Nottingham City

Partnership Process Guidance to Support the Prevention of Hospital Discharge to Homelessness

October 2017

Introduction

This document outlines the protocol for the hospital discharge of people who are identified as homeless in Nottingham. It provides guidance on the process and the roles and responsibilities of the service areas involved.

1 Why is this important?

1.1 **Homeless people have significantly higher health and wellbeing support needs than the general population.** According to a 2014 report from Homeless Link[1], 73% of single homeless people have a physical health problem (41% long term), 80% have a mental health issues (45% with diagnosis). Two in five single homeless people take drugs or are recovering from a drug problem and almost one third have or are recovering from an alcohol problem. Information from the Queens Nursing Institute[2] tells us that rough sleepers have a rate of physical health problems 2-3 times greater than the general population and are eleven times more likely to have mental health issues.

1.2 **Homeless people have high use of emergency health services**. The 2014 Homeless Link report found that A&E visits and hospital admissions are four times higher for a homeless person than for the general public. Of the 2500 homeless people surveyed, 26% had been admitted to hospital in the last 6 months, 35% had visited A&E in the last 6 months. A 2012 report commissioned by the Department of Health found that homeless people use four times as many acute health services and eight times as many inpatient health services as the general population. The average length of stay in hospital for homeless people is 3 times as long as the general population.

1.3 Specific consideration to the needs of homeless people being discharged from hospital is addressed in National Institute for Health and Care Excellence (NICE) Guidance[3] published in December 2015 as outlined below.

1.4 Regarding hospital discharge planning, the NICE guidance states that:
From admission, the hospital and community based multidisciplinary teams should work together to identify and address factors that could prevent a safe, timely transfer of care from hospital. For example: homelessness; safeguarding issues, lack of a suitable placement in a care home; the need for assessments for eligibility for health and social care funding (1.5.13)

1.5 The guidance also identifies the importance of locating housing specialists in hospital based multidisciplinary teams and the crucial role of the hospital discharge coordinator in identifying housing practioner for input into a patient's discharge plan. Homeless people are specifically highlighted as people at risk of readmission and the guidance advises:

If a person is homeless, the discharge coordinator should liaise with the local authority housing options team to ensure that they are offered advice and help (1.5.28)
The guidance also suggests that suitable temporary accommodation and support for homeless people should be available to support people when they are discharged from hospital (1.6.1)

1.6 The guidance makes it clear that one of the key principles of hospital discharge planning is to:

> *Ensure that any pressure to make beds available does not result in unplanned and uncoordinated hospital discharges (1.5.12)*

Despite this, information from Homeless Link suggests that only one third of areas have a hospital discharge protocol and that one third of homeless people are discharged from hospital to street homelessness.

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[1] The unhealthy state of homelessness: health audit results 2014 (Homeless Link)
[2] Improving Healthcare for Homeless People: A Learning Resource (Queen's Nursing Institute) 2010
[3] Transition between inpatient hospital settings and community or care home settings for adults with social care needs, December 2015 (NICE)

1.7 In 2013 the Department of Health allocated a £10m Homeless Hospital Discharge Fund to 52 pilot projects nationwide to improve hospital discharge procedures for homeless patients. Locally Framework Housing Association was successful in their bid to the fund and the money was used during the six month funding timeframe to employ a part-time Hospital Discharge Coordinator.

1.8 Homeless Link was commissioned by the Department of Health to deliver a complete evaluation of the pilot projects. The Homeless Link Evaluation of the Homeless Hospital Discharge Fund shows that where there is commitment to set up and deliver partnership working systems to discharge people into appropriate accommodation, with practices which are embedded and promoted across all strategic levels, there is an increased likelihood that they will sustain their accommodation, have improved recovery and positive health and wellbeing outcomes.

