the new outcomes framework disaggregating data for homeless patients</p>
<p>Local Authorities monitor the number of unplanned presentations at Housing Options/Homeless Person's unit from clients directly from hospital</p>	<p>Add questions to housing options 'script'</p>	<p>Part of centrally captured data by Department of Communities and Local Government (DCLG) on homelessness</p>
<p>Homelessness agencies are proactive at</p>	<p>Part of joint protocol</p>	<p>Contracts encourage partnership working with</p>

<p>establishing links with hospital staff and offering support and advice</p>	<p>Homelessness agencies invite A&E staff to do shifts at local hostels/outreach teams as part of their induction</p> <p>Homeless Link ensure guidance and resources on services are fully promoted</p>	<p>hospitals</p>
<p>Homeless agencies support clients to draw up a charter of rights for homeless people about standards of care they can expect in hospital settings</p>	<p>Through Homeless Link</p> <p>Sign up by NHS organisations</p>	<p>Measures of 'patient experience' in the new outcomes framework disaggregating data for homeless patients</p>

4. APPENDICES

APPENDIX A: ASSESSMENT OF CURRENT GUIDANCE

For this report we were asked to review current guidance aimed at helping local areas develop effective discharge practice for people who are homeless.

In addition to the guidance identified and reviewed for this report we also refer to several reports published on this issue. These were:

- Discharge from hospital: pathway, process and practice, *DH* (2003)
- Achieving timely discharge from hospital: a toolkit, *NHS* (2004)
- Homeless and Health Fact Sheet No.4: Hospital discharge, *ODPM* (2005)
- Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation, *DH, CLG, Homeless Link and London Network of Midwives and Nurses*, (2006)
- CLG Pan-London Hospital Discharge Pilot: evaluation and guidance documents, *CLG* (2009)
- Homelessness Prevention and Hospital Discharge: Three Case Studies, *Housing Learning and Improvement Network and Homeless Link*, (2009)
- Rough Sleepers hospital discharge project final report, *Helen Lewis* (2010)
- Overview of Health Services for Rough Sleepers in London: Report of Evidence Gathering and Stakeholder Engagement. Prepared for the Health Subgroup of the London Delivery Board on Rough Sleeping Regional Public Health Group for London (March 2010)
- Healthcare for single homeless people, *Office of the Chief Analyst, DH* (2010)

National Guidance

The guidance produced by the Department of Health in 2003 made clear that every hospital should have a protocol which takes the needs of homeless people into account, and where this responsibility lies:

'The lead managers for hospital discharge in acute hospitals and social services should ensure that their hospital discharge policy includes guidance for staff dealing with individuals who are homeless and aged both under and over 65 years.'

However there was limited information both in the 2003 and 2004 documents published by the NHS – which do not seem to have been superseded- about how to go about this in practice.

The 2004 Toolkit is a comprehensive guide to effective timely discharge but focuses on the 'simple' discharge cases that make up 80% of patients, and pays limited attention to the admission process. These patients are described as those who usually have their own home to go to, and who have simple on-going care needs. The guidance does contain simple checklists and a factsheets, of which some aspects are still relevant for more complex patient groups- for example patient involvement in discharge planning and how discharge fits within the clinical governance framework. However many of the practical recommendations are not geared toward those with housing or other non-clinical support need.

The 2005 guidance issued by the ODPM attempted to fill this gap. The 'Hospital Discharge' fact sheet raised awareness about the specific challenges of implementing effective admission and discharge policies. It carried a strong message about the need for hospitals

and local authorities to work together to provide effective responses for homeless people and the need for a 'clear understanding between hospitals and service providers on how appropriate and timely referral and joint working between agencies can be established.' The fact sheet included several case studies highlighting how local areas had established this: UCH in London, Cambridge, Leicester and Bristol. While now quite dated, many of the principles remain relevant.

