Homelessness Prevention and Hospital Discharge: Three Case Studies

These case studies explore ways in which housing authorities and hospital trusts are addressing the issue of discharge of homeless people and how they have been using the protocol guidelines developed by Homeless Link and the London Network for Nurses and Midwives.

Prepared for the Housing Learning and Improvement Network by **Homeless Link**.

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DH Department of Health

1. Introduction

This set of three case studies was commissioned by the Department of Health (DH) Housing Learning and Improvement Network (Housing LIN) from Homeless Link.

Homeless Link, along with the London Network for Nurses and Midwives, developed the hospital admission and discharge protocol guidelines in partnership with the Department of Health and Communities and Local Government in 2006. The document is available at:
http://www.communities.gov.uk/publications/housing/hospitaladmission

The purpose of the guidelines was to help housing authorities, hospital trusts and PCT's to develop effective admission and discharge protocols for homeless and insecurely housed people, with the overarching aim of no-one being discharged from a hospital to the streets or to temporary accommodation.

These case studies explore ways in which housing authorities and hospital trusts are addressing the issue of discharge of homeless people and how they have been using the protocol guidelines.

Three different areas were chosen, with different levels of homelessness and different resources to meet the needs of homeless people - Newcastle, West Sussex, and Guys and St Thomas's in London.

Each area has taken a different approach to the issue demonstrating that the approach and the level of investment of time and resources needs to be oriented to the local circumstances. The lessons from the case studies emerge in reading all three and are drawn together in the conclusion.

All areas have someone with a role across housing and health to champion the issue of establishing procedures around hospital discharge and homelessness prevention, but this is not necessarily a full time post and may be shared with other areas of responsibility. Some areas have put a protocol in place for staff to follow. Others have recruited a specialist post to deal with homelessness discharge. Whatever route is chosen, partnership working and embedding effective procedures is the key to success.

It is hoped that the document will raise awareness among housing authorities, hospital trusts and PCT's of the strong link between preventing homelessness and a planned hospital discharge and encourage areas that do not have effective policies and practice in place to address this issue.

2. Case study one – Newcastle

Background

The need for the *Hospital Discharge and Homelessness Prevention Protocol* was originally recognised in Newcastle's homelessness strategy in 2003. It was known that on a fairly regular basis homeless people (an estimated 50 people a year) were arriving at the Housing Advice Centre (HAC) in the City discharged from the hospital with no prior warning and with the HAC as their discharge address.

The City established a homelessness prevention project in 2005 funded through the Neighbourhood Renewal Fund. The overall aim of the project was to make policy and practice changes which would help more people access settled and sustainable housing, and reduce homelessness in Newcastle. Producing a hospital discharge protocol, and the training materials to sit alongside, that became a key part of the work programme.

The need for a protocol was reinforced by the guidelines issued by the Department of Health, Communities and Local Government, Homeless Link and the London Network for Nurses.

Development

Workshops

The initial stage of developing the protocol was to organise a workshop for everyone in the City whose work was affected by homeless people in hospital beds. The aim of the workshop was to:

- Describe current problems from the point of view of health and social care professionals (including a separate group for mental health professionals) and from housing and homelessness agencies
- Describe when and where the problem was most acute
- Describe how problems were currently addressed and what had been tried so far
- Describe what needed to be put in place and what the barriers were

The major message from the workshop was the significant amount of time spent by social workers trying to find accommodation for patients and their lack of knowledge of the routes of referral available.

Hospital discharge and homelessness prevention working group

A working group to develop the protocol emerged from the workshop. This included representatives from:

- Newcastle City Council Strategic Housing Services,
- *Your Homes* Newcastle,
- Discharge Liaison Co-ordinator from the acute trust,
- Public Health specialist from the PCT,
- Urgent Care service manager from the Mental Health Trust
- Social Work Team Manager from the acute hospital
- Advice and support workers and Community Psychiatric Nurses (CPNs) working directly with the homeless client group

The issue is one that impacts widely and not everyone could be represented on the working group. Representatives had sufficient authority in their particular agency to make the decisions that needed to be made. They committed to bringing on board people outwith the group and to communicate with the sector that they represented.

Creating a strong implementation plan meant that members of this group took ownership of the protocol and put their name to the parts of it that they could deliver.

Newcastle also identified a lead person with dedicated time within the work programme of the overarching Homelessness Prevention Project to develop the protocol, to arrange the meetings and to project manage the process. It was important that this lead person had an in-depth understanding of local resources and of local systems and care pathways.

Having a lead officer is one of the strengths of the process in Newcastle, as is the fairly constant working group who have continued to be committed to keeping the protocol live and to championing the issue.

The existence of the Homelessness Prevention Network has helped to embed the protocol. Members of the working group attend network events, build relationships and understand how the local authority is addressing homelessness prevention.

Work programme

The initial workshop also established the basis of a work programme for the lead officer and the partners working on the protocol. The work programme consisted of the following steps:

- Gaining a more precise idea of the number of homeless individuals involved
- Defining a process of assessment for housing and support needs on admission
- Developing a referral system and a communication process on discharge
- Recording and collecting data
- Monitoring, evaluation and liaison
- Agreeing the protocol, implementation plan and dissemination
- Training for staff

How it works and effect on services

A protocol across services

Newcastle wanted their protocol to work across the acute sector, mental health services and A&E, despite the fact that the issues are very different in each sector, mainly because of the lead in time from presentation to discharge. It was also a priority to make it work for social services and reduce the time they spent resolving housing issues. For more information on the protocol in Newcastle, see: http://www.newcastle.gov.uk/wwwfileroot/nhf/HospitalDischargeProtocolfinalMay07updatedFeb09.pdf

Acute services

The acute trust agenda in Newcastle is one of pressure on beds, a very medically driven perspective and rapid discharge. This creates challenges around the appropriate discharge of homeless people for a number of reasons. Firstly, short-term admissions make it difficult to have adequate time to link people into appropriate housing and support and once someone does not require a bed for medical reasons they are required to leave very quickly. Secondly, while there is an understanding of the holistic perspective for elderly people and the package of care that needs to be in place to discharge them, the attitude for complex homelessness cases prior to the protocol was often reported to be '*They walked in here - why can't they walk out.'*

Respondents felt that homeless people did not have easy circumstances in which to recover. For example, access to rehabilitation and intermediate care was restricted for those who did not have an exit address arranged. This meant that they were likely to be re-admitted to hospital within a very short time.