1.9 Recommendations for good practice in hospital discharge procedures include:

- Demonstrating a commitment to multi agency working
- Promotion and integration of the project needs to occur across strategic levels
- Strong links forged with adult social care
- Agreement about the practice of identifying, recording and sharing of information from the earliest point
- Clear monitoring arrangements – evidencing outcomes (e.g. number of readmissions / contact with hospital to receive healthcare, length of stay in hospital, accommodation status on admission and discharge, ongoing housing or medical support post discharge)

2 Local context

2.1 In 2006 Nottingham University Hospital Trust signed up to a joint protocol with Nottingham City Council agreeing that no-one would be discharged from hospital in Nottingham with no fixed address.

A process was put in place which involved the timely transfer of information from hospital staff to Housing Aid to enable accommodation sourcing to be a feature of planned discharge practice**.**

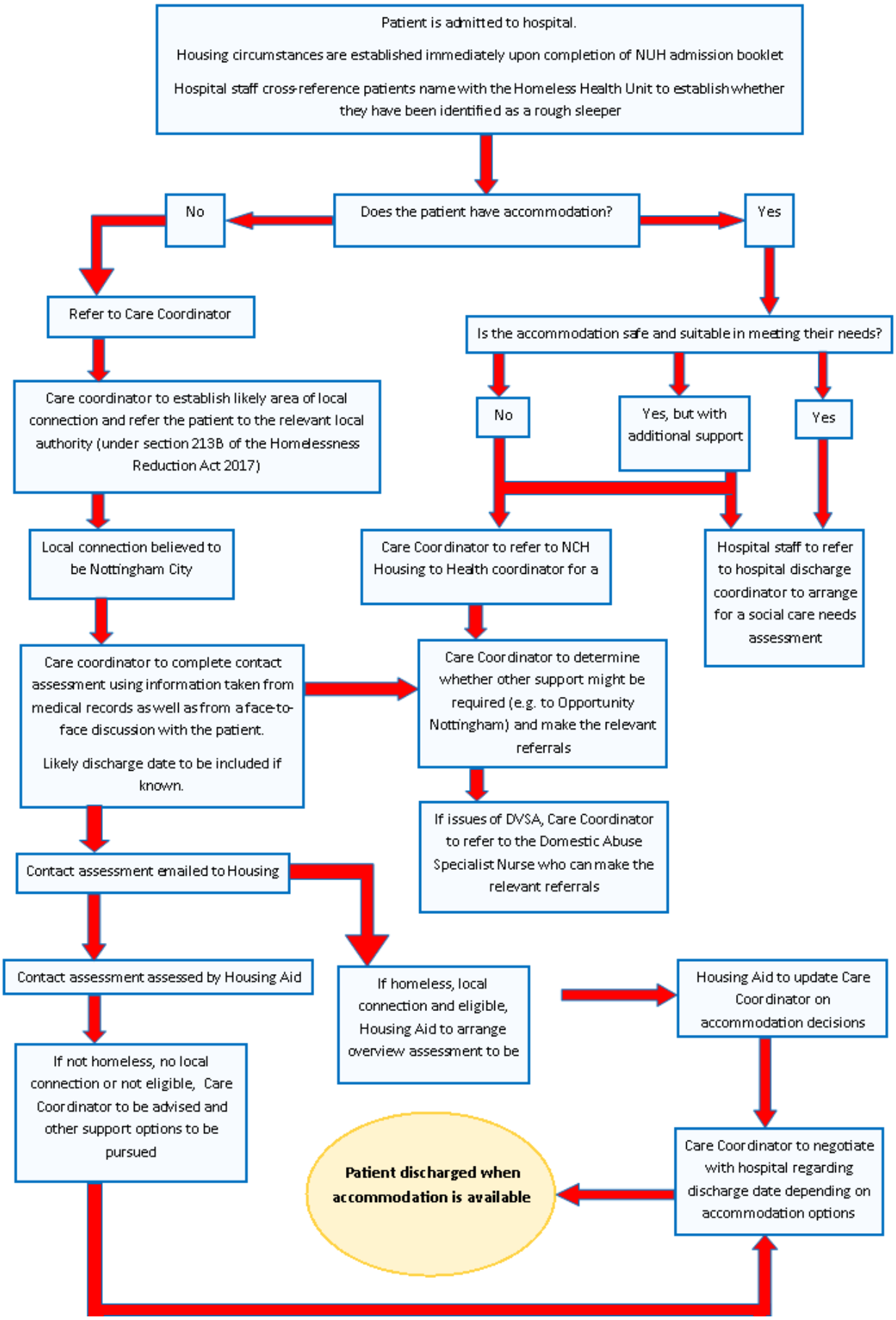
This guidance has been developed to build on the existing protocol and ensure that all workers involved in hospital discharge of homeless people are aware of the process and are applying it consistently.