Homeless Link has been involved in developing many of these case studies and more tailored resources which followed the ODPM guidance. These sought to raise awareness of the needs of homeless people or those at risk of becoming homeless in hospital, and offered practical steps that hospitals and local authorities can take to develop an effective discharge protocol.

The 2006 guidance, produced in partnership with the *London Network of Midwives and Nurses and published alongside DH and CLG*, provides recommended practice and focuses mostly on the steps involved in setting up and maintaining a protocol. Aimed at a wide audience, these included mapping relevant local stakeholders, reviewing how existing systems work, how to set up a protocol and how to monitor its effectiveness. It did not aim to provide a set checklist for the components which a protocol should include but rather a framework for its development. Its scope did not include the specific issues raised by admission to A&E.

The Housing Learning and Improvement Network (LIN) and Homeless Link case studies, which followed in 2009, highlighted three areas which had used this framework to develop an admission and discharge protocol¹³.

This included two areas (West Sussex and Guys and St Thomas's) which had employed posts specifically to co-ordinate discharge for homeless people, as well as one area, (Newcastle) which had mainstreamed their protocol into their homelessness prevention work undertaken by the Housing Advice provider.

It also discussed common lessons identified through the case studies. Most had found that housing partners tended to lead and champion the process. To be effective, they needed to have strategic relevance and be steered by the appropriate person within both sectors. Monitoring of the protocol was also essential to retain a focus and sustain quality. This guidance also reported the importance of training and how relationships were often the key to effective practice.

In 2009 Homeless Link, in partnership with NHS London, developed a series of factsheets to update this work¹⁴. We also updated [Homeless UK](#), a database of agencies for homeless people across England and [Homeless London](#) (a similar database for agencies in the capital) with appropriate sections that could be searched by staff in hospital looking for information for homeless patients.

How useful is the guidance?

When we reviewed the guidance with partners last year, it was positively viewed by those we contacted. However our current research suggests awareness of the guidance is still poor. This is particularly true in health settings. In addition, several respondents consulted for this report were sceptical about issuing more guidance which can be a weaker instrument to instigate change. Research in 2010 which focussed on hospital discharge within London found that stakeholders generally did not mention guidance in discussions, and concluded

¹³ www.dhcarenetworks.org.uk/library/Resources/Housing/Practice_examples/Housing_LIN_case_studies/Case_Study_46.pdf

¹⁴ <http://www.homeless.org.uk/hospitals>

that practice had tended to develop on an individual trust basis rather than as part of a wider strategic initiative.¹⁵

Locally developed guidance

Many areas have developed their own protocols and these have developed along a number of different lines. However evidence suggests coverage is patchy. A survey of all Local Authorities in England indicated that:

- 39% have an admission and discharge protocol
- 26% did not have a protocol but were developing one
- 25% did not have one but wanted one
- 8% did not know
- 2% said they did not need one¹⁶.

However, even where protocols are in place, the extent to which they drive forward effective practice is mixed. This was identified in both our 2010 survey and the research undertaken in this piece of work. Awareness of protocols can be low, particularly where there is high staff turnover. Respondents felt if they are not regularly used and reviewed their effectiveness is also limited.

'A discharge protocol only works where hospital staff are aware and staff members do not change on a frequent basis. Although we have a protocol it is not always used by the hospitals.'

'It would seem that discharges vary from ward to ward as our protocol is in the main with hospital social work team. Not all wards keep to it or are aware of it. On occasion homeless persons have been sent here in a taxi with no prior information given to us, and even when they have no connection to our area.'

The issues surrounding the use of formal guidance were explored in the section Analysis of Current Practice.

¹⁵ 'Rough Sleepers' Hospital Discharge Project', Crunch Consulting, 2010

¹⁶ 'Hospital Discharge Progress Report', Homeless Link, 2010. The survey was sent to all Local Authority Housing Leads as well as Public Health Directors. Results based on 141 responses.

