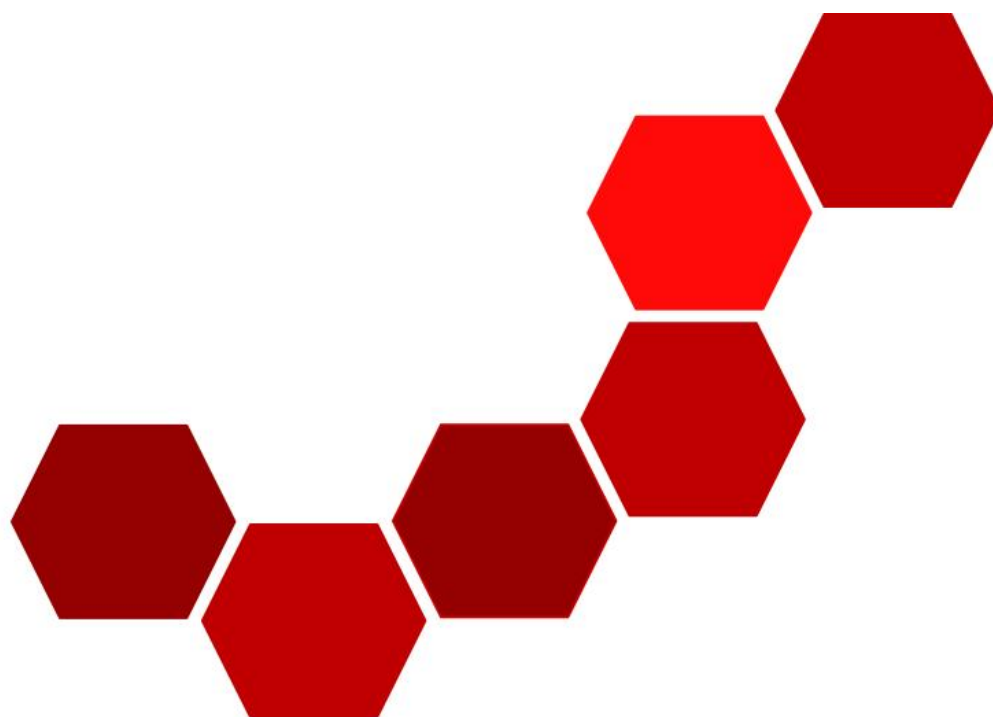


APPENDIX 1:

Transforming out-of-hospital care for people who are homeless

Support Tool

complementing the High Impact Change Model
for transfers between hospital and home



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Healthcare for homeless people

Download all project publications including Briefing Notes to accompany this Support Tool at:
<https://doi.org/10.18742/pub01-007>

Download the High Impact Change Model (HICM) that this Support Tool complements at:
www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high

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Why homeless hospital discharge (HHD) needs to change

Support for people leaving hospital (out-of-hospital care) has been designed mainly with older people in mind, however our research shows that patients who are homelessness are at high risk of early ageing and premature death. **1 in 3 deaths of people in our hospital discharge cohort were due to common conditions such as heart disease that could have been prevented with timely health care.** There is a strong imperative to address this not just by better preventive working, but by ensuring that out-of-hospital care is accessible to all adults who could benefit, including patients who are homeless.

Where there is limited access to out-of-hospital care, the default pathway is to 'signpost' homeless patients to the local housing authority, often without arrangements in place for meeting wider care and support needs. Unplanned discharge leads to poor patient experience and impacts negatively on hospital metrics: **Homeless inpatients have five times the rate of emergency readmission and A&E visits after discharge from hospital compared to deprived housed patients with a similar medical profile.**

Under the Care Act 2014, unplanned discharge can trigger a safeguarding concern linked to neglect and acts of omission (failure to provide access to appropriate health, care and support). Multi-agency adult safeguarding has led to increased scrutiny of poor hospital discharge practices by NHS Trusts under the jurisdiction of Safeguarding Adult Reviews (SARs).