2.2 This guidance has been developed at a time of increasing levels of homelessness in Nottingham. The official estimate of rough sleepers submitted to DCLG in 2016 was 35 individuals. This is an increase of 150% from last year and more than triple times the trend over the last five years.

Information from professionals supporting people who are street homeless tells us that the health and wellbeing support needs of the population are becoming more serious. Appendix 1 outlines some of the issues the Nottingham City Homeless Health Team encounter when supporting homeless people locally.

During the latest review of the Homelessness Prevention Strategy in August 2017, local services reported increases in the numbers of people with multiple and complex support needs including a high prevalence of people with enduring and worsening health and wellbeing needs. The level of mental health support needs amongst homeless people is particularly acute.

3 Partnership Process Guidance


Patient is admitted to hospital.
Housing circumstances are established immediately upon completion of NUH admission booklet
Hospital staff cross-reference patients name with the Homeless Health Unit to establish whether they have been identified as a rough sleeper
Does the patient have accommodation?
No
Yes
Refer to Care Coordinator
Care coordinator to establish likely area of local connection and refer the patient to the relevant local authority (under section 213B of the Homelessness Reduction Act 2017)
Local connection believed to be Nottingham City
Care coordinator to complete contact assessment using information taken from medical records as well as from a face-to-face discussion with the patient.
Likely discharge date to be included if known.
Contact assessment emailed to Housing
Contact assessment assessed by Housing Aid
If not homeless, no local connection or not eligible, Care Coordinator to be advised and other support options to be pursued
If homeless, local connection and eligible, Housing Aid to arrange overview assessment to be
Is the accommodation safe and suitable in meeting their needs?
No
Yes, but with additional support
Yes
Care Coordinator to refer to NCH Housing to Health coordinator for a
Care Coordinator to determine whether other support might be required (e.g. to Opportunity Nottingham) and make the relevant referrals
If issues of DVSA, Care Coordinator to refer to the Domestic Abuse Specialist Nurse who can make the relevant referrals
Hospital staff to refer to hospital discharge coordinator to arrange for a social care needs assessment
Housing Aid to update Care Coordinator on accommodation decisions
Care Coordinator to negotiate with hospital regarding discharge date depending on accommodation options
Patient discharged when accommodation is available

4 Roles and responsibilities

4.1 Role of clinicians

On admission to hospital the Hospital Front Door Team are to determine the housing circumstances of the patient as part of the admission assessment (the initial MDT review where a PDD is set). This includes whether there is accommodation for the patient to return to / move into as well as whether that accommodation option is suitable in meeting their needs and safe for them to occupy.

It may be that there is accommodation available but it requires some form of adaptation to reflect a change in the patient's circumstances. If this is the case, the hospital staff should engage social care at the earliest possible stage for an assessment of the patient's needs.

The Hospital Front Door Team should cross reference with the Homeless Health Unit to identify any presentations of patients recorded as NFA. This is important as previous correspondence addresses could be on the system and be misleading as appropriate addresses for discharge.

If it is determined that there is no safe or suitable accommodation for the patient to live in once they are medically fit for discharge, the homeless patients enter the Complex Discharge Pathway under Discharge to Assess (D2A). Hospital staff should refer the patient to the Care Coordinator. The hospital staff should discuss this with the patient and obtain their signed consent for their medical information to share for the purpose of assessing housing needs (For AMH this would be via CPA).

The hospital staff should provide the Care Coordinator with any information necessary to support the assessment of needs for accommodation. The hospital staff should continue to liaise with the Care Coordinator to arrange the discharge date of the patient.

