What Community Nurses Say About …

Hospital Discharge for People who are Homeless

In 2014, The Queen's Nursing Institute surveyed over 180 nurses who work directly with people who are homeless to get their views of current hospital discharge arrangements. This document captures their feedback.

This report includes:

- Moving from Hospital Discharge to a Transition of Care approach
- The main challenges experienced by community nurses in the 'Transition of Care' of patients who are homeless
- The reasons for these challenges
- Suggested solutions and case study examples
- The QNI's response

Transition of care

The term *'transition of care'* can be used to describe what is happening for the patient during a discharge from hospital.

Hospital admission and discharge represent 'transition of care' points as care moves between hospital care and community care (self-care, carer-support, support from community health professionals, housing and voluntary organisations).

> *Evidence suggests that the rate of avoidable rehospitalisation can be reduced by improving core discharge planning and transition processes out of the hospital; improving transitions and care co-ordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management. (**Institute for Healthcare Improvement**)*

It is very likely that people leaving hospital with good family support, good housing, and access to a GP will be better placed to negotiate these transitions than people who have inadequate/no housing, little or no family support, and are not registered with a GP.

Transition of care planning will work best when the quality and ethos of care in place upon leaving hospital does not diminish. This is most effective when joint protocols and systems of effective sharing of information exist between hospital and community health staff, social care, housing services, and other voluntary organisations. This is also aided when health professionals explain clearly how to use self-care information, and when they address patient concerns. Further work with carers (if involved), to ensure they are clear about how to manage additional care responsibilities and their routes of support, is also central to this transition.

Hospitals adopting approaches similar to those outlined above have seen a reduction in their readmission rates, and improvements in their overall efficiency.

The main challenges experienced in the *transition of care* of patients who are homeless

The following quotes have been chosen to illustrate opinions emerging from respondents about the challenges they experience in their work.

Poor communications

- "Discharge information is not communicated, there's no forward planning, and patients are subsequently discharged to no fixed abode."
- "There's a lack of joined up working (i.e. having to chase up where people are, chase discharge summaries)."
- "Hospital workers do not get in touch with our service even when contact numbers have been left with them."
- "We've a poor knowledge of patients being discharged and are provided no health summary to know what to do next."

"I worked as a Practice Nurse for Homeless People for 14 years. I saw this every week – people with Pneumonia, Endocarditis, Hepatitis and Leg Ulcers all discharged to the streets"

Inappropriate/unsafe discharge

- "Patients are discharged to the streets or to hostels that are full so they have to sleep on the floor."
- "Clients are discharged inappropriately with no care plans especially if alcohol dominates. Housing is underfunded so staff cannot provide adequate support and knowledge."
- "Patients are often discharged into chaotic and inappropriate settings."
- "Patients discharged to unsuitable/unsafe accommodation with no access to cooking facilities or hot water."
- "Stabilizing health is difficult when the patient has nowhere to live."
- "Staying in hotels, temporary accommodation, or staying with friends may not provide the suitable bed or private space necessary to meet often complex health and social care needs, especially if patients are in need of palliative care."
- "We find that people are often discharged either back into very chaotic hostels, or into temporary accommodation (B&Bs) where there is a lack of support. We worked with one person who was in hospital for three months and completely stopped drinking and using but was discharged into a B&B above a pub - it was like the council were setting him up to fail."

Access to appropriate accommodation or step-down care

- "It's difficult to get accommodation which can mean loss of contact with patients."
- "Often there is no recovery accommodation for individuals."
- "There is a lack of available temporary accommodation for homeless patients for whom the Local Authority has no legal duty to house. "
- "If the patient has complex health needs there are no suitable accommodation providers."

Other problems experienced by health staff

- Dealing with relapse
- Identifying palliative care needs
- Paying for travel and ongoing services
- Access to generic services
- Legislative/entitlement barriers such as no recourse to public funds
- Trust between patients and health services
- Conditions requiring long-term treatment such as TB require more complex discharge.

Reasons for these challenges

Poor joint working between organisations

- "I am working with a teenage mother whose baby has died. Services are finding it hard to contact her and are not working collaboratively."
- "If health and housing services worked more effectively together they could be trusted to provide accommodation merely with a supporting letter. Currently if people attend alone they often are not accommodated."
- "Often acute services have not contacted community services about a patient being discharged. Instead they 'discharge to GP' – even when a GP for that client doesn't exist."
- "Some clients move hostels frequently. If we knew they'd been discharged we could seek them out."
- "The referrals to community services arrive too late in a patient's hospital admission."

Lack of local supported housing

- "I believe if patients had a place to stay and recover many more would consider quitting substances."
- "In order to treat TB, treatment needs to be monitored to ensure compliance. When someone has no fixed abode this cannot be maintained. This increases the risk for non-compliance and deterioration in the patients' health, and increases the risk of drug resistant disease."