The evidence about what works in securing safe, timely transfers of care between hospital and home has been synthesised by the Local Government Association (LGA) and partners in the **High Impact Change Model (HICM)**. DHSC, MHCLG and NHSE require local Health and Wellbeing Boards to implement the HICM as part of their plans for Better Care Funding (BCF). This involves pooling health and social care budgets to deliver metrics such as reduced delayed transfers of care, A&E attendances and non-elective readmissions. **Work to address homelessness at the point of hospital discharge must be linked to implementation of the HICM to be sustainable in the longer term.**

How to transform homeless hospital discharge

- 1. Strengthen existing 'HHD Protocols'** to ask housing authorities work to similar timescales as adult social care e.g. complete housing assessments within 72 hours to facilitate early discharge planning and improved monitoring of system flow (including ID of housing related 'pinch points').
- 2. Integrate hospital-based specialist homeless health care teams** (sometimes called Pathway teams) alongside existing multi-disciplinary discharge coordination services. Out-of-hospital care must be integrated so people can move seamlessly between different services, depending on changing needs.
- 3. Provide alternative 'housing-led' (step-down) pathways out-of-hospital** for people who need time for recovery and reablement but who cannot go home (they are homeless) but whose needs would be over-catered for in a care home.
- 4. Use trusted assessment and boundary spanning** to bring the specialist clinical expertise of the homeless health care team into 'housing-led' intermediate care.

Evidence from our research that this is effective and cost-effective:

- ✓ Out-of-hospital care tailored to the needs of patients who are homeless is **more effective and cost-effective than standard care.**
- ✓ NHS Trusts with **specialist homeless discharge schemes had fewer Delayed Transfers of Care** compared to those that relied on standard care.
- ✓ Hospital based homeless healthcare teams **increased access to elective follow-up care.**
- ✓ HHD schemes with a 'step-down' service were associated with a reduction in subsequent hospital use, with an **18% reduction in A&E visits** compared to HHD schemes without a 'step-down' service.

About this research: This Support Tool draws on the findings of our evaluation of the Homeless Hospital Discharge Fund (HHDF) to show how the HICM can be sensitised to meet the needs of patients who are homeless, and how this can contribute to meeting Better Care Fund metrics. The HHDF funded 52 schemes to develop specialist discharge and 'step-down' services to tackle issues such as discharge to the street. The evaluation, led by King's College London, used a range of qualitative and quantitative methods to explore effectiveness and cost-effectiveness, exploring outcomes for over 3,882 people who used a HHD scheme.

Disclaimer: This Support Tool is based on independent research commissioned and funded by the NIHR. The views expressed here are those of the authors and not necessarily those of the NHS, the NIHR, the Department of Health and Social Care or its arm's length bodies or other government departments. The main research report for this study is under review by the NIHR and the Support Tool may be revised once this is completed.

High Impact Change Model (HICM): CHECKLIST OF SENSITIVITIES FOR HOMELESSNESS

Change 1: Early Discharge Planning

In elective care, planning for discharge should begin before admission. In emergency / unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

SENSITIVITIES FOR HOMELESSNESS:

- [1:1] It is routine practice for **all staff to show 'concerned curiosity'** about housing and homelessness on admission, recognising that some patients may not wish to disclose that they are homeless due to stigma.
- [1:2] Homeless Health Care Teams (or Housing Workers) undertake **specialist ward rounds** to identify patients who are homeless and start discharge planning at the earliest opportunity.
- [1:3] Homeless Health Care Teams (or Housing Workers) support patients who are homeless to **have their voices heard** in discharge planning.
- [1:4] There is **good legal literacy** around Annex G of the Care Act, 2014 and the Homeless Reduction Act, 2017. It is recognised that many patients who are homeless will have both housing needs and needs for care and support, including housing related support. This will trigger the issuing of both 'Assessment' and 'Duty to Refer' Notices to Adult Social Care and the local housing authority respectively.
- [1:5] 'Baton-passing' and 'signposting' are not used to free up hospital beds. All staff are aware they have role to play in securing **safe, timely well-planned transfers of care**.

Change 2: Monitoring and Responding to System Flow

Develop systems across health and social care to provide real-time information about flow. All partners should work together to match capacity and demand by responding to emerging system needs, making effective strategic decisions, and planning services around the individual. Data about flow should also be used to identify and respond to system blockages.