4.2 Role of Care Coordinator

On a daily basis, the rough sleepers commissioned services (currently Street Outreach Team) forward the details of rough sleepers identified the previous night and the Care Coordinator enters the information onto the Homeless Health Unit and records the address as NFA.

On receipt of information from the hospital staff that a patient does not have accommodation that is safe and suitable for them to return to, the Care Coordinator should initially determine the area of local connection of the patient and refer to the appropriate local housing authority.

The referral must be made to fulfil the requirements of section 213B of the Homelessness Reduction Act 2017, which places a legislative duty on public authorities to notify a housing authority of service users they consider may be homeless or threatened with homelessness (within 56 days).

If the area of local connection is believed to be Nottingham City, the Care Coordinator should access the medical records of the patient and use the information to complete the Housing Aid Contact Assessment form (appendix 2).

The Care Coordinator should meet with the patient and add the information obtained from them to the Contact Assessment form. The likely discharge date of the patient should also be included.

The contact assessment form should then be emailed to housing.aid@nottinghamcity.gov.uk for the attention of the duty manager.

If Housing Aid are to secure accommodation for the patient they will inform the Care

Coordinator who will act as a liaison point between the hospital and Housing Aid to negotiate / communicate the discharge date and arrangements.

If Housing Aid inform that they have made a decision that there is no statutory duty to accommodate the patient, and no accommodation is available via the homelessness prevention gateway, the Care Coordinator is to follow the advice given by Housing Aid and make referrals to voluntary / community sector agencies who may be able to support with access to accommodation. The Street Outreach Team should also be updated at this point.

The Care Coordinator should continue to pursue all options to support the patient into accommodation, at the same time as negotiating with the hospital regarding the discharge date of the patient.

4.3 **Role of Housing Aid**

On receipt of a completed Contact Assessment form from the Care Coordinator Housing Aid are to make an assessment of housing need, taking into consideration all of the information included on the form.

If the patient is eligible for assistance, Housing Aid will contact the Care Coordinator to make arrangements for the completion of the Overview Assessment. This is the more detailed support needs assessment that will assist with the appropriate housing plan for the individual. Housing Aid will aim to complete the assessment within a target of five working days from receipt of the contact assessment. This target is flexible depending on the discharge date providing that the contact assessment has been shared at the earliest opportunity. Housing Aid will conduct a face-to-face or telephone assessment as capacity determines.

In cases where a homeless person has attended the emergency department and is not admitted to hospital, Housing Aid will endeavour to assess their circumstances on the same day.

If Housing Aid believe they have a statutory duty towards the patient they will ensure that accommodation is available for them to occupy following discharge from hospital.

If Housing Aid determine there to be no statutory duty towards the patient they will inform the Care Coordinator and advise them of further action they can pursue. If the patient is eligible to access the Homelessness Prevention Gateway, Housing Aid will advise on whether a bedspace will be available by the discharge date.

At the point of developing this guidance there are considerable pressures on direct access accommodation. It should be understood that if the assessment finds there is no statutory duty towards the patient (under Part VII of the Housing Act 1996) it is unlikely that there will be a bedspace available for the patient in supported accommodation on the same day they are referred.

<u>When accommodation is available</u>

- If accommodation is available for the patient to access from hospital the approved support plan will be followed to ensure that the patient has the best chances of successfully maintaining the accommodation.

<u>When accommodation is not available</u>

- If accommodation is not available for the patient to access from hospital (for example, in circumstances where it is determined there is no duty to provide accommodation and a bedspace cannot be secured in time or reconnection is refused by the patient) 'Out of Hospital' commissioned services (currently <u>Homeless Health Team</u>) will liaise with Housing Related Support for rough sleepers commissioned services (currently Street Outreach Team) to continue to support and

attempt to secure accommodation.

4.4 Social Care responsibilities

Citizens who are admitted to an acute bed within NUH or Nottinghamshire NHS Foundation Trust who are homeless will be assessed for short or long term social care needs and have these met using the same process as all other acute discharges.

This will follow the submission of an Assessment Notice and Discharge Notice from the ward. Social Care colleagues will work with the Care Coordinator to identify how and where support will be provided where citizens are eligible.