The existence of a protocol has not solved all these issues, but the perspective of the social work team and the discharge liaison in the acute sector is that things are a lot better than they were. The protocol has set in place a system that is clear and functional and has taken the stress out of the discharge situation. The discharge liaison facilitator signposts nurses and social workers to the protocol and they can then follow the set procedure.

This does not mean there are not problems. For example, the hospital advice and support worker from '*Your Choice Homes'* who is available to come to wards and help with housing applications and resettlement issues is not taking on homeless cases as

there is not enough time to put in place an application for permanent housing. She currently focuses on elderly people or people with disabilities, who cannot return home and who need a permanent and sustainable home.

This means the Housing Advice Centre takes applications over the phone, sends someone to the hospital or is attended by the patient on discharge. The HAC gets more notice of discharge than prior to the existence of the protocol but would prefer that a dedicated advice worker in the hospital fulfilled this role.

The perspective of some of the respondents is that the role played by the advice and support worker in the hospital needs to be explicitly a homeless prevention /hospital discharge role, to pick up on all the short term cases, build up links with hostels and supported housing and have a wider remit than helping with applications of permanent housing. These suggestions are currently under consideration.

Accident and Emergency

The issue of lack of time to usefully link people into services is even more pronounced in A&E. The Newcastle protocol does address A&E and there is a poster in the protocol pack to be displayed in A&E departments. However, the feeling among respondents is that the protocol is probably not working well in A&E and that the awareness of it is low.

Figures have been collected recently showing a group of sixty people who experience a mixture of substance dependence, mental health issues and sometimes homelessness, who between them have had over 1,000 admissions to A&E in the course of a year.

The PCT are recognising that this group are not receiving the sort of wraparound care that is preventing re-admission. They plan to look more closely at this group, who they are, and what sort of interventions would be effective in preventing the current level of A&E use and hospital admission. It is hoped that more effective use of the protocol will help in identifying this group and their presenting needs.

Mental health

Mental health services generally have quite a long lead-in time for discharge, as people occupy the beds for longer. In Newcastle, homelessness is not viewed as a major issue in the mental health trust. Delayed discharge is more likely to be caused by not being able to find long term supported accommodation or provision with 24 hour care. If discharge to a homeless hostel is seen as appropriate there are usually adequate bed spaces. There is also a sense that mental health nurses and clinicians are familiar with housing issues and that at the moment clinicians allow people to stay in a bed if there are acute housing problems. This may change with the introduction of payment by results.

The mental health trust employs two CPNs to work in temporary accommodation. There is also a mental health adviser employed in *Your Homes* Newcastle. Both play a role in responding when mental health wards have homeless patients and have a liaison role between mental health wards and housing.

The perception among respondents is that the development of the discharge protocol has been a very positive process and that the legacy in mental health services is a much clearer pathway when issues do occur.

Data collection and monitoring

Newcastle did not have baseline data about how big a problem discharge from hospital into homelessness was before they put the protocol in place. They had made an informed estimate of 50 people a year coming directly to the HAC from hospital, but it was recognised that there would be others who were sent to the HAC as their discharge address but didn't present. As a result of the protocol the HAC now keeps monitoring

data of all presentations, where they come from and whether they are priority homeless or not so they will have better data for future use.

The acute trust does not record housing status except for having the category No Fixed Abode (NFA). Respondents argue that this does not capture any information on people living in hostels or shelters and it records as NFA people who are not homeless but visitors or those who do want to give their address, so it is not very useful. The mental health trust is not able to bring to the table any information which captures the housing status of patients at admission or discharge which would help to set a baseline or demonstrate outcomes.

The effectiveness of the protocol is currently monitored by the discharge from institutions figures on the local authority's P1E returns, by data collected by a clearing house for temporary accommodation (Newcastle Homeless Liaison Project), and by feedback from the professionals involved in the Homelessness Prevention Hospital Discharge Working Group which meets every six months and discusses the effectiveness of the system in place. The group's main mechanism for monitoring is exception reporting – picking up on where there have been failures in the system and tracing them back to see what should have happened and what the barrier or the failure was. Eighteen months after the protocol was produced the group are at a stage where they are finding it useful to stand back and look at it from a whole systems perspective and to see the gaps and the barriers and the missing elements.

Respondents report that it was a conscious decision not to put an onerous monitoring mechanism in place in the protocol as this causes extra work and resentment from staff.

Awareness of the protocol and training issues

The protocol is now available on the hospital intranet, there should be posters on all the wards and everyone involved should be made aware of it. However keeping awareness of the protocol alive is an ongoing and challenging issue, particularly in the context of the labyrinthine nature of the health service, the vast organisational change and high staff turn over.

A lot of effort initially went into dissemination of the protocol. It was sent, along with a large number of the posters to the PCT, social services, housing advice, the hospital trust and the mental health trust, *Your Homes* Newcastle, health centres and the voluntary sector. The pack includes a training presentation on implementing the protocol that can be used with any group of staff to raise their awareness of why it is needed, who has signed up to it, the key elements of it and how to use the resource pack that sits alongside it. For example, all the staff in the Housing Advice Centre know about the protocol, it is part of their induction and all staff use it in their working practice.