APPENDIX B: GOOD PRACTICE TEMPLATE

The DH asked Homeless Link and St Mungo's to develop a 'generic good practice template for each stage of the pathway to hospital discharge, providing criteria against which discharge policy and practice can be self-assessed and improvement needs identified.'

This will not duplicate existing guidance but rather a set of principles which can be applied regardless of the specific model in place – i.e whether there is a specific post in place to co-ordinate admission and discharge for homeless people, or if responsibility fits within mainstream discharge practice¹⁷.

From speaking to individuals during our research, it was felt there are several key stages which this template needs to cover:

- Identification of homelessness (point of admission)
- Responding to housing need (during admission/treatment)
- Arrangements for leaving hospital (point of discharge)
- Continuous Quality/Monitoring to ensure all this happens

From speaking to stakeholders during the course of this project, it was felt the template needs to:

- Be simple and quick to use
- Support staff to identify what might be missing from their current practice
- Support staff to elicit the information they need from clients who might be reluctant to share status on housing (this was identified as a bit of an obstacle by hospital staff).

The below table presents the stages of the pathway and questions/triggers for staff to 'self-assess' against. It is recognised hospitals will work in different ways, so **these questions are designed to help staff identify what is in place and any gaps, rather than prescribe actions to meet the outcomes.**

¹⁷ For existing guidance please refer to 'Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation', DH, CLG, Homeless Link and London Network of Midwives and Nurses, (2006)

GOOD PRACTICE TEMPLATE

OUTCOME for stage of the pathway	Self-assessment checklist of the steps needed	Indicators/probes
1. IDENTIFICATION OF NEED		
<p>Homeless patients identified and recorded effectively on admission.</p> <p>WHO: HOSPITAL AND LOCAL AUTHORITY</p>	<p>a. Are all staff aware of the importance of identifying homeless people and those at risk of homelessness?</p> <p>b. What housing status is included in this definition (e.g. rough sleeper, hostel dweller, temporary accommodation, at risk of homelessness etc.)? <i>template to provide guidance for this</i></p> <p>c. Are staff equipped with the skills to ascertain people's housing status? Is there an agreed set of questions to use (see right)?</p> <p>d. Is there a method to record housing status in the hospital data systems?</p> <p>e. What timeframe is given for identifying need?</p>	<p>c) <i>Suggested prompts</i></p> <ul style="list-style-type: none"> • Do you have accommodation? • Can you return there? (Do you need support to do so?) • Are you at risk of losing it while you're in hospital?
<p>Relevant support agencies which client is engaged with (e.g. accommodation and support services) are identified and contacted</p> <p>WHO: HOSPITAL</p>	<p>a. Is there a list of up to date contacts and external agencies available on each ward?</p> <p>b. If the client is living in temporary accommodation (hostel, supported housing, shelter), has the service been notified?</p> <p>c. Is there a method to gain client consent to share information with external agencies?</p> <p>d. Have you checked if the client is linked in with any community based support or health services and notified them?</p> <p>e. Can staff access CHAIN (London only) to identify relevant support agencies?</p> <p>f. If client discloses substance misuse need has appropriate action been taken to notify relevant services?</p>	<p>b) <i>Suggested list of external agencies to link to:</i></p> <ul style="list-style-type: none"> • GP or nurse led team • substance misuse • mental health • day centre • outreach team • hostel/supported housing project
2. RESPONDING TO HOUSING NEED		
<p>If housing need identified, ensure clear process for referring for assessment and appropriate response (either internal or external point of contact. Where the term 'housing service' used this includes housing options, homeless prevention worker, housing advice, or outreach worker or link worker as appropriate).</p> <p><i>NB if there is a specialist liaison worker as in UCH model some of these Qs may not be as relevant?</i></p>		
<p>Appropriate steps agreed and taken in order that accommodation response can be identified</p>	<p>a. Are all staff aware of which service (internal or external) to notify when homeless person presents?</p> <p>b. Within what time period will contact be made?</p> <p>c. Is there a named contact in</p>	