4.5 **Patient responsibility**

It is acknowledged that there are likely to be occasions where the process guidance cannot be followed because of patient unwillingness to engage and self-discharge.
As far as is possible, partners should demonstrate person-centred flexibility in their approaches to encouraging patients to engage in the process.

However, if the patient does choose to leave hospital to a situation of homelessness, this should be recorded and monitored at the monthly meetings. This information should be readily accessible on RIO as a risk marker for the next time they are in hospital so agencies can support appropriately.

4.7 **Commissioned community / voluntary sector support responsibilities – post discharge**

- 'Out of Hospital' commissioned services (currently Homeless Health Team) will provide follow up if the need is not met by GP due to lack of engagement with GP or individual not being registered with a GP.
- If a referral has been made to Opportunity Nottingham and the patient has been accepted onto the ON programme, follow up support to assist people maintaining their tenancy and engage further with Primary Health Care will be provided by Opportunity Nottingham
- If a referral has been made to and accepted by commissioned domestic violence services (if they are experiencing domestic abuse) they will provide this support (currently IRIS).

5 Monitoring, governance and review

5.1 Adhering to this guidance will help prevent homelessness and in particular, street homelessness. This in turn will have a positive impact on wider healthcare utilisation e.g. reduction in avoidable ambulance call outs, A&E attendances, hospital readmissions, physical health services etc. It will also significantly reduce the risk of preventable death in a very vulnerable group.

5.2 If there are instances where it is felt that the process guidance has not been followed the issue should be raised with the member of staff involved and then escalated to a more senior member of staff if it remains unresolved. The internal complaint procedures for individual service areas should also be considered and followed as appropriate.

Issues of concern need to be addressed in real time and always in line with safeguarding processes.

In addition, Providers should ensure Commissioners are made aware when the guidance is not being followed. This should include highlighting when there are blockages/issues with either the 'sending' service or the 'receiving' service (or both). For non-urgent concerns, the appropriate escalation route will be through Provider contract/service review meetings. For immediate concerns, and if Provider discussions have not sufficiently resolved the issue, these should be raised directly with commissioning contacts at the soonest possible

opportunity.

5.3 If there have been occasions where the guidance has not been followed and the reporting processes as set out in 5.2 followed, these should be logged for learning and development purposes.

Furthermore, emerging issues and trends should be highlighted and noted by all involved in the process.

This monitoring will be completed, discussed and analysed by the task group as set out in 6.1. and reported to the Hospital Discharge Subgroup of the Health and Housing Partnership Group annually in line with the review outlined in 5.4.

5.4 The review of this partnership process guidance will commence in (May 2018) and be completed annually thereafter.

Further work will be required to develop the partnership process including:

- Identification of hospital discharge champions within hospital departments
- Consideration of joint commissioning of additional options such as accommodation broker / assessor services / interim accommodation solutions
- Further expansion of this model into the County

6 Task group

6.1 A task group of partners involved in the hospital discharge process is to be set up. The group is to be attended by the CityCare Care Coordinator, representatives from Nottingham City Council Housing Aid, NUH Trust, Healthcare Trust, Nottingham City Council Social Care and Nottingham City CCG, as well as relevant partners from relevant commissioned housing related support and out of hospital services (including Opportunity Nottingham).

A schedule of bi-monthly meetings will be set and the meetings will be facilitated by Nottingham City Council Housing Strategy.

6.2 The primary purpose of the meetings is to discuss cases that have led to concern that any part of this hospital discharge process guidance has not been followed. The meetings are also intended to:

1. Identify areas for improvement in the partnership process and further develop the guidance[4]
2. Develop a communications plan for further promotion of the guidance to identified stakeholders and provision of ongoing support, awareness and training to Hospital Staff
3. Audit the discharge cases and identify emergency readmissions within 30 days and unplanned A&E use within 7 days
4. Gather evidence about how interventions can deliver positive health and wellbeing outcomes for individuals as well as costed savings for health[5]
5. Capture learning about homelessness locally including; identifying trends, emerging issues and apparent gaps in service provision meeting needs
6. Review the guidance annually and report to the Homelessness Prevention Strategy Implementation Group.