There was some training activity right at the beginning in the hospital, but it is not explicitly anyone's role to ensure that new nursing staff or new social workers are trained in how the protocol works and it is not embedded in the system in such a way that it is automatically brought to the attention of those who need to know about it during their induction. This means that the further away it is from the launch and the initial pushes on the protocol, the less staff are aware of it.

To address this respondents suggest putting the protocol on the agenda at Sisters' meetings and Matrons' meetings, to find time to train nurses on the protocol and for the hospital bulletin to be used to promote it.

The protocol has been re-circulated in early 2009, and all partners within the working group have been asked to make sure it is placed on intranets, and highlighted to staff in newsletters and bulletins.

Wider benefits

Joint working

There is complete consensus across all the respondents that the process of developing the protocol has improved joint working across the sectors. There is general appreciation of the impact of having a meeting that pulls together people from different sectors, enhances understanding of what each other do and encourages the formation of relationships. Everyone in the group now feels they know who to go to discuss difficulties or breakdowns in the system.

'Personal relationships are always useful when you are dealing with big institutions.'

There is acknowledgement that this benefit is greatest for the people actually involved in the working group and that the protocol does not necessarily enhance joint working among other colleagues. There is a general feeling that more of the change happened while the protocol was in development compared to now it is in place. This reflects the level of focus the issue requires from a multi-agency partnership.

Understanding of services

Developing a protocol requires a clear look at the systems that are in operation, an understanding of the barriers to ensuring that people do not leave hospital into homelessness and the barriers to using both hospital and housing resources effectively and efficiently. It is clear that one of the major barriers prior to the protocol in Newcastle was effective communication between sectors. This is illustrated by a comment from the Discharge Liaison facilitator in the hospital.

'I used to think we needed a big old bus station with feeding facilities and shower rooms and beds that we could discharge people to but now that I am aware of the hostels and services that exist I realise we don't need that.'

Newcastle has a Homeless Liaison project which gives information on vacancies in hostels on any given day, yet it seems that it is not a service that hospital social workers were previously aware of. Nurses were uncomfortable with the fact that they were discharging people straight to the streets or to the Housing Advice Centre due to pressure for the bed, but they did not have the information to know about the alternatives.

There is now an improved understanding in the hospital of the range of services available for homeless people and the referral criteria into them.

Development of additional protocol

The development of the hospital discharge protocol led to a further protocol about how to support people leaving hospital, and others, whose home needed to be cleaned to avoid either homelessness, a longer stay in hospital, or a move to residential care.

3. Case study two - West Sussex

Background

Work on the issue of hospital discharge and housing need came about in West Sussex as a result of the appointment of a Housing Health and Social Care co-ordinator appointed to take forward the actions identified in the Older People's Housing and Support Strategy for Adur, Arun and Worthing.

Developing a protocol to reduce unnecessary hospital stays arising from a lack of suitable housing and ensuring that alternative housing solutions are in place on discharge was one of the key action points in the strategy.

West Sussex is an area with a high percentage of older people and there was a recognition that agencies in the health, housing and social care sectors needed to work better together. The post was originally joint-funded across district councils, the county council adult services department and the PCT for one year.

The post holder has now been in place for four years. She was initially focussed on older people but now operates across all adult client groups. She is explicitly employed to work across practitioners in frontline service delivery roles as well as to impact upon organisational level and strategic decisions.

Working across a two tier area requires a complex set of relationships. The Worthing and Southlands Hospital Trust relates to seven district housing teams and West Sussex PCT is the fourth largest in the country. The Housing, Health and Social Care co-ordinator post relates to three of the seven districts.

Development

The initial stage of the work involved the post-holder meeting all the different organisations involved and finding out what the issues were:

- What system was currently in place?
- What were the problems with it?
- What needed to be put in place?
- What were the barriers to more effective working?

From the hospital perspective a significant amount of time was being spent in acute hospital beds by people of all ages with complex needs, including housing. Some were older people who following a hospital stay could not return to their previous housing because it was no longer suitable or because family could no longer accommodate, others were younger people with chaotic lifestyles and substance misuse issues and young people who had amputations and needed adapted properties. Weekly delayed discharge meetings at the hospital had led to a growing awareness that there were a small number of people with complex health, social care and housing needs occupying hospital beds for long periods. It was recognised that what was needed was a fully furnished and disabled-adapted property that could be used by any of these individuals while they were waiting for a permanent housing solution.

From the housing perspective, the main message that they wanted to get across at the meeting was the importance of being informed from day one of an admission if a patient had a housing issue. The homelessness teams had been getting no warning of discharge, with people being sent from the hospital with a letter stating that the person needed housing. A significant sum was being spent on Bed and Breakfast accommodation while homeless investigations were carried out and homelessness teams were aware that they were putting an unfair burden on B&B proprietors, who were taking people straight from hospital before any enquiries were made to check whether it was a suitable placement. Bed and Breakfast landlords were starting to refuse to take those clients, especially where there were alcohol issues.

While there are hostels in the area, there is no direct access accommodation and the nearest night-shelters are in Chichester, Brighton or Crawley, all of which prioritise local people. There are problems of access when people from neighbouring districts arrive as homeless.

These issues were raised at the large multi-agency meeting to which all the relevant organisations were invited and a work plan was developed to be taken forward by the post holder and through the homelessness forums. As the overarching hospital discharge procedures were already being reviewed, it was felt important to engage with this process rather than develop a separate protocol for homeless people.

How it works and effect on services

Discharge from the ward

Discharge folders have been developed and are available on every ward with information about local housing and homelessness services and there is a flow chart in the discharge protocol about what to do when someone is homeless. Relationships have been built between the hospital discharge co-ordinator and the housing departments that previously did not exist.