<p>WHO: HOSPITAL AND LOCAL AUTHORITY</p>	<p>hospital and housing options team/housing advice service?</p> <p>d. How are referrals made? (<i>eg fax, email, phone call, standard form?</i>)</p> <p>e. What information is required by housing option teams when referrals are made?</p> <p>f. Are ward staff aware of this and how to obtain it?</p> <p>g. What is the agreed time frame for housing service to respond to referral?</p> <p>h. Is provision in place for more complex clients- e.g. case conferencing?</p> <p>i. Is there emergency provision in place for clients in non-priority need?</p> <p>j. Is provision in place if the discharge happens out of hours?</p> <p>k. Are staff aware of steps to take to prevent loss of tenancy if at risk?</p>	
<p>In event of self-discharge, ensure steps are taken to minimise risk of harm</p> <p>WHO: HOSPITAL</p>	<p>a. Have you contacted local services to alert them of client's self-discharge?</p> <p>b. Have you recorded self-discharge on client's record?</p> <p>c. Have you reviewed as a team why this happened?</p>	<p>c) Prompts can include:</p> <ul style="list-style-type: none"> • If the client had substance use needs had these been addressed? • Did the client have mental health needs assessed and identified and had these been addressed?
<p>Clients are able to access on-going care or treatment following discharge</p> <p>WHO: HOSPITAL, LA, VCS</p>	<p>a. Has a social needs assessment been completed (<i>where applicable</i>)</p> <p>b. Has their GP been notified?</p> <p>c. Has the client and any relevant agency aware been made aware about follow up treatment?</p> <p>d. Has client and any relevant agency been given copy of discharge plans?</p> <p>e. Has the client received medication and steps taken to ensure they can follow any prescribed follow up care?</p>	
<p>Clients are able to safely get to accommodation or other destination on day of discharge (i.e to housing options appointment if this has been pre-arranged)</p> <p>WHO: HOSPITAL</p>	<p>a. Have you notified the housing agency/hostel if appropriate? With (24 hours minimum notice?)</p> <p>b. Is the client able travel to accommodation or do they require support to get there?</p> <p>c. Are travel expenses required?</p>	

a. MAINTAINING QUALITY AND EFFECTIVE PRACTICE		
<p>All staff have the skills and confidence to provide an effective service to homeless patients</p> <p>WHO: HOSPITAL, LA</p>	<p>a. Are staff aware of homelessness issues and housing options for clients?</p> <p>b. What options are in place to meet training and skills needs?</p> <p>c. How are new staff inducted/trained in homelessness issues?</p> <p>d. What resources are available for hospital staff to help them with discharge (eg guidance, Homeless UK, info pack on services)?</p> <p>e. Can all staff access resources via the intranet?</p>	<ul style="list-style-type: none"> this should include access to www.homelessuk.org and discharge factsheets
<p>Outcomes for homeless people's admission and discharge are regularly monitored</p> <p>WHO: HOSPITAL AND LOCAL AUTHORITY</p>	<p>a. What system is in place for monitoring homeless patients and their discharge outcomes?</p> <p>b. What indicators can be used?</p>	<p>Possible indicators</p> <ul style="list-style-type: none"> Unscheduled readmission within 28 days Unplanned A&E re-attendance within 7 days
<p>Homelessness agencies support local areas to improve practice</p>	<p>a. Are staff team aware of local protocol if in place?</p> <p>b. Do local hospitals have information about your service how to refer (if appropriate)</p> <p>c. Have you identified opportunities to meet hospital teams and offer support/training?</p> <p>d. Have you reviewed recent hospital discharge with clients and fed back any issues to hospital and local authority?</p>	
<p>Joint approaches are taken with local agencies to reduce frequent attendances</p> <p>WHO: HOSPITAL AND LOCAL AUTHORITY</p>	<ul style="list-style-type: none"> How are frequent attenders currently identified, if at all? How can this data trigger a case review? Who should have responsibility for monitoring this data? 	
<p>WHO: ALL</p>	<ul style="list-style-type: none"> Are there shared contact lists and are these regularly updated? 	