Inadequate health service resources

- "TB needs daily treatment and recovery and good nutrition and rest. This is simply not possible with no access to money or no accommodation. The cost of keeping TB patients in hospital is much more than if supported housing and food provision was available."
- "There is pressure on acute hospitals to not keep patients longer than they need to."
- "Working in an overstretched / under resourced mental health system."
- "Services cut and so there is no specialist provision."
- "Small size of mental health team (Homelessness Outreach team)."

Lack of awareness of community services amongst hospital staff

- "Hospital not always aware of Homeless Healthcare Team."
- "Lack of awareness of homeless services in acute settings."

Staff from all sectors need support to improve their skills in working with people who are homeless

- "Finding patients after discharge sometimes needs an assertive approach from heath care staff."
- "There are prejudicial attitudes from some staff and poor understanding about addiction."
- "There's poor training about homelessness in community nursing."
- "There are poor attitudes from health care staff towards homeless patients."

Homeless people receive a poorer experience of healthcare

- "Past experience has taught patients to distrust GP surgeries and hospitals, why would I be any different."
- "There is a poor service from local secondary care provider, and a lack of understanding of healthcare needs for homeless people."
- "Clients' chaotic lifestyles, poor literacy skills or English as a second language mean they often do not initially understand what to do next regarding health treatments."
- "Patients are often unable to comply with treatments e.g. special diets etc."
- "Patients struggle with hospital regimes."

Organisations have limited resources for the care of high-needs people

- "Housing services failed to house a man who would have died if on the streets. He had to remain in hospital for nine months post fit for discharge as two previous discharges to no fixed abode ended up with two intensive care admissions."
- "If a patient self-discharges, then no discharge summary is sent through to community health staff."
- "There is an increase in the number of patients requiring residential/nursing care but still wanting to drink or use drugs. Local residential homes will not accommodate them so they have to be placed in hostels with a specific care package."

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Unless homeless people in secure accommodation, it can be difficult to maintain contact

- "Individuals are often discharged back into the same situation they were living in prior to admission – (rough sleeping or sofa surfing) and maintaining regular contact with these individuals can be difficult"
- "Mostly we see patients in the evening. It can be difficult to maintain contact because of their lifestyle"
- "Having no address or mobile phone makes the patient hard to reach."
- "My role involves assertive outreach and without a suitable place of contact, it is very difficult to engage the client and provide service."

NHS systems are not designed for mobile populations

- "People move from borough to borough and so care is fragmented - NHS IT and the transfer of health notes are not designed with a mobile population in mind."

Ensuring all necessary treatment / investigations are completed remains challenging

- "Many people are discharged still needing investigations for which they need referral from GP. This creates an additional barrier and time delay and more patients not attending."

Homelessness does not automatically trigger a clear process within discharge planning

- "Homeless people who no longer are seen to have a health need have been discharged to homeless welfare. On some occasions no referrals have been made for follow up care. The patient's housing situation is not discussed in great detail on admission."
- "Often hostels are full yet hospital declares someone medically fit for discharge even though they have nowhere to go on discharge."

Suggested solutions and case study examples

The nurses were asked to identify potential solutions to these challenges, and identified the following:

Improvement	%
Better Communication and Integration	38
Better Discharge Planning	18
Staff Training in Homelessness	15
Dedicated Accommodation	13
Lead/Co-ordinating Professional	9
Dedicated Programme e.g. Pathway	7

Respondents told us more detail about their proposed solutions to the challenges identified. The QNI have added case study details showing examples of current hospital discharge schemes and supporting work that focuses on the health needs of patients who are homeless.

"Hospital may need to think about getting more done while the person is an inpatient rather than getting everything done as an outpatient"

Introduce better processes

- "[The process could be improved by taking] a more streamlined and integral approach from the point of a patient's initial admission. We could work together to explore ways of reducing attendances at A&E by offering our services in a more structured way and being proactive rather than reacting to a crisis situation."
- "Developing better screening for accommodation status upon admission and closer links with housing services."
- "Arrangements can be made to ensure housing [is organised] in priority need cases on discharge without wasting clinicians' time or by having non clinical advocates who can attend housing appointments with patients. Ensuring there is a streamlined housing pathway that does not involve the same pre-homeless application housing options interview, as this holds up the discharge from hospital. Priority should be given to people medically fit for discharge from hospital."
- "No one should be discharged to the streets. Discharge letters should be completed properly prior to discharge and available to the professionals that are involved with the clients' ongoing health needs."
- "It's vital to inform staff that the client will be returning to their hostel. More openness about client care during and after treatment would be welcomed, as would being part of multi-disciplinary meetings."
- "Hospitals to contact the homeless charity, supported housing or hostels on admission."
- "Healthcare staff should alert us once a homeless patient is admitted in hospital instead of waiting until they are discharged."
- "More co-ordinated discharge planning with the homeless services."
- "More work with housing to look at suitable accommodation and support before discharge"
- "A GP Specialist who liaises with acute care and other health providers to ensure that care is being given. The role would ensure people are registered in services while they are transient or in unsettled accommodation i.e. hostels."
- "Utilising homeless health professionals for advice and guidance regarding the best place to house patients especially when there are co/trimorbid health issues. "
- "Giving homeless health teams the ability to commission bespoke health and social care packages."