Patients are no longer sent to the housing department on discharge with a note asking for them to be housed. Instead, social workers or the Housing, Health and Social Care co-ordinator fills in the housing register application form and if homeless investigations are needed they can be done while someone is still in hospital so that bed blocking can be avoided.

It is recognised that on occasion the hospital still sometimes discharges people to the street if that is where they presented from, because there are not always alternatives, but the impression is that they generally alert relevant services if they do discharge to the street or if someone self discharges.

Accident and Emergency

The work in A&E is currently underdeveloped and it is recognised that this is an issue that needs to be addressed. Challenges arise in the implementation of the protocol in A&E because people are there for such a short time. However, if they are admitted with a medical issue they go to the EAU (Emergency Admission Unit), which is covered by the Hospital Discharge Co-ordinator and she works effectively to link them in with local voluntary and statutory agencies.

Training

One of the key developments in West Sussex are training sessions on housing and homelessness issues that are now offered jointly by the Housing, Health and Social Care co-ordinator and the homelessness managers from the district councils to staff in the hospital. This is a rolling programme attended by social workers, ward staff, and discharge co-ordinators.

The training sessions have involved an exchange of information and the homelessness staff stress that they are there to learn how the hospital works and what its priorities are as much as communicating issues to hospital staff on housing and homelessness.

Wider benefits

Joint working

The Housing Health and Social Care co-ordinator stresses that she adopts a ‘can do’ approach within the resources available and this comes across in how effective the results have been in achieving some real joint-working across sectors, where previously there was very little.

There is now a consensus among the agencies consulted that communication and early notification to relevant agencies about patients presenting in housing need or who are homeless is effective. The Hospital Discharge Co-ordinator reports good relationships with housing options workers and multi-disciplinary meetings occur in a way that did not happen previously to the post being in place.

‘The health side trust us that we are doing all we can to house the person, both are working together for the best outcomes for our customers.’

This saves costs on Bed and Breakfast and means that people who are unwell do not have to go through the process of making a homeless application. The stated position of one of the housing departments is now that if they have to use the homeless process that is a sign of failure. The work should be done and the housing issues addressed before they reach that stage.

It is clear that the Housing Health and Social Care co-ordinator is a key link in this process, and everybody in the partnership refers to her as the key facilitator. The ideal was that systems would be put in place, which would continue to work in her absence, however the reported reality is that everyone is working under pressure and to their own agency's priorities, there is high staff turn over and people readily go back into their silos if the link post is absent.

'It would fall apart if X was not there. If she is off sick it starts to fall apart.'

Understanding of services

The training programme on housing and homelessness is a rolling programme and all parties feel that the training sessions have been valued and are useful. The hospital discharge co-ordinator now has a good knowledge of the role of local housing departments and the range of voluntary sector agencies locally. She picks up on issues such as rent arrears or threatened eviction or need for tenancy support and knows which agencies to refer to.

Worthing Churches Homelessness Project and the *Crime Reduction Initiative alcohol street outreach team* both report that referrals that are made are appropriate and backed up by an understanding of what services they can offer.

Representatives from both organisations felt that the litmus test was the number of phone calls they got saying someone was being discharged that day and could they deal with it? This is now a rare occurrence and when referrals are made they are happy to go to the hospital and make an assessment, as they are confident it will be appropriate.

'It works better, there is more co-ordination, when the hospital discharge co-ordinator comes into contact with someone who is NFA she is very empathetic, doesn't just look at the medical needs but at the whole picture.'

A countywide tenancy support service, *Signpost*, was mentioned by a number of the respondents as being a very useful resource that they could refer to when concerns arose about the need for housing advice, arrears or housing support issues. They are perceived as helpful and responsive and will do hospital visits if needed.

Impact on homeless prevention

The homelessness manager from one of the districts now plans to extend the training initiative and provide a training programme on homelessness to all the GPs in the area as her experience has been that extending the understanding of the issues and how the homeless legislation works has a crucial impact on homeless prevention.

This is a priority that is shared by the community services manager in the PCT who feels that a lot more could be done through health professionals understanding the housing issues of their patients. She is keen to do some work on raising awareness of homelessness risk among community nurses.

'It is amazing how we still work in silos- the nurse will go in and do a dressing or give an injection and not notice what is going on around them for that person because it is not perceived as their job. We need to change those attitudes and give them an understanding of what help there is to get for someone.'

Discharge accommodation resource

The resource issue that kept coming up around hospital discharge and housing need was the sourcing of suitable disabled adapted accommodation and lengthy related delayed transfers of care.

It was decided to approach an RSL to request an empty disabled adapted property and to jointly commission an interim housing pilot for a year. At the nine-month service review this interim housing model has saved 251 hospital bed days, saving £63,000 of health resources. The PCT have estimated that had they had a second flat an additional £50,000 could have been saved. It has therefore been put into the commissioning plans as a clear invest to save priority.

This model was highly recommended by all the respondents. The cost to the PCT is £10,000, most of which is reimbursed through rental income. It is a small amount of money which effectively prevents bed blocking and means that people, who could be getting on with living independently, are not stuck in an inappropriate rehabilitation bed for weeks or months. If the property is not filled by someone being discharged from the hospital, it can also be used by the homelessness team for a temporary placement.

The improvements in joint working and the establishment of the interim housing service have resulted in significant reductions in the percentage of patients staying in acute hospital beds as a result of delays caused by a lack of housing. In 2006 32% of patients delayed, as a result of housing remained in hospital beds, by 2008 this figure was only 7%.

Respondents reported that there is also a need for specific accommodation for people who have detoxed but still require a safe place for 11 to 14 days after the initial medical issues have stabilised. Currently there is no suitable alternative to remaining in hospital.

Influencing strategy

One of the very positive aspects of the housing health and social care co-ordinator post is the influence it has been able to bring to bear at different levels.