6.3 Cases are to be forwarded to the named task group facilitator one week in advance of the meeting who will circulate it on to appropriate agencies to allow for background research prior to discussion at the meeting.

[4] This will include considering the use of explicit consent info sharing agreements, identification of other partners who could be involved in the process. Thinking about what further services or partnerships we would want to see developed.

[5] This will include deciding upon the areas for evidence gathering, how to incorporate the use of Public Health outcome tools. Additionally, plotting patient journeys to show their hospital / primary care usage for 6 months before and 6 months after interventions.

Specialist officers from other service areas (e.g. mental health, domestic abuse) are to be invited to the bi-monthly meetings depending on the presenting issues of discharge cases listed for discussion.

Action notes will be taken at the meeting and reviewed at the beginning of the following meeting. An action log will be held and reported on regularly to the Homelessness Strategy Implementation Group

6.4 It is important to note that these meetings are not for the purpose of raising issues of concern for the first time. Any circumstances that arise need to be addressed in real time in line with safeguarding processes. However, the details of what happened can be captured and addressed at the meetings for learning and improvement.

7 Additional information

7.1 The 'Out of Hospital' commissioned service (currently Homeless Health Team) will provide every ward with information packs including any appointment details made for them, leaflets of how to find and access drop in clinics for follow up support, as well as the details of how to find and access Specialist GP Services. These items are also to be given to the patient as part of the discharge. Included in the information pack is a:

- Framework Street Outreach Team Card
- Black and Red cards, or discreet literature for women fleeting domestic abuse
- Emmanuel House leaflet
- The Friary leaflet
- The Health Shop leaflet
- Recovery in Nottingham leaflet
- Wellness in Mind leaflet

Posters will be displayed in every Doctors Office and at Every Nurses Station

7.2 The purpose of the additional information packs is to raise awareness of the services that are available to assist homeless and other vulnerable people in the community. None of these is an accommodation provider, so referral to them is not an option to facilitate the discharge of a patient who is homeless. The hospital discharge procedure as outlined in this process guidance should be followed in all cases.

Appendix 1.

Case Studies September 2016 – Suzey Joseph, Nurse Specialist, Homeless Health Team, Nottingham City Care

TYPES OF ILLNESS TREATED BY THE HOMELESS HEALTH TEAM – HHT, WHEN A PATIENT HAS BEEN DISCHARGED FROM HOSPITAL TO STREET HOMELESS

All of the below Patients have Mental Health Problems. 5 are Hepatitis C Positive. Some have Chronic Bacterial & Viral Infections