Case study: Homeless Patient Pathway, Sandwell and West Birmingham and Heart of England NHS Trust

The Homeless Patient Pathway identifies those at risk of rough sleeping prior to discharge. The clinical team led by an experienced GP works alongside housing specialists to provide health and housing support and advice. The team worked alongside hospital trusts and other health partners to develop a clear pathway for all patients who access acute hospitals who are risk of being homeless.

In the first six months of the pathway over 180 patients experiencing homelessness were safely discharged to suitable accommodation, as well as being supported to better manage their health once out in the community. The pathway's ground breaking work was acknowledged when they won a GP Enterprise Award in the Caring for Vulnerable Groups Category in 2014.
Find out more

"Intermediate residential and nursing care homes are required to help provide aftercare from acute hospital admissions, to re-settle or transition homeless patients to better supported living environments"

Provide respite beds

- "We are currently involved in an initiative to provide an appropriate hostel which can provide domiciliary care for people who have complex health needs or who are end of life."
- "There should be more hostels with healthcare provisions."
- "Intermediate Residential and Nursing Care homes are required to help provide aftercare from acute hospital admissions, to re-settle or transition homeless patients to better supported living environments."
- "Specialist step down services can help if they are actively used. Teams like the Homeless team in SLAM[i] and the St Mungo's Discharge Network (see case study below) can help things improve with their expertise and advocacy skills. More services based on these models would go a long way to improving the health of homeless people."
- "That the ward contact at time of hearing of admission of someone who is No Fixed Abode/Homeless start arranging plans for discharge. Plans to include contacting housing department, homelessness agencies etc. as per the Department of Communities and Local Government guidance document."
- "It would help to have health workers working with the homeless to have accommodation allocated to them by the Council for placements. This would be especially useful following discharge, for patients with personality disorders that often get discharged as untreatable when homeless health teams can work with them to help them during each crisis."

Case study: Hospital Discharge Network, St Mungo's Broadway

The London Homeless Hospital Discharge Network provides step-down from acute hospitals and step-up from homelessness services. They help homeless people recuperate from a stay in hospital, and learn to manage long-term conditions more effectively. They help homeless people to secure mainstream health and social care services and stay engaged with services. The team has support from a GP service, a part-time clinical psychologist and two part-time psychotherapists. Clients are then registered with a local GP practice for the provision of core primary services.
Find out more

Encourage better collaboration between agencies

- "It will help to link up working and create pathways between care and health settings."
- "Where possible, it would be great to link services before admission and have a three way meeting to make transition for the patients easier."
- "To facilitate more communication between acute and community services – ideally helped by using a joined up patient data IT system."
- "Integrated health and housing services working within hospitals."
- "Before they are discharged, contact is made with the GP Surgery to make an appointment and is given to the patient before discharge. All mobiles need to be updated and local GPs informed upon discharge, each patient is allocated a homeless worker upon discharge to

follow them up and make sure re-admission is kept to a minimum."

- "Policy needs to be put in to practice by close co-ordination between national organisations such as the QNI, Healthwatch and Homeless Link."
- "Planning should begin as soon as the patient is admitted. Better communication is needed between primary and secondary care. Specific residential homes for high needs patients are needed."

Case study: Groundswell Homeless Health Peer Advocacy

Homeless Health Peer Advocacy is a project that aims to help improve the health of currently homeless people - primarily through Peer Advocates offering one to one support to help access health services by accompanying people to appointments. The Peer Advocates receive formal training and get insight into hospital and primary care services by working alongside nurses, GP's, administration staff and clinicians. Health providers get an insight into the issues homeless people experience when trying to get their health needs met. In this way we hope to encourage services to be more flexible and responsive to homeless people.
Find out more

Develop partnership protocols

- "Protocols signed up by all partners, sharing of information, identification at admission and discharge planning."
- "Stronger co-ordinating links and care prior to discharge"
- "Weekly meetings between primary and secondary care. Networking with secondary care to help identify any prejudices."
- "Making sure there is a robust discharge protocol for homeless. Not just discharging to a hostel or night shelter which may not be appropriate."
- "We have just launched Bolton's Homeless discharge protocol so hopefully this will improve things. We are specifically looking into developing greater awareness of what it means to be homeless and the different types of homelessness – and addressing these on admission."
- "Multidisciplinary meetings with staff to ensure services have been set up as required."

Case study: The Newcastle upon Tyne Hospitals NHS Foundation Trust - Hospital Discharge and Homeless Prevention Protocol

Approved in October 2014, Newcastle's Hospital Discharge Protocol for Homeless, makes clear reference to preventing homelessness, and clearly identifies the roles and responsibilities of hospital staff, nursing staff, Social Services, Housing, Homeless Prevention Officer (Hospital Discharge), Emergency Homelessness Service, Homeless Liaison Project, Specialist Health Visitor for the Homeless, Your Homes Advice and Support Team, Mental Health Advisor, Occupational Therapist (Housing), Specialist Practitioner (Health and Housing), Psychiatric and Community Psychiatric Nurses, and the Mental Health Social Worker. Find out more

Use or develop a Hospital Discharge for Homeless Patients Scheme

- "It would help to have a Pathway team in all hospitals to provide fully integrated care with community homeless teams."

- "Increased understanding of homeless healthcare needs; and utilisation of Pathway model across all acute trusts would help."
- "We are part of the Pathway in Brighton and this model should be used countrywide."
- "We have developed a model called Breathing Space offering 4 weeks respite but this needs to be more widely available."

Case study: Pathway Model

The Pathway Charity has developed a simple model of enhanced care for homeless patients admitted to hospital. Led by specialist homeless general practitioners, dedicated nurses and Pathway Care Navigators, their goal is to improve care for homeless patients in hospital.

Pathway has developed a medical respite centre model to offer short term rehabilitation and convalescent beds to homeless patients coming to the end of an emergency hospital admission, where the patient would benefit from a further period of health-led care and support. A Pathway medical respite centre will be medically led with a focus on recovery and convalescence. Average length of stay might be around 14 days, but some patients could stay much longer. Each centre will be built as a 'psychologically informed environment', operate to standards defined by the Faculty of Homeless & Inclusion Health, and be based on Pathway's core values – high quality professional care coupled with dignity, respect and compassion. Find out more

Case study: Breathing Space

Breathing Space is a homeless hospital discharge service which provides 24 hour support in a healthy and positive environment. It was set up in February 2014 and aims to break the cycle of admission to hospital and give homeless people a better chance of recovery following discharge. Clients are drawn from hospital discharge patients who are homeless and have an ongoing medical need. So far, they are reporting very positive outcomes.
Find out more

Employ a Discharge Specialist Worker and train staff in homeless health issues

- "To commission a Hospital Discharge Worker."
- "Having a Hospital Liaison to support clients through the "system" would be a real help."
- "New Homeless Advisor post covering all acute services should improve awareness"
- "We need to improve the attitude to non-homeless specific clinicians through education."
- "Early Identification of Homelessness training for hospital staff, mandatory training for relevant healthcare staff in Homelessness Awareness."
- "Staff Cultural Awareness training in attitudes to homeless patients."

Case study: Hospital Discharge Project, The Passage

The Hospital Discharge Project is run by The Passage in partnership with Connection at St Martin's and West London Mission. They are working in three hospitals: Chelsea and Westminster, St Mary's and St Thomas'. They aim to prevent homeless clients being discharged to the streets, with a special focus on long-term more complex clients who frequently use hospital services. A key part of the project is to provide information, resources and training to hospital staff to enable the initiative to be self-sustaining. Find out more

The QNI's Response

- The QNI has sent this evidence to the national inquiry into hospital discharge for homeless people led by Healthwatch England.

- The QNI will identify the barriers and challenges preventing effective discharge planning from hospital to home for all patients, identifying best practice and key recommendations to improve discharge experience for patients, carers and their families. The 12 month project is funded by the DH and the QNI and will start in March 2015. This report will provide evidence for this work.

- The QNI will continue joint work with national partners including Pathway, Faculty of Homeless and Inclusion Health, St Mungo's Broadway, Homeless Link, Public Health England, NHS England and others to continue to share information and develop the evidence base and ensure key information is well communicated across the community nurse sector.

- The QNI will undertake a mapping of national specialist homeless health services, and provide a searchable online map, acting as a resource directory for professionals.

- The QNI will create Brief Online Learning Guides for health staff working with people who are homeless, to improve their knowledge.

- The QNI will continue to highlight issues, and share good practice in transitioning the care of patients who are homeless, by sharing information among our network and with health leaders.

We welcome you to contact us about this report, please contact david.parker-radford@qni.org.uk or call 020 7549 1410. With many thanks to the QNI's Homeless Health Network and all of survey respondents.

[i] South London and Maudsley NHS Foundation Trust – Start Team