The post was put in place in order to deliver some of the priorities identified in the Arun, Adur and Worthing Older People's Housing and Support Strategy. A solutions-focussed approach has been adopted with solutions being put in place at the frontline, organisational and strategic levels. This has resulted in an impact on commissioning priorities for the PCT and health and social care priorities being embedded in to the homeless strategies for both Adur and Worthing councils. It has also meant that relevant issues identified in the strategies can be flagged up to the health and social care co-ordinator for joint action.

Worthing single homeless strategy has noted a need to break the revolving door cycle of hospital admission for a group of mental health patients and the Housing, Health and Social care co-ordinator will work with them to find interventions that will be effective.

4. Case study three – London: Guys and St Thomas's

Background

Guys and St Thomas's NHS Foundation Trust, which serves the London Boroughs of Lambeth, Southwark and Lewisham, has had a specific homeless patient's discharge co-ordinator post in place for over two years. The post is funded from the Lambeth homelessness grant. The impetus for the post came from the street population co-ordinator and his involvement with some local research that was carried out on the level of health needs of homeless people. This piece of work uncovered the poor discharge practice that was happening locally:

Homeless clients in Lambeth are discharged from hospital without appropriate support packages in place and also without physical health care needs always being met. [1]

There was an existing post in University College Hospital in Camden, which had been working specifically on effective discharge of homeless people for many years. This served as a model for the development of the post in Lambeth.

Development

Previous to there being a post in place, discharges of homeless people were dealt with by the generic discharge co-ordinators. There are six posts in the Trust plus one discharge manager. All co-ordinators have a professional background in nursing and none has any specialist housing knowledge.

The hospital does have access to the Simon Patient Hotel, opposite Lambeth Wing at St Thomas's. This offers bed and board and a minimal amount of personal care and is available for patients who are unable to return home when they are well enough to leave the ward but are reasonably self caring. Patients can stay there for between one day and six weeks and it is a step down facility paid for by the NHS. This can be used for homeless people while alternatives are sought so it is an additional option that has been open for the discharge team.

Respondents describe the process before the specialist post as:

'We pretty much just kicked them out to the Homeless Persons Unit- with those that had obvious issues such as mental health or substance misuse issues we would try to link them in somewhere. It was very ad hoc.'

The report described the difficulties they experienced as manifold and resulting in frequent problematic discharge, including:

- Difficulties in determining a person's local connection
- A lack of appropriate accommodation to discharge people to
- A lack of understanding of the roles of different services in working with homeless people.

From the street outreach perspective, the sense was that before the specialist post clients were pushed out with minimal planning:

'Our over-riding sense was that homeless clients were regarded as too difficult and their needs too multiple. Not just by the discharge co-ordinators, but the nurse and the doctors. They are using drugs, they are always out for a smoke, they are difficult patients to have around, they are not compliant, they would be rushed out with no forward planning and six days later they would be back.'

"The Road to Recovery" makes it clear that this is not a minority issue as far as the rough sleeper population is concerned:

'75% of street homeless people in the borough would, or at least should, be hospitalised in the next six months.' [2]

The person appointed to the homeless patient's discharge post had previously worked in homelessness and housing in the voluntary and statutory sector. She had been involved in support and resettlement work and been the link worker between a Homeless

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[1] Lane, Robyn On behalf of the Homeless Intermediate Care Steering Group
The Road to Recovery A Feasibility Study into Homeless Intermediate Care
December 2005
http://www.olderhomelessness.org.uk/documents/ic_feasibility_study_final_version.pdf

[2] ibid

Persons' Unit and a mental health trust in South London. She had also worked in a day centre for homeless people. Her background meant that she was very well placed not only to understand the legislation and the role of different agencies but also had existing contacts in many of the agencies that she needed to co-ordinate with and an understanding of the client group.

An initial focus of the work was to make contact with all the relevant street outreach services, day centres and hostels, attend their team meetings and make herself known. Part of this role meant explaining the hospital perspective and the pressure they are under to discharge when someone is medically fit.

How it works and effect on services

The homeless patient's discharge co-ordinator post is situated in the social work department alongside the other discharge co-ordinators and managed by the discharge manager. The post holder works with all the wards across Guys and St Thomas's hospital, although being situated in St Thomas's most of the referrals are from there. Guys tend to refer their most complex cases to her. She does not take referrals from A&E as the turn around is too fast. If a patient is very vulnerable at A&E, they are likely to admit them to the Clinical Decision Unit and the post-holder will assess them there.

There are posters up on all the wards about the discharge co-ordinator's post and she works closely with the rest of the discharge team so if any homeless person is referred to any of them the case is passed to her.

Written protocol

The post-holder is not working to any specific written protocol in relation to discharging homeless people, however, on admission a patient should be asked about their housing and if they are homeless it is written in their notes and they are referred to the homeless discharge co-ordinator. If the needs are solely around housing she will deal with the case. If there are care needs involved it will be managed jointly by her and one of the other discharge co-ordinators.

Information on patient history

The post-holder has access to the CHAIN database, the London Combined Homelessness and Information System, which gives authorised users the capacity to:

- View the history of a client's engagement with services such as outreach teams, hostels, day centres and resettlement teams
- View information to help with support planning
- Access information to help with linking clients in with available services
- Find background information about clients

This means that as soon as the discharge coordinator is contacted by staff and told that a homeless patient is on the ward she will be able, if they have slept rough and been in contact with services in London in the last five years, to find out what outreach team they have had contact with, what accommodation they have been referred to and who their current key worker is if they have one.

The response from a member of the outreach team about the impact of the post was:

'I don't know how we managed before. Our patients would come and go from hospital, be in and out, even in intensive care and we would never be informed so we didn't know where they were. It was a bonus if we got any information, but it was often on the day of discharge.'

Now street outreach respondents say that they are generally given notice of the discharge, can make sure scripts are ready and if necessary co-ordinate meetings with the substance misuse nurse and the ward prior to discharge.

'It used to be a letter to the HPU, no call ahead , and they would sit there all day only to be told they couldn't be housed.'

Monitoring information

The Homeless Discharge Co-ordinator provides monitoring information every quarter outlining how many homeless admissions have been referred to her, what their local connection is, what their health and support needs are, what the discharge destination is and how many re-admissions of homeless people there have been.

In July 08 –Sept 08, there were 75 homeless referrals. Discharge destinations were predominantly to the HPU and street outreach services but often with complex follow up needs, such as drug and alcohol services, or primary care. There were two re-admissions of clients who had previously been assessed.

Wider benefits

Specialist knowledge of the post holder

The homelessness system is complex, particularly in London. Patients arrive at the Trust's hospitals from a whole range of London boroughs, in addition to the three whose borough boundaries the hospitals are within or very close to. Each local authority has a different system of street outreach to rough sleepers, each Homeless Persons Unit operates differently and every local authority has day centres and hostels providing services to the homeless population. In addition, there are different restrictions in place about what services Central and Eastern European and other migrant populations have access to.

The specialist knowledge held by the post-holder and the range of contacts and access to CHAIN is recognised as invaluable by the rest of the discharge team, the nursing staff and the homeless sector agencies with whom she liases. It was difficult before for nurses knowing they were discharging unsatisfactorily, difficult for homeless workers engaged with the client and most of all difficult for the patient. As a ward Sister says:

'She has access to their housing history, who they were last seen by, who their case worker was, and that is absolutely crucial…. as well as the massive amount of information in her head it is invaluable, before we were literally discharging onto a blank canvas.'

The specialist knowledge also means everything can be done more quickly and efficiently as this quote from a discharge manager shows:

When she is on leave a whole day can be spent chasing housing benefits, ID, birth certificates, someone with specialist knowledge can cut through a lot of it.

Improved relationship with homelessness agencies

The work of the post-holder now means that contact can immediately be made with a person's key worker if they had one. If the case is complex, a key worker can be invited to attend a multi-disciplinary meeting.

Importantly, if the individual was in a hostel on admission to hospital and that bed needs to be kept open for them, that request can be made. The post holder attends tasking meetings in Lambeth, a multi agency meeting about rough sleepers in the area. Complex cases are reviewed at the meetings so the post holder has prior awareness of them if they are admitted to the hospital.

Window of opportunity

The rough sleepers outreach service describes its work in terms of windows of opportunity, describing how homeless people go through moments when they are really motivated to change their situation. An admission to hospital, when they are alone, out of the chaos of life on the street, scared about their health and de-toxed, offers a massive opportunity to services to start working with that individual. As an outreach manager says:

'The real opportunity is to not let them touch the ground, ensure they don't go back to the street from a hospital bed, but are taken straight to accommodation, or if they have been started on methadone in hospital taken straight to a scripting appointment.'

Having the homeless discharge co-ordinator post in place means that street outreach can inform her which clients have really complex needs and they can be informed straight away if someone is admitted to hospital so that they can do their job of making sure services are co-ordinated and will be there when they come out.

Increased understanding of hospital staff

The homeless discharge co-ordinator has not done any specific training with hospital staff but it is on her agenda to do some basic training on homelessness with new doctors. However the impression of hospital staff is that the existence of the post has raised the awareness and general understanding of other staff around homelessness issues.

The post –holder feels there is a lot more understanding than when she started and that she can now work together with the hospital, so that if a patient needs two extra days in a bed to wait for a hostel place to become available that can usually be negotiated. This is echoed by street outreach respondents, who feel there is generally a better understanding of homeless people's health problems in the hospitals.

Hospital staff feel that the specialist knowledge of the post holder gives them the confidence that patients are getting the right advice about their housing rights and their options. Once it is clear what their potential housing situation is, medical professionals can make the decision about whether discharge to that situation is a medically safe option.

The opinion of hospital staff is that this type of knowledge could not be replaced by training doctors and nurses directly, because it is quite specialist, services for homeless people change quite regularly and advice needs to be up to date and accurate. Because the post holder is working in this specialist field daily they can be confident that she is aware of all the options and achieving the best outcome for patients.

Decrease in re-admissions

Re-admissions of homeless clients are monitored in the quarterly reports but respondents were not able to make the figures available to show the decrease in re-admissions over the period the post has been operational.

However the sense of the discharge manager is that since the post has been in place they have had a lot less people returning. There used to be a number of homeless people that were constantly in and out of hospital and this has decreased.

Better deal for patients

Homelessness and housing need is going to be part of the picture for any hospital in central London. On the general medical emergency ward in St Thomas' at any given time there are one or two homeless people. The perception of the ward sister is that the discharge post has been invaluable and significantly improved the care that patients have received. There is sometimes an expectation that hostel places can be found

unrealistically quickly, and homelessness staff would like to see some agreements in place about the planning and timing of discharges of homeless people.

It has enabled medical staff to understand the patient's position and to see the bigger picture. It has also enabled the nursing staff to feel there is expertise to draw on and not to feel so overwhelmed by presenting needs, which they do not have the knowledge to address properly.

Knowledge of gaps in services and clearer evidence base

The current monitoring reports show the discharge destination but they do not clearly show the outcome of the intervention and whether homelessness was prevented. Many of the discharge destinations are to the HPU or to street outreach. It is clear from talking to the agencies that liase with the post holder that these are informed destinations and that the preparatory work has been done to find out the nature of the housing options available. It would be useful to have some additional evidence from the HPUs and street outreach to find out the longer-term outcome for patients referred from the hospital.

Having a specialist in post does not eradicate delayed discharges in hospital due to not being able to place people appropriately on discharge. One of the big issues for the post-holder and for staff generally is the increase in rough sleepers who are of Central and Eastern European origin and have no access to hostel accommodation. The discharge manager and the Homeless Patients Discharge Co-ordinator have recognised the need to develop a protocol on the care pathways and possible options for this client group.

There are still wrangles about what local connection a person has and if their care and support costs are likely to be high these can be very protracted and involve legal advice and complex negotiations. There are also patients whose condition means it is very hard to find a placement. A homeless patient who needs to go into a rehabilitation service will not be accepted without an exit strategy, which can mean long delays in the hospital.

Another example that was given was a patient with Korsakoffs and physical disabilities for whom it was very difficult to find a placement. This is generally seen as a gap that needs to be addressed. Wet houses tend to be available for people who are able to be fairly independent, but finding placements for people that continue to drink and have physical disabilities is much harder. Access to the specialist knowledge of the post – holder means where these difficulties are identified they tend to be gaps in services rather than gaps in knowledge about what is available.

5. Lessons across the three areas

Development of protocol or specialist post?

- The case studies show how different areas have approached the issue of hospital discharge and homelessness prevention. Some areas have put a protocol in place for staff to follow. Others have recruited a specialist post to deal with homelessness discharge. Others have a post with wider responsibilities across housing and health that include taking responsibility for co-ordinating effective discharge.
- In a hospital trust in a large urban area with a significant homeless population it is worthwhile to have a specialist post to co-ordinate the discharge of homeless patients. This can be funded through homelessness grant or Supporting People money. Expertise in housing and homelessness, an understanding of the client group, and preferably existing local contacts are invaluable when appointing a Homeless Patient's Discharge Coordinator

Housing lead

- Prevention of homelessness and the discharge of homeless people is never going to be the overriding priority in health. The impetus for a protocol is likely to have to come from housing and homelessness services working closely with health colleagues.

Window of opportunity

- A hospital admission represents a window of opportunity to work with a homeless person in relation to their motivation while they are off the streets. Protocols should aim to maximise the opportunity of a hospital admission to put in place improvements in the quality of life of the homeless person.

Strategic relevance

- Hospital discharge should be seen as a key part of wider local systems such as homelessness prevention, housing advice, prisons, drug and alcohol services and the well-being agenda. Ensuring a smooth transition from hospital should be the joint responsibility of all local services.
- Preventing homelessness before a homeless application is made fits with the direction of the Government's homelessness policy. From a PCT/hospital trust point of view, homelessness prevention supports independence in the community and prevents lengthy housing related delayed transfers of care.
- It is a challenge to develop a system that works across all hospital services, the acute sector, mental health and A&E. Any protocol or specialist post will have to be flexible to work with different systems.

Driving the development of a protocol

- The DH/CLG/Homeless Link/London Network for Nurses protocol can be used as a template/checklist when developing a protocol.
- Developing a protocol requires a lead person to coordinate the process, with a good knowledge of local services. A steering group should include the right people with the right level of authority, from all the relevant agencies. The group should continue to be engaged as champions after the protocol is agreed.
- It is worthwhile talking to people from other authorities that have had a protocol in place for a while.
- If difficulties are encountered, take the process to the Local Strategic Partnership (or whatever body is working in a cross cutting way on the well-being agenda).
- If a specialist discharge co-ordinator is recruited alongside a protocol, thought must be given to how these processes inter-relate.

Data collection

- A mapping exercise pulling together the data that evidences the need for the protocol or the post and where the funding might come from is worth carrying out in preparation. For example if the catchment area of a hospital crosses local authority areas a case can be made for joint funding from a number of local authorities and/or PCT's.
- Once the protocol or specialist post is in place be clear about what outcomes are worth monitoring and put an effective data collection system in place but ensure it is not burdensome.

Strategic engagement

- A protocol or specialist post should focus on practical outcomes but also feed into the organisational level and in turn influence strategic priorities

Maintaining a protocol

- It is important to hold regular meetings to monitor effectiveness, liaise on delayed discharge and report results.
- Once stakeholders think hospital discharge for homeless people is working they will move onto the next issue. Opportunities need to be found to reinvigorate and refresh the protocol and to keep the relationships focussed and positive.
- The pressures in health and social services mean that people easily revert back to their organisational priorities. The staff turnover means there can be no guarantee staff know about the protocol when they need it.
- Relationships between agencies are key to the protocol working. Part of the job of staff using the protocol should be to seek out the relationships that do work between housing and health and maintain them.
- Have a plan for training staff across sectors and embedding the protocol into induction procedures.

Related resources

- Access to CHAIN (London Combined Homelessness and Information System) is absolutely vital for hospital discharge workers in London to link in with appropriate homelessness services.
- A jointly funded interim housing service providing temporary disabled adapted accommodation for people in hospital beds in housing need saves money and provides a better solution for the patient.
- A patient hotel which offers bed and board and a minimal amount of personal care for patients who are unable to return home when they are well enough to leave the ward, but are reasonably self caring is a solution for people who cannot return home or do not have a home to return to immediately. Patients can stay there for between one day and six weeks, it is a step down facility paid for by the NHS. (see Guys and St Thomas's)
- Effective monitoring of homeless people's hospital use generally shows there are individuals who are revolving around the system, whose presentation is related to social problems and unmet support needs. It is useful to know where referrals can be made so that helpful support interventions can be put in place.

6. Appendix

List of respondents

Newcastle

Name	Position/Organisation
Sheila Spencer	Hospital Discharge and Homelessness Prevention Protocol Co-ordinator, Homelessness Prevention Project
Neil Munslow	Housing Services Manager, Newcastle City Council
Ron Weddle	Service Manager (Non-urgent Care), Mental Health Trust
Sue Cummings	Discharge Liaison Nurse, Newcastle Hospitals Trust
Pat Barrett	Advice and Support Worker, Your Choice Homes Newcastle
Morag Thompson	Homelessness CPN
Norma Armstrong	Mental Health Advisor, Your Choice Homes Newcastle
Debra Shiel	Homeless Prevention Officer, Newcastle City Council
Elizabeth Howliston	Hospital Social Services Team Manager
Annette Payne	Health and Housing Specialist Practitioner, Newcastle PCT
Lynda Seery	Public Health Specialist, Newcastle PCT

West Sussex

Name	Position/Organisation
Kathryn Howard	Housing Health and Social Care Co-ordinator
Jane Mules	Community Services Manager, PCT
Di Howes	Discharge Co-ordinator, Worthing and Southlands Hospital
Ed Rowney	Street outreach Team, Crime Reduction Initiative
Christopher Dunn-Coleman	Worthing Churches Housing Association
Dawn Budden	Hospital Social Work Team
Marilyn Stephens	Homelessness Manager, Adur Council
Tony Nurse	Housing Needs Manager, Worthing Council

London – Guys and St Thomas's Hospital Trust

Name	Position/Organisation
Monena Curniffe	Homeless Patient's Discharge Co-ordinator, Guys and St Thomas's Hospital Trust
Jane Chester	Hospital Discharge Manager, St Thomas's hospital
Eammone Egerton	Manager, SPOT Team Southwark
Adrian	Connections, Westminster
Michelle Adam	SORT team, Thamesreach Lambeth
Mohammad Khan	London Borough of Lambeth
Sarah Murray	Ward sister, General Medical Ward, St Thomas's

7. Other Housing LIN Resources

No One Left Out - Communities ending rough sleeping

This Housing LIN Briefing No28 provides a detailed summary of the Department for Communities and Local Government's (CLG) Rough Sleepers' strategy "No One Left Out: Communities ending rough sleeping"

http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing/Topics/browse/Homelessness/?parent=980&child=5112

Achieving positive shared outcomes in health & homelessness

Published by the Homelessness and Housing Support Directorate this report outlines why joint planning between local government, health and other partners is essential in improving outcomes for homeless people. The report suggests local shared outcomes and indicates how national targets on health inequalities and homelessness can be met jointly.

http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing/Topics/browse/Homelessness/?parent=980&child=1726

Getting involved with health - an introduction for homelessness professionals

This Housing LIN Briefing No19 is designed to assist people employed in homelessness services to increase joint working with local health services. The health service structure, systems, services and relevant policies are described.

http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing/Topics/browse/Homelessness/?parent=980&child=2467

Prevention of homelessness - the role of health & social care

This Housing LIN briefing No11 describes practical steps that can be taken by health and social care staff to prevent individuals becoming homeless. It also suggests policies and procedures that will support staff in achieving this objective.

http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing/Topics/browse/Homelessness/?parent=980&child=1985

Other Housing LIN publications available in this format:

Case Study no.20:	**BME Older People's Joint Service Initiative - Analysis and Evaluation of Current Strategies (Sheffield)**
Case Study no.21:	**Estimating Future Requirements for Extra CareHousing (Swindon)**
Case Study no.22:	**'The Generation Project': a sure start for older people in Manchester**
Case Study no.23:	**Developing ECH in Cheshire: the PFI route**
Case Study no.24:	**Commissioning an ECH Scheme from Social Services' Perspective - Leicester**
Case Study no.25:	**Broadacres Housing Association Older Persons Floating Support**
Case Study no.26:	**Unmet Housing-Related Support Needs in Wokingham District - an investigation**
Case Study no.27:	**Dee Park Active Retirement Club - Age Concern Berkshire**
Case Study no.28:	**Essex County Council Older Person's Housing Strategy** (Summary)
Case Study no.29:	**Pennine Court: Remodelling sheltered housing to include Extra Care for people with learning difficulties**
Case Study no.30:	**Dementia Care Partnership: More Than Bricks and Mortar**
Case Study no.31:	**Anticipating Future Accommodation Needs: developing a consultation methodology**
Case Study no.32:	**Park View: an 'Independent Living' scheme with support for individuals with a learning difficulty**
Case Study no.33:	**Private Sector Leasing Scheme for People with Learning Difficulites in Norfolk**
Case Study no.34:	**Mini-Cost Model of Housing with Care Project**
Case Study no.35:	**Ledbury Community Health and Care Centre**
Case Study no.36:	**Duddon Mews Extra Care Scheme for People with Mental Health Problems and Physical Frailty in Cumbria**
Case Study no.37:	**Private Sector Engagement with Extra Care Housing Development**
Case Study no.38:	**Healthy Outcomes in Blackburn and Darwin's Extra Care Housing**
Case Study no.39:	**Implementing an Extra Care Housing Strategy in Oxfordshire - Delivering System Change**
Case Study no.40:	**Combining Extra Care Housing with Health Care Services at Barton Mews**
Case Study no.41:	**Integrating Retirement Villages with the Local Community at Painswick**
Case Study no.42:	**De-Commissioning & Decanting Sheltered Housing at The Manors**
Case Study no.43:	**Reeve Court Retirement Village: Block Contracting Care In Bands, & Individual Budgets**
Case Study no.44:	**Vertical Housing with Care: Remodelling a tower block as extra care housing at Callendar Court, Gateshead**
Case Study no.45:	**Supporting Independence and Integration for Disabled People: Foundations for Living Project, the Papworth Trust, Huntingdon**

The full list of Case Studies can be seen and downloaded at our website:
www.dhcarenetworks.org.uk/housing

The Housing LIN welcomes contributions on a range of issues pertinent to Extra Care housing. If there is a subject that you feel should be addressed, please contact us.

Published by: Housing Learning & Improvement Network
304 Wellington House
135-155 Waterloo Road
London
SE1 8UG

Tel: 020 7972 1330
Email: info.housing@dh.gsi.gov.uk

www.dhcarenetworks.org.uk/housing