SENSITIVITIES FOR HOMELESSNESS:

- [2:1] There is a locally agreed '**Homeless Hospital Discharge Protocol**.' The protocol specifies the timescale for the local housing authority to respond once a 'Duty to Refer' notice has been issued by the hospital about a patient who may be homeless or at risk of homelessness (e.g. within 72 hours).
- [2:2] Delays due to housing and waiting for housing assessments are properly recorded in monthly **Delayed Transfer of Care Situation Reports**.
- [2:3] Partners use a **shared understanding of system flow** to coordinate service delivery (e.g. hospitals do not 'signpost' homeless patients to housing unannounced).
- [2:4] **Local system partners work together** to address any housing related 'pinch points' and 'bottle necks' – ensuring housing schemes are able to match capacity and demand.
- [2:5] **Flow across the system** is smooth, timely, safe and effective. Safeguarding referrals are raised where this does not happen.

Change 3: Multi-disciplinary Working

Multi-disciplinary/multi-agency teams (MDTs) work together to coordinate discharge around the person. Have a member of your local housing team as a real or virtual member of your discharge planning team.

SENSITIVITIES FOR HOMELESSNESS:

In hospitals that see 200+ homeless patients per year, ward staff will have access to a **specialist multi-disciplinary homeless health care team** offering:

PATIENT IN-REACH (CLINICAL ADVOCACY)

- [3:1] To **reduce stigma and promote dignity** on the ward, e.g. provide patients who are homeless with toiletries and clean clothes.
- [3:2] To **prevent early self-discharge**, e.g. advising on substitute prescribing for patients with substance misuse issues.

[3:3] To **improve access to elective (planned follow-up) health care**. This is especially important because research suggests 1 in 3 deaths of homeless patients are due to common conditions such as heart disease and cancer that are amenable to timely healthcare.

SPECIALIST DISCHARGE COORDINATION

[3:4] To provide patients who are homeless with a **named point of contact providing expert advice** on housing legislation and options and homelessness service provision and/or

[3:5] To **facilitate ‘Discharge to Assess’ (D2A)** or the coordination of a joined-up discharge plan – across all relevant agencies, e.g. adult social care, drug and alcohol services, mental health.

Change 4: Home First

The aim of Home First is for agencies to work together to discharge people from hospital as soon as they are medically optimised and it is safe to do so, recognising that hospital is not a suitable environment to carry out an assessment of someone’s long term need. Discharge to Assess (D2A) or providing short-term care and reablement in people’s homes or using ‘step-down’ beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital.

SENSITIVITIES FOR HOMELESSNESS:

[4:1] Patients who are homeless have ‘**breathing space**’ before making decisions about life changes, including new accommodation and support. There are *specialist* (housing-led) ‘step-down’ beds and units of accommodation available in the community where people who are homeless can stay while undergoing a full assessment of their health, housing and social care and support needs.

[4:2] Arrangements are in place for ‘**trusted assessment**’. Patients only have to tell their story once as homeless health care teams have direct referral rights into *specialist* ‘step-down’ intermediate care.

[4:3] There is enhanced health care (*specialist* ‘clinical in-reach’) to support **genuinely integrated care planning** in ‘housing led’ step-down. The wider out-of-hospital care system is accessible to people who are homeless where there are more complex health needs.

[4:4] Step-down support continues until longer-term community services are in place and working well. There is someone in post who can **manage the transfer from ‘end to end’** ensuring appropriate follow-up and multi-agency review.

[4:5] If support extends beyond 12 weeks local system partners take **action to address ‘bottle necks’ and ‘pinch points’**.

OTHER HICM CHANGES:

Change 5: Flexible Working Patterns – Services are available 24/7.

Change 6: Trusted Assessment – Using trusted assessment to carry out holistic strengths-based assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe timely way – ensuring for example, that homeless health care teams have direct referral rights into intermediate care.

Change 7: Engagement and Choice – Having a robust choice protocol, underpinned by a fair and transparent escalation process. This is mainly for use in the acute sector where older people and their families are exercising choice about a care home placement. However, it can be useful in specialist intermediate care to have a ‘choice protocol’ to address occasions where rehabilitative (physical) goals are met but the patient is waiting for a property or post code to become available through choice-based lettings, which can cause long lengths of stay.

Change 8: Improved discharge to care homes – Ensure long-term care services are easily accessible to people under 55 years of age, e.g. where chronic homelessness has led to early ageing/complex health and care needs.

Change 9: Housing – Effective referral processes and alternative pathways for people who cannot go straight home.