APPENDIX C: PROFILE OF CLIENT PARTICIPANTS

Most commonly clients interviewed in our sample (Bristol, Leeds, Birmingham and London) had accessed hospital through A&E:

Walked into A&E	42% (24)
Ambulance to A&E	25% (14)
Referred by GP	18% (10)
Unknown	7% (4)
Sectioned	4% (2)
Self referred to psychiatric hospital	2% (1)
Planned operation	2% (1)
Arrested	2% (1)

The method of admission does not seem to have a big impact on the type of experience received in hospital. Fairly similar proportions to the overall satisfaction levels are found among those who access hospital through A&E.

Of those we interviewed 13 came into A&E as a result of injury linked to attacks, fights and accidents. At least 8 of the admissions through A&E were people with self-described serious long term health problems including hepatitis, pleurisy and heart problems. A further 6 came into A&E with some kind of infection such as an abscess or chest infection. There were 4 people whose primary reason for coming into A&E was substance related though many others had underlying substance use issues this was because of overdose's or fits.

From the information gathered about admissions it would seem that much of the care being received by people is unplanned with people attending A&E when they are in pain, pass out or reach some other crisis point.

The table below highlights the outcomes for clients who reported that they had been discharged too early. The majority were discharged back to the streets or with no support to return to their accommodation. This provides compelling evidence about the journeys and outcomes for homeless people where admission and discharge practice is not in place.

Type of illness	Type of admission	Accommodation	Experience	Discharge
Long term head injury	unknown	Street homeless	Poor	to streets
Blackouts (other illness but unclear what)	Ref by GP	Street homeless (now hostel)	Poor	to streets
Mental health problems, Hep C, drug use	Arrested	Temporary accommodation	Poor	With somewhere to go
Overdose, coughing up blood, substance use	A&E	Street homeless	Poor	To streets
Abscess, septicaemia, heart problem	Ref by GP	Hostel	Poor	Without support
Pericarditis (heart), drug use, viral infection, other health problems	A&E	Street homeless	Poor	To streets

Schizophrenia, ADHD	Self ref to psychiatric unit	Street homeless	Poor	Self discharge
Heart attack, overdose, sclerosis, personality disorder, PTSD, depression, self harming	A&E	Street homeless	Poor	To streets
Arm cut (off) in attack	Ambulance to A&E	Street homeless	Poor	To streets
Heart, attempted suicide, OCD, arthritis, alcohol issues	Ambulance to A&E	Street and family	Mixed	Self discharge
Hepatitis	unknown	streets	Mixed	Self discharge
Kicked in the head, substance use	A&E	hostel	Mixed	With support, support withdrawn in community
Hep C	Ref by GP	Street homeless	Poor	No support
Sceptic knee, HIV, Hep C, DVT, burst artery	A&E	Street/ squat	Poor	With support
Liver problems	A&E	hostel	Mixed	No support
Alcohol seizures, broken arm	Ambulance to A&E	hostel	Poor	Self discharge

Homeless Link is the national umbrella organisation for frontline homelessness organisations in England. Currently we have more than 500 member organisations. As the collaborative hub for information and debate on homelessness, we seek to improve services for homeless people and to advocate for policy change. Through this work, we aim to end homelessness in England. www.homeless.org.uk



St Mungo's opens doors for homeless people. Mainly based in London and the South, we provide over 100 accommodation and support projects. We run emergency services - including street outreach teams, emergency shelters for rough sleepers and hostels. We support homeless people in their recovery - opening the door to safe housing, drug and alcohol support and physical and mental health care. www.mungos.org