Female - Acute Coronary Syndrome, Alcohol Dependence, Asthma, Osteoporosis, Self harm, Severe Depression, Domestic Violence – heard at Marac. Discharged to the street after an admission for chest pain. Treated urgently in the grave yard by HHT	Female – Chronic Pancreatitis, Alcoholic Liver Disease, Poor Memory, Partially Sighted, Domestic Violence – heard many times at Marac. Palliative Care. Discharged to the street as refused to engage with alcohol services. Nursed and monitored on the street by HHT	Female – Alcohol & Drug Dependence, Asthma, Sacral wounds, Domestic Violence – heard many times at Marac. Admitted to ICU critically ill with Pulmonary Sepsis, put into medically induced coma. Once able, **took own discharge**. Nursed on the street by HHT	Portuguese Female – Chronic Kidney Disease, Diabetes, Hypertension, Cellulitis, Hypothyroidism, Extremely Poor Mobility. **No recourse to public funds.** Rough sleeps in a tent by the canal where HHT visit her to deliver healthcare & support.
Male – Epileptic. Collapsed several times and was admitted due to having multiple fits in rapid succession. Medications were changed and needed monitoring. Discharged to the street. Treated and monitored by HHT whilst sleeping in a tent at the side of the river.	Male – Alcohol Dependence, Seizures, Korsakoff's Syndrome, Incontinence. Repeatedly admitted with head injury, collapse and seizures. Repeatedly discharged to the street as refuses to engage with alcohol services. Nursed and monitored on the street by HHT	Male – Alcohol Dependence & Drug Misuse. Multiple abscesses, thought to originate from a plate in his chest. Seen at hospital multiple times for severe abscess to neck. High risk of sepsis. **Repeatedly self-discharged**. Monitored and treated on the street by HHT	Polish Male – Alcohol Dependence, Seizures, Blood Disorder – at risk of haemorrhage. Admitted to hospital extremely ill following a collapse with infection. Discharged to the street. **No recourse to public funds.** Nursed and monitored on the street by HHT
Male – Admitted with a severe groin abscess. Received radical surgery and needed daily complex dressings. Was discharged NFA. High risk of sepsis. Picked up by Housing Aid post discharge & placed in hotel. Treated by HHT at LRS	Male – Alcohol Abuse, Mental Health Problems, Bilateral leg swelling. Admitted with a head injury following a fight. Received suturing and was discharged to the street. Followed up & sutures removed on the street by HHT	Male – Alcohol Dependence, Severe Asthma, Seizures, Victim of Violent Assault. Repeatedly admitted to hospital with collapse, head injury, seizures, breathlessness. **Often self-discharges**. Treated on the street by HHT	Polish Male – Alcohol dependence, Severe Seizures. 999 admission to hospital after having seizures in rapid succession - Unresponsive. Discharged to the street. **No recourse to public funds.** Nursed on the street by HHT

Appendix 2.

HOMELESSNESS PREVENTION GATEWAY

Contact Assessment									
Surname:			Forename(s):				Joint Application: Y / N		
Date of Birth:		Age:		Gender:			NI No:		
Ethnicity:			Interpreter Required:			Language:			
Does client consider themselves to have a disability?			Sexuality:			Religion:			
Telephone Number:			Reference No:			Homelink Ref:			
Source of Referral									
Referral Agency			Name of Assessor			Date of assessment			
Contact Tel:			Email:						
Brief description of applicant's presenting problems, difficulties or concerns									
Medical History									
Recent medical / hospital admission:	Yes		No		Has there been a mental health diagnosis?	Yes		No	
Involved professional(s)									
Agency		**Contact Name**			**Location**				
GP:				**Dentist:**					
Emergency Contact:									
Identified Support Needs									
Learning Disability		Drugs Misuse		Budgeting Skills					
Mental Health		Alcohol Misuse		Life Skills					
Ex Offender		Care Leaver		Domestic Violence					
Sex Working		Other Vulnerable Person							
Comments / Details:									
Other Factors to Consider									
Physical Disability		Mobility		Sensory Impairment:					
Literacy		Communication Needs		Cultural /Spiritual considerations					
Comments / Details:									

Household Members	Date of Birth	Relationship to applicant
Is anyone within the household pregnant:	Detail:	Due Date
Does the applicant have pets?		

Current Accommodation					
Own Tenancy		Living with Friends / relatives		Living with partner	
Owner Occupier		Supplied with employment		Supported Accommodation	
Hostel		Hospital		Prison	
Rough Sleeper		No Fixed Abode		Other	
Address:					
Contact Details for Landlord:					
When does applicant need to leave accommodation					

Brief Address History (5 Years)			
Address	**Time there**	**Landlord**	**Reason for leaving**

Current Employment / Education					
Employed		Unemployed		Engaging in training / education	
Detail:					
Current Income (inc. claims)					

Risks Arising					
Medication Management		Social Isolation		Self Neglect	
Mental Ill Health		Self Harm		Suicide	
Vulnerability		Physical Health		Falling	
Risk to children		Violence towards others		Domestic Violence (to applicant)	
Accidental fire setting		Arson		Other	

Comments / Details:

The information on the Contact Assessment Form will be shared in it's entirety with accommodation providers, for the purpose of assisting to resolve the applicant's housing issues and accommodation needs. By signing this form, you agree to the sharing of this information for the intended purpose.

Signature of applicant:	Date:
Signature of Assessor:	Date: