Homelessness

Experiences of Hospital Discharge and Post-Discharge Care

September 2022

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Disclaimer

This report relates to our findings. Our report does not represent the experiences of all people but only those who contributed at the time.

Executive Summary

Executive Summary

Healthwatch Leicester and Healthwatch Leicestershire is the independent voice of the public in health and social care services. We collect feedback from the public about their experiences of using health and social care services and use that feedback to work with service providers and commissioners to find ways to improve services. One of the ways that we collect feedback is by carrying out focused projects as part of our annual workplan.

Context for the study

The Homelessness Reduction Act 2017 (HRA) places a statutory duty on hospital trusts, walk-in centres, and A&E departments to refer anyone who is homeless, or at risk of homelessness in the next 56 days to the relevant housing authority for an assessment with the person's consent. The Duty to Refer (DTR) came into effect in October 2018, and local hospital trusts and local authorities worked closely to develop a homeless hospital discharge protocol.

Our project set out to look at how the HRA works in practice for homeless people in Leicester and Leicestershire by gathering feedback from homeless people and those who work directly to support them.

Our aim was to understand the experience of hospital admissions and discharge of homeless people and the ease of accessing post discharge care in the community.

Aims and objectives

This project sought to understand:

- The rates of emergency readmission for homeless people.
- The rate of planned readmission for homeless people.
- The experiences of homeless people through the hospital discharge process.
- The protocols that are in place to adhere to the Duty to Refer aspect of the HRA in the city and county and how these work for homeless people.
- The options that are available for homeless people to receive post discharge care in the community in the city and county.

What we did

A key component of this study was to find out about how the implementation of the HRA impacts on homeless people who have been admitted to hospital and the accessibility to appropriate post discharge healthcare for those with on-going healthcare needs. In doing this it was important to set this within the context of understanding what services are available for people and how individual organisations and agencies carry out their functions and duties both under the act and in the services provided.

We initially undertook desktop research to identify all the services available for homeless people in Leicester and Leicestershire and then made contact by email and phone calls to managers directly providing services, including the strategic leads for homelessness strategy and procedures in the city and district councils.

We followed up by arranging online, and phone meetings with those who responded to us. This was with a view to finding out from them what protocols were in place to enable them to discharge their duties under the act and what if any issues were faced in doing so.

We further contacted staff with responsibility for DTR in the hospitals and primary care and arranged online meetings with University Hospitals of Leicester NHS Trust (UHL), The Hospital Housing and Enablement Team, Inclusion Health Care, Leicester City Council Housing Options Team and a District Council Housing Options Team.

We contacted most service providers and shared an online survey for both staff and residents/ service users to be completed anonymously online and finally attended several drop-in sessions to conduct individual and group discussion about their experiences.

Main Findings

Through our contact with individuals and service providers we found a real passion, commitment and motivation, which was evidenced in some excellent collaborative working examples and service provision. There was evidence of strong partnership working and a real commitment to continuous improvement for the benefit of the people they worked with. There was a strong collaboration between different elements of the service to ensure that where possible people did not fall through the net.

There were however disparities that became apparent during our study, particularly between what staff providing services told us and what people told us about their experiences of hospital discharge and access to community health services which is evidenced through our survey results and group discussions. The majority of homeless people we spoke to were in some form of temporary accommodation, many supported through a range of hostel accommodation, drop-ins and day services run by the voluntary, community and charitable groups.

We spoke to over 60 people designated under the DTR as homeless or at risk of homelessness and 23 people completed our online survey, in addition 29 staff members from support services completed surveys which mirrored quite closely the responses from service users.

Most of the people we spoke to did not recognise that any form of assessment under DTR had taken place whilst in hospital or that any plan had been drawn up to address their housing or on-going health needs following discharge.

Most respondents also did not believe that they had left hospital with a clear plan to address on-going health needs and this view was supported by staff who worked with them after discharge. Access to on-going mental health services was highlighted as a particular problem and again supported by the staff at their temporary accommodation.

There were clearly issues highlighted about how information is shared and communicated to patients upon discharge and a tightening up of the procedures for communicating with patients and the methods of doing so were clearly highlighted.

What should happen next - key messages

- That Duty to Refer procedures at UHL and The Bradgate Centre are reviewed regularly to ensure that they are still 'fit for purpose' and ensure that there are written procedures that all staff have access to so that they can fulfil their duty effectively.

- That training of the Duty to Refer Legislation takes place at regular intervals for new staff working on relevant hospital wards (at all relevant hospitals) to ensure that they are aware of their responsibilities under the Homeless Reduction Act 2017. This might be best undertaken by the Hospital Housing Enablement Team who appear to be most expert in this area. Training should also include anti discriminatory practice and unconscious bias that can adversely affect how homeless people are treated within the medical system. Homeless patients must feel reassured that they are not stigmatised for their homeless status.

- More partnership working between secondary and primary care and better Multi-Disciplinary Team (MDT) discharge planning for homeless people when care is transferred from hospital to community services, by utilising the roles of liaison worker and peer mentor in Inclusion Healthcare to make the connections between hospital and community care, ensuring that those needing aftercare will receive it in a timely manner, thus reducing the possibility of patients falling through the net.

- Procedures are reviewed to ensure that homeless patients are listened to and involved in the decisions that affect them. This may include considering how and when information is provided and communicated to people and whether, with permission, information can be shared with staff supporting patients at their accommodation so that they can be supported to access any on-going care they might need if they are unable to manage this themselves.

- Review protocols aimed at improving access to mental health services for patients with on-going mental health care needs after discharge to ensure that their mental health does not deteriorate through lack of care or follow up.

Introduction

Healthwatch Leicester and Healthwatch Leicestershire is the independent voice of the public in health and social care services. We collect feedback from the public about their experiences of using health and social care services and use that feedback to work with service providers and commissioners to find ways to improve services. One of the ways that we collect feedback is by carrying out focused projects as part of our annual workplan.

Background

During the Covid-19 pandemic the **'everyone in'** campaign ensured that many people who were sleeping rough or insecurely housed were offered emergency accommodation. Leicester City Council reported that almost all the 900 people that were accommodated during this time have now been offered permanent accommodation. However, the 'Rough Sleeping Snapshot in England: Autumn 2020' showed that 26 people were sleeping rough on a single night across Leicester and Leicestershire.

In addition to rough sleepers there are many individuals and households across the city and county who are in temporary accommodation, who may be 'sofa-surfing' or who are living in hostel type accommodation, and these people are also classed as homeless. The data on this more hidden type of homelessness can be found through the number of homelessness assessments that have been completed by the local authority housing services, and this will be drawn on for the purpose of this study.

A cohort study conducted by Lewer et al. found that when compared with housed patients, homeless people had 2.49 times the rate of emergency readmission to hospital after discharge, 2.57 times the rate of A&E visits, and that the 12-month risk of emergency readmission was higher for homeless people whilst the 12-month risk of planned readmission was lower. They concluded that hospital patients experiencing homelessness have high rates of emergency readmission that are not explained by health, and that this highlights the need for discharge arrangements that address their health, housing and social care needs.

The most recent data held by the office for National Statistics shows that the number of deaths of homeless people has increased each year since 2014, and that in 2019 the average age of death for homeless men was 45–49 years, and for homeless females was 40-44 years. This means that the average age of death for homeless people is 30 years lower than that of the general population.

The Homelessness Reduction Act 2017 (HRA) places a statutory duty on hospital trusts, walk-in centres, and A&E departments to refer anyone who is homeless, or at risk of homelessness in the next 56 days.

The Duty to Refer came into effect in October 2018, and local hospital trusts and local authorities worked closely to develop a homeless hospital discharge protocol.

This project will seek to gather feedback from homeless people to understand their experiences of hospital admissions and discharge and accessing post discharge care in the community and make recommendations for improvements.

Aims and Objectives

This project will seek to understand:

- The rates of emergency readmission for homeless people.
- The rate of planned readmission for homeless people.
- The experiences of homeless people through the hospital discharge process.
- The protocols that are in place to adhere to the Duty to Refer aspect of the HRA in the city and county.
- The options that are available for homeless people to receive post discharge care in the community in the city and county.

Methodology

The project used mixed methodology to achieve its objectives.

The first stage was to utilise desktop research to develop an understanding of homeless hospital discharge policies and procedures that are in place to identify people who are homeless, or at risk of homelessness within 56 days who are then referred to the local authority housing services for assessment.

The second stage focused on identifying agencies that support homeless people to build up a network of people who enabled us to access homeless people through agencies they are involved with and trust. We used desktop research to identify agencies operating in Leicester and Leicestershire and contacted them through telephone calls and emails.

Organisations and agencies contacted

Housing Providers

- Housing options Leicester
- Housing options Oadby & Wigston
- Housing options Blaby
- Housing options Charnwood
- Housing choices NW Leicestershire
- Customer services Leicester
- Hhs Harborough
- Housing options Melton
- Housing Hinckley & Bosworth

NHS providers for homelessness

- University Hospitals of Leicester NHS Trust (UHL)
- Leicestershire Partnership NHS Trust
- Homeless NHS
- Inclusion Healthcare
- Bradgate Unit
- Homeless Mental Health Service Leicester

Homeless Service Provision

- Action Homeless Leicester
- Help the homeless
- One Roof Leicester
- The Bridge, Homeless to hope
- Samaritans Leicester
- Midland Langar Seva Centre
- The Exaireo Trust Ltd
- Bradgate Centre
- The Bridge
- Falcons Support Centre
- The Dawn Centre
- The Centre Project
- The Stairway Project
- Dear Albert
- Leicester's Homelessness Charter

Most services were contacted several times by email and follow up telephone calls due to the difficultly in identifying the appropriate named people to speak to.

Despite our efforts, the response from some of the services was disappointing, particularly Housing providers who failed to respond to several emails and telephone calls. We received responses from Leicester City, Blaby and Melton though the latter was very new in post and was unable to help us on this occasion.

Most information gleaned came from the individual housing authority websites.

The third stage of the project used surveys to capture the views and experience of staff working directly with homeless people who have experienced hospital discharge and post discharge care from community services.

A separate survey was used for homeless people to capture their experience of hospital admission and discharge, experience about how their homeless status was addressed and any post discharge care that was needed.

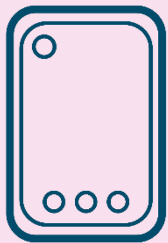
We also spoke to people using a semi structured approach talking to both homeless people and support staff which took place at a series of drop-in sessions at various service provision across the city and county.

60

people were visited and spoken to at drop in services

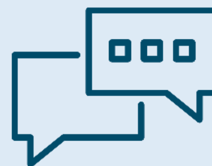
15

men and women spoke to us from The Stairway project



18

Service providers spoke to us by telephone



24

People talked to us at The Falcon Centre

We received

29

Survey responses from staff working at services

We spoke to

20

People at The Bridge Homeless to Hope service

We held online meetings with;

- The Team Leader from the Hospital Housing and Enablement Team and the Team Leader from Leicester Housing Options service.
- The CEO of Inclusion Healthcare.
- The Head of Nursing, Patient Flow and Discharge at UHL.
- The Homelessness and Housing Systems Team Leader at Blaby District Council.
- The Frequent Attender Nurse at UHL employed via LPT.
- Homelessness prevention and support officer (Homeless Outreach Team).
- Project Coordinator Leicester's Homelessness Charter Together Leicester.

We spoke with the following homeless/ vulnerable persons provision representative by phone and sent patient and staff surveys to:

- Action Homeless Leicester
- Help the Homeless Leicester
- One Roof Leicester
- The Bridge, homelessness to hope
- The Exaireo Trust Ltd
- Falcons support services
- The Dawn Centre Leicester
- No 5, Hill Street Leicester
- Y Support project
- The Centre project

We also made visits to the following drop-in services and spoke to approximately 60 people about the project.

- Two visits to The Bridge Homeless to Hope service and spoke to 20 people. We also attended a drop-in session with a group of asylum seekers and spoke separately to a group of women who all had experience of accessing maternity services.

- Two visits to the Falcon Centre in Loughborough which is the largest service for homeless people based in Loughborough and offers a range of housing and community support services for people who are homeless or at risk of homelessness and in need of community support. We spoke to 24 people in total.

- The Stairway Project - The Hope lived experience forum which was a mix of 15 men and women of a similar age.

- The Exaireo project allotment group - we spoke to a group of six men.

We also left surveys with all these services and in total we received 23 completed surveys back from people who had direct lived experience of hospital admission over the previous 18 months.

Unfortunately, we were unable to visit in person the city's largest provider of homeless accommodation and services, The Dawn Centre, despite several telephone calls and emails requesting to visit to talk to staff and service users in person.

To set the context and as background to our project we refer to the following documents:

- Homelessness Reduction Act 2017 www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer which outlines guidance to referring agencies under the 'duty to refer'.
- Homeless & Rough Sleeper Strategy 2018-2023 Leicester City Council
- Homelessness & Rough Sleeper Strategy Update Overview Select Committee: 10th November 2021
- Leicestershire Homeless Housing partnership. incorporating;
    - Leicester City Council Homelessness Strategy 2018-2023
    - Hinckley and Bosworth Homelessness Strategy 2015–2020
    - Charnwood Homelessness Strategy 2018–2020
    - Harborough Housing and Homelessness Prevention Strategy 2018–2031
    - Oadby and Wigston Homelessness Strategy 2016
    - Blaby Prevention of Homelessness Strategy 2014-2019
    - Melton Homelessness Strategy 2018-2023
    - North West Leicestershire Preventing Homelessness Strategy 2013 – 2018

- Homelessness code of guidance for Local Authorities – Department of Levelling up, Housing and Communities Feb 2018 updated October 2021.
- Blackpool homelessness report Healthwatch Blackpool 2021.
- West Berkshire- access to, and experience of health and social care services for rough sleepers in West Berkshire – Healthwatch West Berkshire 2018.
- Conversations with people who have experienced homelessness in Sandwell, Their experience of health, social care & the Care Quality Commission. Sandwell Healthwatch.
- Evaluation of the Implementation of the Homelessness Reduction Act: Final Report Ministry of Housing, Communities and Local Government 16 March 2020.
- Statutory Homelessness, January to March (Q1) 2019: England Ministry of Housing Communities and Local Government.

Main Findings

Homeless Reduction Act Role and Responsibilities

The Homelessness Reduction Act (HRA) 2017, introduced on 3 April 2018, places a legal duty on housing authorities so that everyone who is homeless or at risk of homelessness will have access to meaningful help, irrespective of their priority need status, if they are eligible for assistance. To determine whether a person is eligible they need to meet one of the 5 tests of homelessness.

The five tests are:

- Is the applicant homeless or threatened with homelessness?
- Is the applicant eligible for assistance?
- Is the applicant priority need?
- Is the applicant intentionally homeless?
- Does the applicant have a local connection?

Eligibility for assistance is met if a person is homeless or at risk of becoming homeless within the next 56 days, are not intentionally homeless and has a local connection to the area to which they are applying for housing. A person meets the following priority need if they:

- Are pregnant
- Have dependent children
- Are victims of domestic abuse
- Are vulnerable because of old age. mental illness, physical illness. learning or physical disability
- Are care leavers

A range of public authorities have a Duty To Refer (DTF) people they consider are homeless (or threatened with homelessness) within 56 days.

The DFT is aimed to help to ensure that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they encounter public authorities. It is also anticipated that it will encourage local housing authorities and other public authorities to build strong partnerships which enable them to work together to intervene earlier to prevent homelessness through, increasingly integrated services.

The public authorities with a duty to refer are:

- **Prisons**
- **Young Offenders Institutions**
- **Secure Training Centres**
- **Secure Colleges**
- **Youth Offending teams**
- **Probation Services (including rehabilitation companies)**
- **Jobcentres**
- **Social Services Authorities (both Child and Adult)**
- **Emergency Departments**
- **Urgent Treatment Centres**
- **Hospitals in their function of providing Inpatient Care**
- **Secretary of State for Defence about members of the regular Armed Forces**

In addition to contacting each of the housing authorities, we looked at each of their websites to find out what information is made available to public authorities about the HRA and the process for referring. We found that all had good information about the act and the responsibilities under it, and though some were more accessible than others, each district has their own procedure in place to refer to.

It is important to note that the duty to refer in legal terms is no more than notification to a local housing authority that a patient on the ward is either homeless of 'threatened with homelessness' and it is up to the local housing authority to contact the patient and assess them. This can provide several challenges for nursing or clinical staff if they had to refer to each local authority in Leicestershire or beyond, each area with their different processes and systems and then tracking the progress of referrals to ensure that patients are assessed properly and timely in relation to their stay in hospital.

In Leicester and Leicestershire however, the process is made easier by having a team of staff co-located with secondment arrangements in the hospitals who undertake this task on behalf of hospital staff. This is seen as an effective way of facilitating referrals under the DTF.

Hospital Housing Enablement Team (HHET)

The Hospital Housing Enablement Service (HHET) is a collaboration between Leicestershire Partnership NHS Trust (LPT), UHL, Leicester City Council, and other district councils within Leicestershire. It is a unique service that does not appear to be replicated elsewhere as far as we could ascertain. The service was established in 2014 and works within hospitals to prevent delays in discharge for patients with housing related issues. The team carry out assessments on behalf of the wards, and if a person meets the five tests and the priority needs, the team will complete a DTR to the Housing Authorities in Leicester or Leicestershire as required by law for any patients who are homeless or threatened with homelessness.

The service places housing specialists within the hospitals, to work with the patient and hospital staff to identify any housing issues that are a barrier to discharge. The team then puts in place the right steps so patients can return home as soon as possible after treatment. It also enables ongoing support to people once they are home, including practical help and access to benefits.

We met with the Team Leader for the service along with the Leicester City Housing Options Service Team Leader who talked us through the process of referral to the HHET, the assessment, and the collaboration with the Housing Options Service to achieve a timely and effective discharge of people. The team covers wards at UHL and the Bradgate Unit but do not have funding to cover A&E in Leicester Royal Infirmary.

The service was described as an advanced DTR or DTR+ in that the officers in the HHET are trained housing professionals by background, so they will take a full address history of the patient, find out why they lost their last accommodation and work out which Local Authority the patient is connected to under local connection rules whether they might be considered priority need regarding being offered temporary accommodation. They will also start some of the work where possible.

For example, sometimes they have patients who were living with family members before their admission to hospital and the family members refuse to have the patient back on discharge. With the patient's consent, they will contact the family and try to mediate the patient's return with the offer of support; perhaps a housing application to secure a permanent move in the future.

They still send in the DTR as this is a legal obligation, but they can start work and sometimes resolve issues before the patient is discharged. The other advantage of the service is that they can support on cases that the local authority would not, such as those patients that are non-eligible and have no recourse to Public Funds (NRPF).

This includes patients who are from non-EU countries as well as those from the EU.

The first place they start with these cases is to check if they have settled status and if not, look to see how long they have been in the UK and help them to apply for settled status if eligible. For those patients who do not have settled status, it largely depends on their circumstances as to what support can be offered.

For example, if the patient is working and will be fit to return to work after their discharge, the team can support with finding private rented accommodation. Some EU nationals have wanted to return to their country of origin and have been supported to do that where it has been safe to do so.

They also assist on cases where the patient has accommodation but there are some other barriers preventing discharge, such as hoarding issues. The real value of this service was described as "the bridge between frontline hospital staff and Local Authority Housing Options Officers."

The team cannot issue legal decisions on homelessness or priority need and do not have access to temporary accommodation. However, because they have the knowledge and skills in this area, this has built up good working relationships with local authority housing services and because of this are able to coordinate cases so that accommodation is available for a patients discharge on most occasions.

The general view from housing options and the HHET is that the system for the most part works very well. Assessments can be done quickly resulting in very few delays in discharge. The teams meet regularly together and address any issues that arise in a timely manner.

The HHET also cover wards at the Bradgate Unit, an acute mental health admissions unit who tend to have longer term patients with a predominance of younger males referred for assessment. We were told by one of the district housing authorities that housing people with mental health issues was often more complex and present several challenges.

Many of the districts do not have their own stock holding for homeless people so often the temporary accommodation offered will be Bed and Breakfast accommodation. This is often not suitable for people with long term mental health issues who may in the past have presented with behavioural issues that has led to a breakdown of previous accommodation. In addition, referrals can sometimes come in late (e.g., just before discharge) and the expectation is that the bed is required in the hospital and the patient is ready for discharge.

It was suggested that earlier notification would be helpful where a person is returning to their area and is homeless. The other issue is that it is sometimes very difficult to get social care services involved in the support of a patient as the threshold for involvement is very high and many patients do not meet the threshold for services. The HHET Leader however, felt that the numbers who present with these issues are small because generally the HHET do pick up people in the Bradgate Unit at an early stage and work with them to reduce these issues. The view is that the system works well overall and that timely and effective discharge is more the norm than not

Number of Duty to Refer forms sent anywhere in Leicester, Leicestershire, or Rutland 2021/2

	Bradgate Mental Health Unit (BMHU)	University Hospitals of Leicester NHS Trust (UHL)
Q1	**25**	**38**
Q2	**16**	**46**
Q3	**8**	**27**
Total	**49**	**111**

We were unable to obtain comparative data from other years so cannot make a comparison to ascertain whether the figures reported indicate an upward trend in the number of people referred under the HRA.

District Housing Authorities

We spoke to a District Housing Authority Homeless and Housing Team Leader who spoke of the challenges for districts as outlined above. It was explained that as a housing authority, it does not have individual protocols in place for dealing with homeless people but there are countywide protocols that are followed and there is the collaboration between districts, city and NHS as discussed. When asked what improvements would be made to the service the response was that a unit of accommodation for people discharged from mental health units, that could support people with complex needs, who are not ready for independent living but who fall below the threshold for social care support. Unfortunately, some districts have too few people to make this a viable proposal as an individual authority and it is politically difficult to get any sort of joint venture off the ground in this financial climate, so this remains an unmet need. The other significant issue is the lack of available social or private rented housing in some areas such as more rural locations where people can wait a considerable time for suitable housing to become available and therefore can stay in temporary accommodation for long periods of time.

Inclusion Healthcare

We met with the Chief Executive Officer of Inclusion Healthcare. This service was established in 2010 as a Community Interest Company to provide healthcare to vulnerable people across Leicester City. Their work is predominantly with people who are homeless and asylum seekers. They provide a range of services which includes GP services based at their main premises, Charles Berry House, and GP and nursing clinics based at the Dawn Centre, Monday to Friday morning.

They also offer registration to homeless people, residents of two hostels and women working in prostitution. In addition to the usual GP services offered by practices, they also provide the following services:

- Visiting ophthalmic optician
- Midwife appointments
- Practice therapist for common mental health problems
- Health checks & chronic health reviews

In 2015 the service was rated outstanding in all areas following an inspection by the Care Quality Commission. We were informed that the team generally become aware of patients who have been in hospital via the GP letter that informs them of a patient's discharge, and they will follow that up with any patient living in the community.

Given the complexity of some of the patients it would be useful to have additional information but at the present time this is the system they are working with.

Asked about whether the team are made aware of patients being admitted to wards and being involved in discharge planning, it was explained that presently this does not happen but in the past and up to 2017 there was a Primary Care Plus Nurse who essentially had a liaison role with the hospital and would follow patients through their hospital stay to facilitate a smooth discharge. The role was funded via the Clinical Commissioning Group (CCG) but was decommissioned in 2017.

We were informed that this role has been reinstated and it is expected that this will significantly improve the pathway between hospital and the community for people who are homeless and known to Inclusion Healthcare and those that are not known currently but may need follow up care upon discharge.

We were also told that funding had been applied for to fund a role through Leicester City Council's rough sleepers' initiative. The proposal is to employ a peer mentor to help people engage with secondary care and will also work with frequent attenders to A&E. Both roles if agreed could be key in producing significant improvements in outcomes for both the hospital and the patients by providing continuity of care, and more effective discharges from hospital.

We were informed that collaboration with housing providers is good as is the relationship with the Homeless Outreach Team and other agencies such as Turning Point and the HHET. From the perspective of the Inclusion Healthcare service, the reinstatement of the Primary Care Plus Nurse has the potential to significantly improve the discharge and continuity of care for patients.

At present there is 18 months guaranteed funding when it is hoped to prove its vital role in improving hospital discharge and patient care to extend the funding.

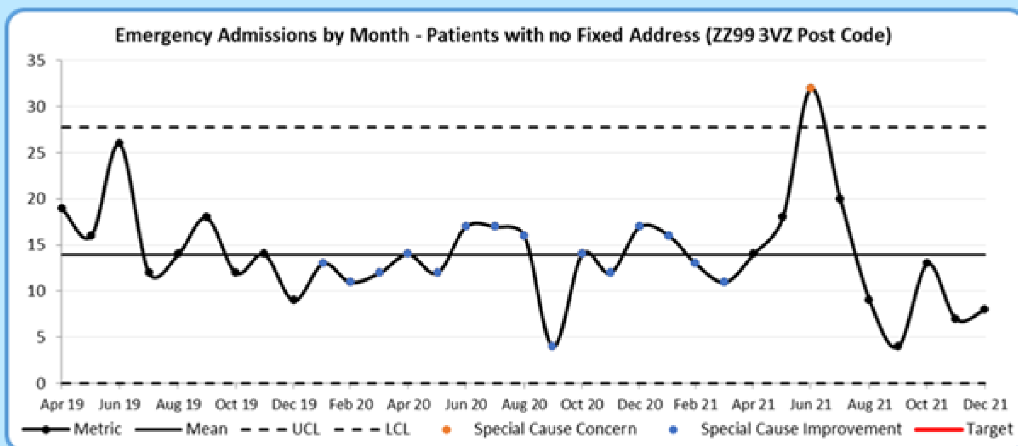
Hospital Discharge

We met with the Head of Patient Flow and Discharge at UHL who talked us through the process for implementing DTR and working with homeless people admitted to hospital. She informed us that the discharge protocol for people who are homeless in the main works very well and mostly patients are referred to the team at an early stage of their stay.

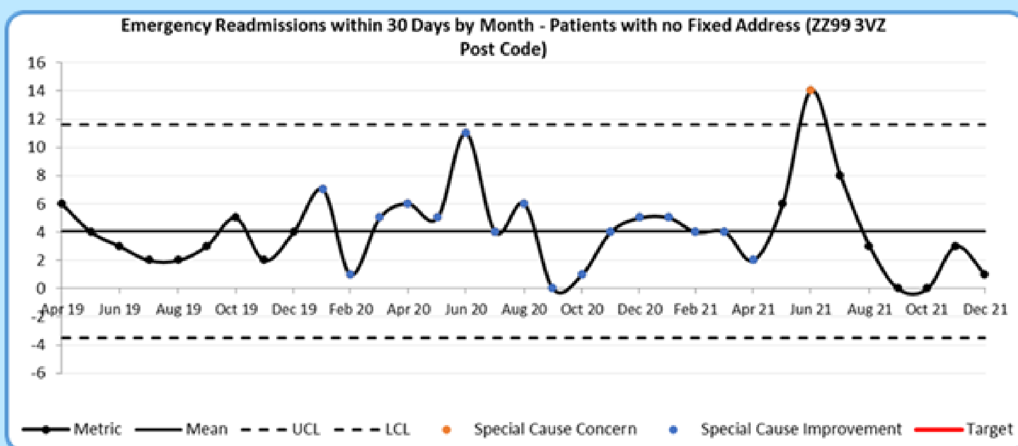
The wards work very closely with the HHET who contact patients, undertake the DTR referral to housing authorities and play a very proactive role in the timely discharge of patients. There were a few issues that were highlighted though, the hospital does not track or keep figures on length of stay of homeless patients through their hospital stay and therefore do not know if any delays to discharge are caused by a person's homelessness or ongoing health care needs. The hospital does have links to the Dawn Centre and can refer patients who do not wish to be referred to the HHET but on occasions staff at the Dawn Centre have expressed concern that people are referred inappropriately, and their needs cannot be met. It was unclear as to whether there are clear written protocols in place to implement DTR and whether staff have regular training on their duty under the act.

The head of patient flow and discharge was unaware of the initiative by Inclusion Healthcare to reinstate the role of the Primary Care Plus Nurse whose role will be to track patients through their hospital journey with a view to improving continuity of care from the community through the inpatient stay to discharge. The information was however greeted positively as having potential to facilitate and smooth the discharge process.

It was recognised that there are some patients who fall through the net because staff on some wards are not aware of the DTR procedure. We were told that this is due to staff turnover, current hospital pressures and the fact that currently regular training is not carried out with staff on the DTR legislation. The HHET do try to address this and have taken posters and information to wards but don't do regular training with new clinical staff of the DTR legislation. This is an area where it was agreed needs to be addressed going forward.



Data was requested about the number of emergency admissions and readmissions to UHL. The charts show the emergency admissions and emergency readmission to UHL from April 2019 to December 2021. Whilst the figures do not highlight any significant issues regarding emergency admissions or readmissions, large spikes, can be indicative of health care needs not being met in the community and follow up care not being delivered appropriately in the community.



In terms of actions that could be taken improve the patient flow system, the following were suggested as potential actions for improvement.

- Meeting regularly with the HHET to identify any areas that could support the discharge process
- Asking the HHET to provide regular training of new staff of the DTR
- Reviewing systems and processes within the hospital to see if these could be made slicker and prevent people from falling through the net.

We also spoke to the Frequent Flyer Nurse (FFN) who covers the Emergency Department (ED) at UHL. This contact was made based on the DTR homeless people to housing authorities which includes Emergency Departments.

The FFN is employed by the LPT rather than UHL and has a key role in addressing the issues that bring people into contact with the ED on a regular basis. We were initially told that the HHET team did not cover ED, but this was disputed by the FFN who told us that referrals are made to the Leicester Royal Infirmary HHET and that DTR's are made to housing options teams directly.

This was clarified with the HHET leader who told us, "DTRs are not made to our service because we are not a Local Housing Authority and work for the hospitals. We do not cover ED directly, but we do offer advice and help on such cases where we can". Given the turnover of patients through the ED department, it would be unlikely that there would be sufficient time for the HHET to undertake an assessment on behalf of the housing option teams.

We were told that the ED have very strong relationships with the homeless out of hours team and the Homeless Outreach Team who are, in the FFN's view, 'excellent' in that they can be relied on to pick up referrals from ED and deal with them efficiently and effectively.

The FFN informed us that the team in ED know what to do to refer a homeless person and therefore there are few issues..

However, there are no written protocols in place, and this is something that should be considered going forward in light of our subsequent findings.

Those people who fall outside of the homeless services either through choice, criteria or have no recourse to public funded support are usually referred to No. 5 or the Dawn Centre and care plans are drawn up for those who are continuously homeless to offer ongoing advice or support from the homeless outreach team.

Homeless Outreach Team

We spoke to the Homelessness Prevention and Support Officer (Homeless Outreach Team). His role is to work with rough sleepers and with people who do not meet the criteria for housing through the housing options team either through ineligibility or those who have no recourse to public funds.

We were informed that where people are homeless there are places in temporary accommodation that can be used and therefore there is no need for people to have to sleep on the streets.

However, there are people entrenched in long term homelessness and his role is to support those people on the streets to ensure that they still have access to services including healthcare when they need it. The main role however is to work with people and support them into temporary accommodation and then into long term accommodation with the appropriate support in place.

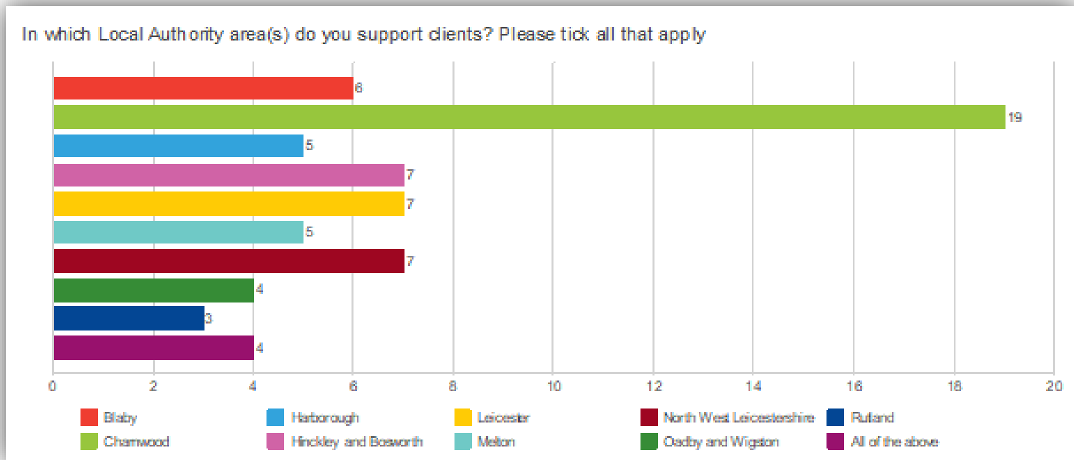
To this end, the outreach role works closely with Inclusion Healthcare, homeless mental health services, Turning Point, and goes onto the streets early morning with these agencies to target individuals who are vulnerable and who are of concern to services. Working in this way provides a 'wrap around' service to some very vulnerable individuals. We were informed that 99.9% of people who need accommodation can be accommodated and the Dawn Centre is the first point of call. They also work closely with other services such as No. 5, The Bridge, the Y service, and other services such as Day Centre's drop-ins etc. We were told that collaborative working is excellent and there is a good network of support available to homeless people including access to healthcare.

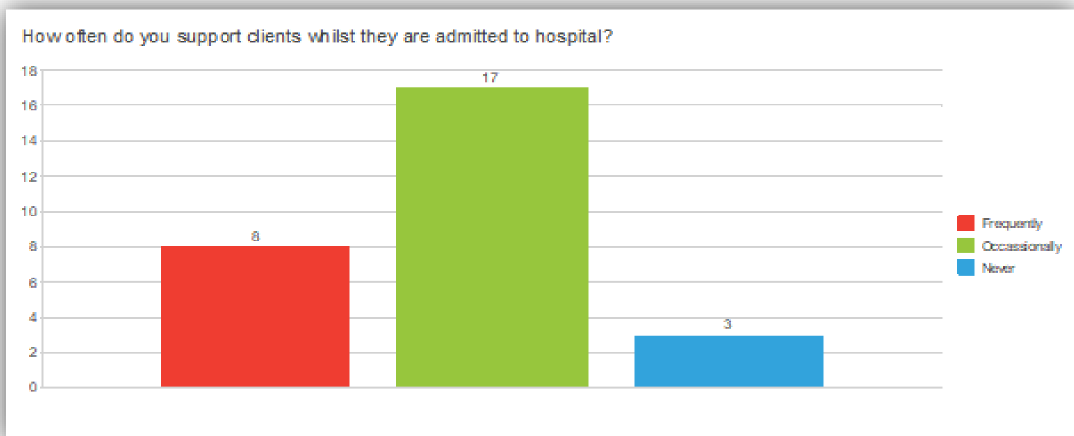
The main challenges were described as the number of homeless people which increases year on year and particularly people who have nil income, no rights or access to benefits, healthcare, housing, or work. Many of these are people are from the European Union, people who come to the country illegally, and people whose visa has expired. This is a growing number of people year on year and present many challenges to the charitable organisation such as 'One Roof' who support them with no government financial support, relying solely on grants and charitable donations.

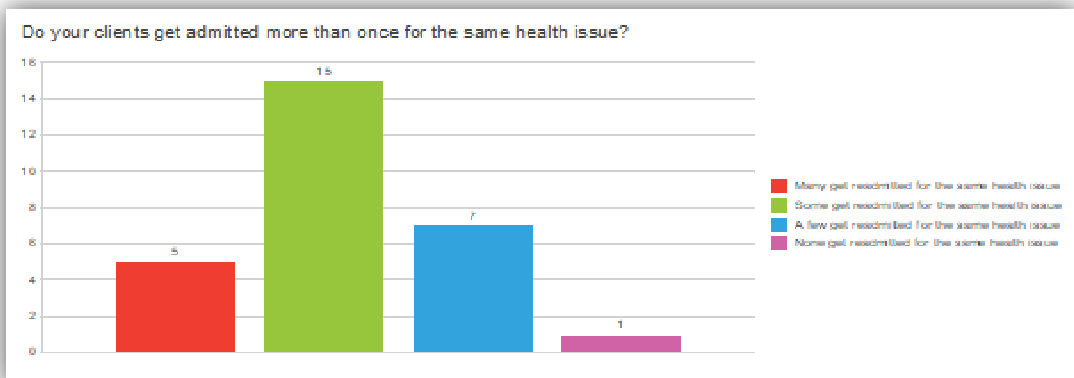
Survey Results

The purpose of the staff survey was to find out whether the experiences of staff working with and supporting homeless people in accommodation, drop-in services, day services, support the professional views of how systems work on the ground with the homeless people they work with. Also, some of the circumstances in which homeless people live does not always result in wholly accurate reflections of experiences they may have had so a balanced view is useful to support those given by homeless people themselves and those who provide housing and health services.

Staff survey - 29 surveys were returned from staff.





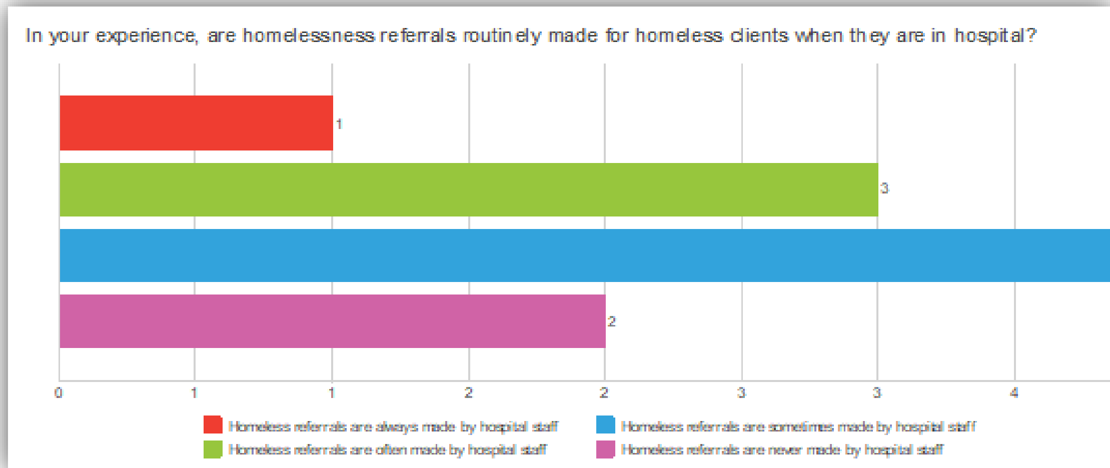


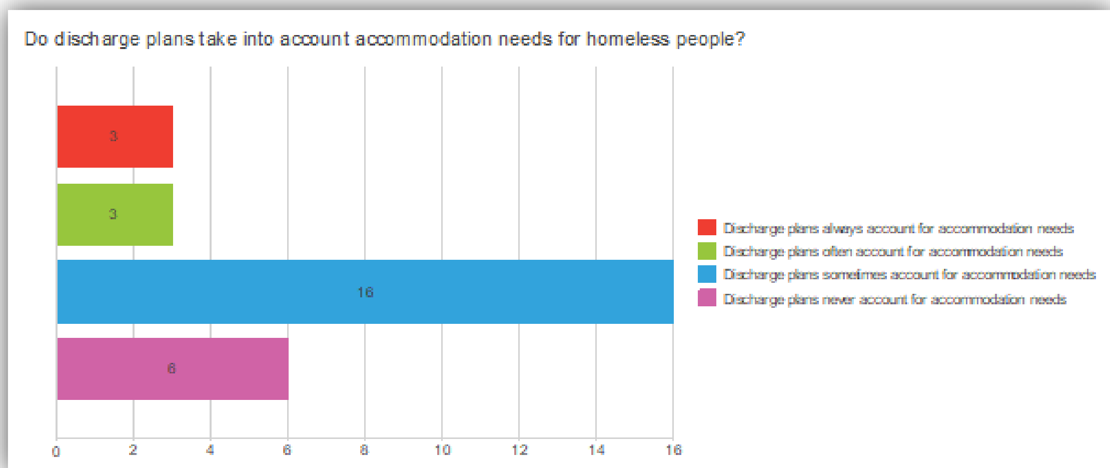
Do you believe that readmissions for the same health issue could be prevented?

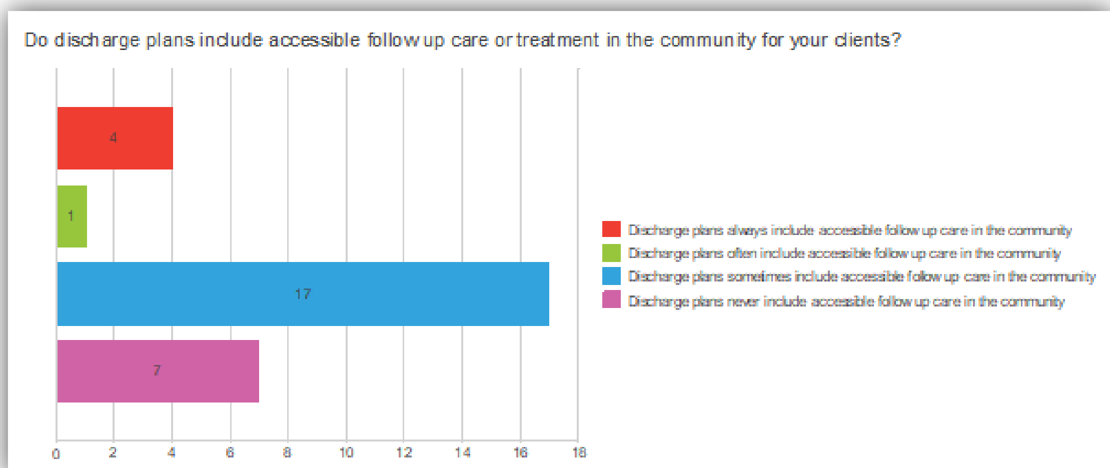
A total of 27 responses were received for this question, and 4 themes emerged from the feedback. Themes were **Community services, Discharge Planning, Mental Health Support** and **Complex needs.**

Access to community services	Discharge Planning	Mental health support	Complex needs
Yes - Sometimes it is really difficult for them to access the appropriate care early on, so by the time they are seen, it has become much more serious. Often it is because the person buries their head and leaves it until serious.	I believe they should be given clear discharge procedures, and it should be picked up and addressed in the community. Then there may not be so many readmissions. Also, everything should be checked before discharge, including accommodation needs.	Yes - Sometimes it is really difficult for them to access the appropriate care early on, so by the time they are seen, it has become much more serious. Often it is because the person buries their head and leaves it until serious.	I believe they should be given clear discharge procedures, and it should be picked up and addressed in the community. Then there may not be so many readmissions. Also, everything should be checked before discharge, including accommodation needs.
Many of them regularly run out of credit before pay day, and sometimes they pawn their phones. They don't want to waste their credit in a long phone queue for an appointment.	This depends on the circumstances of individual cases. Some readmissions are preventable with access to support but not every patient meets the criteria for this. Other times, patients may decline support or have conditions that are likely to relapse regardless.	Yes, especially when they are admitted due to their mental health. There could be more follow up support put in place for when they are discharged from hospital to stop the cycle.	I believe its different person to person, but I do feel that some of the homes I have visited in the past are of a very poor standard and although not a given I do feel that if they were or had to be of a basic standard it would help massively in keeping the individuals mental state above water.
Yes, in some cases. They could get follow up GP appointments/ aftercare quicker and this would prevent readmissions.	Yes, with additional support after discharge to enable people to better take care of themselves.	Yes, I believe readmissions could be avoided if CAP were more involved.	This is dependent on person. Guidance can be given to try and prevent readmission, but it is up to the individual whether they accept.
If they had easier access to a GP or the ability to walk into a surgery and make appointments.	Yes, if where they are sent back to has facilities to support with their health issues. Do not release no fixed abode.	With better support with mental health, I believe it could be prevented.	Sometimes dependant on the individual's capacity and health issues or mental health issues.

Yes, if we had more open access services, or services opening back up to see people face to face.	Sometimes residents don't remember all the information they are told and therefore we struggle to support them due to this.	Yes, especially with mental health.	Yes. Our frequent attenders tend to be admitted with IVDU and alcohol related issues.
Yes. Being able to access appointments with GP's surgeries easier would help.	Yes if enough resources were made available.		Yes - if clients with drug/alcohol issues could go to rehab, for example.
Most of my clients do not have online access to their GP.	Yes, often I find residents are sent away without any real care, often told to wait for a letter. However, often they have to wait a long time for the letter or next appointment.		Some of them struggle with speaking to people on the phone; some of them don't trust authority figures including doctors; some of them struggle with reading and writing. Therefore, they leave health problems until they are at a crisis point.
			Yes, a lot of recurring health problems are made worse by poor living conditions and lack of facilities for self-care.


In your experience, are homelessness referrals routinely made for homeless clients when they are in hospital?
1
3
2
0
1
1
2
2
3
3
4
Homeless referrals are always made by hospital staff
Homeless referrals are often made by hospital staff
Homeless referrals are sometimes made by hospital staff
Homeless referrals are never made by hospital staff


Do discharge plans take into account accommodation needs for homeless people?
3
3
16
6
0
2
4
6
8
10
12
14
16
Discharge plans always account for accommodation needs
Discharge plans often account for accommodation needs
Discharge plans sometimes account for accommodation needs
Discharge plans never account for accommodation needs


Do discharge plans include accessible follow up care or treatment in the community for your clients?
4
1
17
7
0
2
4
6
8
10
12
14
16
18
Discharge plans always include accessible follow up care in the community
Discharge plans often include accessible follow up care in the community
Discharge plans sometimes include accessible follow up care in the community
Discharge plans never include accessible follow up care in the community

In your experience, are homelessness referrals routinely made for homeless clients when they are in hospital? Please explain your response

– 12 comments 3 themes

Duty to Refer	Discharge to rough sleeping	Partnership working
My service, the Housing Enablement Team (HET) is commissioned to assess and support homeless patients in hospital at the UHL hospitals and the Bradgate Mental Health Unit. The only area of the hospitals that we do not cover is A&E where some DTRs may not be done because the job falls to clinical staff.	I have worked with many guests who have not been released appropriately, who have not wanted to be discharged because they are frightened and back on the streets.	I am not clear on the duty of care towards homeless people from a hospital.
Yes. Any referral we receive for homelessness is referred into the local authority under our duty (with consent). With a high turnover of ward staff, they are not always aware that there is a housing team, and if there are admissions at a weekend we are not available.	We find a lot of people attend our day centres being released from hospital who are still homeless.	We don't get full details before being discharged if they are in our accommodation services.
I do have a client currently who was in hospital while rough sleeping, but they did not make any homelessness referrals.	I do see people discharged with no accommodation.	I do not know the hospitals procedure.
I have had a couple of experiences where people have been referred to our homeless service from the hospital and has stayed in hospital until they had a place to go after discharge.		I am aware that there is a plan but not really sure.
There used to be a duty of care from the local council but that seems to have been scrapped.		

Please describe your experiences of supporting your clients through hospital discharge

- 25 comments 4 themes

Partnership working		
Clients would give the information that they were in supported accommodation if they were prompted during the admission or discharge protocol, but they are not, if they were we could be part of the discharge and aftercare planning.	As a support worker I have often been called on for transport or support by my clients but have never been involved by the hospital or included in the discharge plan.	If staff at the hospital checked if clients were in supported accommodation and the client gave their permission to contact us it would mean we could help support their discharge and any follow up needed with hospital or GP.

Clients would give the information that they were in supported accommodation if they were prompted during the admission or discharge protocol, but they are not, if they were we could be part of the discharge and aftercare planning.	As a support worker I have often been called on for transport or support by my clients but have never been involved by the hospital or included in the discharge plan.	If staff at the hospital checked if clients were in supported accommodation and the client gave their permission to contact us it would mean we could help support their discharge and any follow up needed with hospital or GP.
I just receive a call from the resident at the hospital and usually pay for them to get a taxi back to their accommodation.	Hardly any liaison from the hospital about the discharge. In quite a few cases the resident has just appeared back at the hostel.	Very mixed. Sometimes there has been good communication from the hospital staff. Often the person is discharged without us knowing.
I have asked the hospital to call me before someone is being discharged so I know the health and outcome of treatment.		
Discharge and aftercare plan		
I have worked with people discharged from hospital, with injuries and care needs but they are released as NFA. I do not know why, this happens a lot, the guest only knows they have to leave is when they are told to get up and leave.	Clients are often unaware of what follow-on care they are going to have; they can miss appointments due to their chaotic lifestyle and are often unable to access aftercare.	Clients have been discharged without adequate pain medication or have problems accessing a prescription in the community and do not know how to resolve it.
The majority of the time we have to pay for transport for clients who have been discharged from hospital otherwise they have been known to walk from the hospital back to Loughborough down the A6 which is very dangerous especially when they have been admitted from a mental health issue.	Often clients will come in to say that they have been in hospital, there is no information about the support they need when discharged. Some of them do not know what they need to do next. There are no support plans in place.	If a client has been discharged after an admission for a mental health crisis, an overdose, or a drug or alcohol detox my experience is that they often get discharged from Leicester hospitals without any money or phone- 10 miles from home.
I am sure there are discharge plans for patients, just people I work with do not have a hospital discharge plan, that they are aware of at least.	It is usually down to us to sort out any transport or contacting the council for homeless clients. None of this is done by the hospital.	Clients may not have a telephone, leading to difficulties in receiving follow-on community care.
The client had the crisis team supporting him after discharge.		

Discharge destination		
I speak with the person to gain details/consent to enable to DTR into the relevant LA. The DTR is completed into the LA. Once a patient is deemed medically fit to be discharged I ensure the LA authority are aware, although unfortunately, whether it is short staff/lack of resource/unwillingness, this process is often difficult (mainly LCC). It is a very small percentage of referrals that are assessed and placed whilst in hospital, with a person often being discharged before this happens/forced back into a situation. I had 2 recent DV cases that returned to the perpetrator because they felt bad about staying in a hospital bed, with UAVA following them up post discharge. A person who is placed will often wait a week in a hospital bed medically fit due to LA delays. The ward will ensure that if there is any follow up/district nurse required that this is in place prior to discharge.	All homeless patients are assessed by the HET team and our officers look into the circumstances and cause of homelessness for the patient and will plan to resolve the homelessness issue on ready for discharge. We also have Support Officers who can provide follow up where needed for a small period of time. In addition, we work alongside the Local Authorities in Leicester, Leicestershire and Rutland so that they are aware of homeless patients in hospital and can provide accommodation where appropriate.	We often see people discharged to no accommodation and are rough sleeping, leading to further declines in their health and longer recoveries
One of my cases was discharged from hospital after knowing he had somewhere to live. But this is not always the case.	If it's a rough sleeper, they are just discharged and that's it.	
Complex needs		
I have worked with people who have self-discharged as they have addictions and the craving for drugs is so much more than ANY pain they are in. It would help to be given something asap to manage their addiction, and this might help with treating them.	Clients tend to discharge themselves or are discharged without feeling supported. Clients can have behavioural challenges due to ACEs, trauma and substance misuse. The system does not necessarily account for these. But at the same time, I recognise that resources are very stretched in the NHS.	I have had to support clients to understand their hospital letters and to contact the hospital about their follow up care. I have sometimes felt that the client would have been left in a difficult position if I had not been there to ask questions, challenge or clarify.

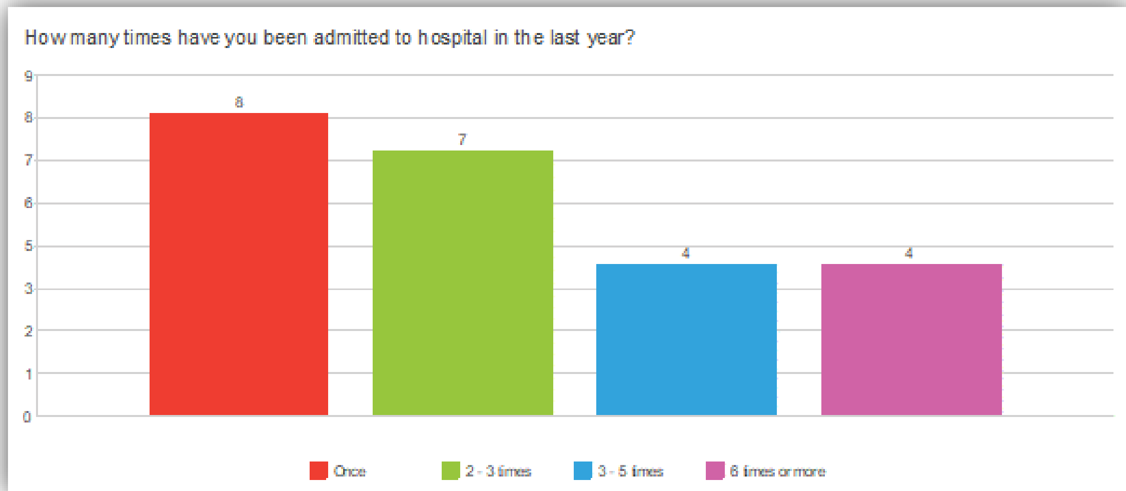
Please use this space to tell us anything else you would like us to know about hospital admissions, discharge or follow up care for homeless people.

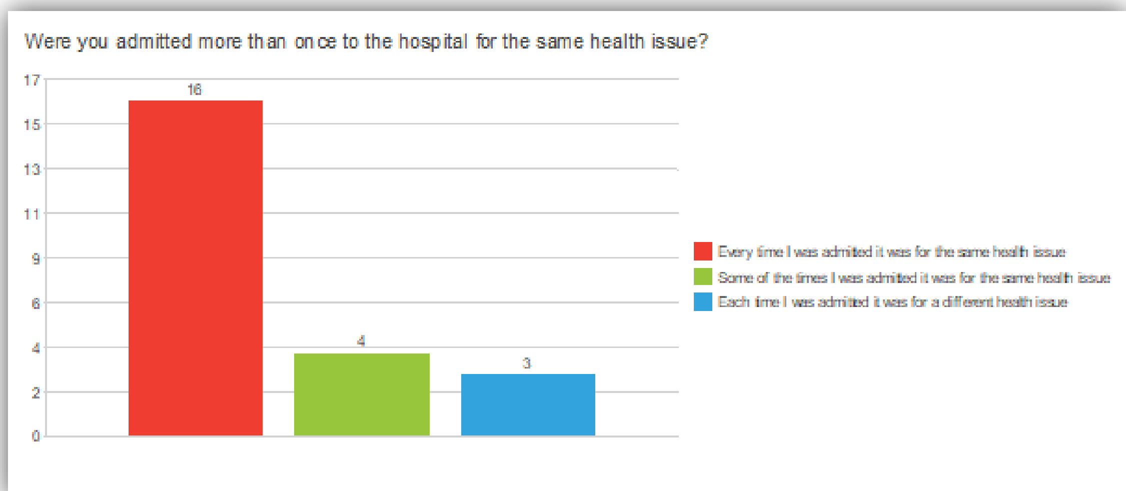
- 11 comments, 3 themes

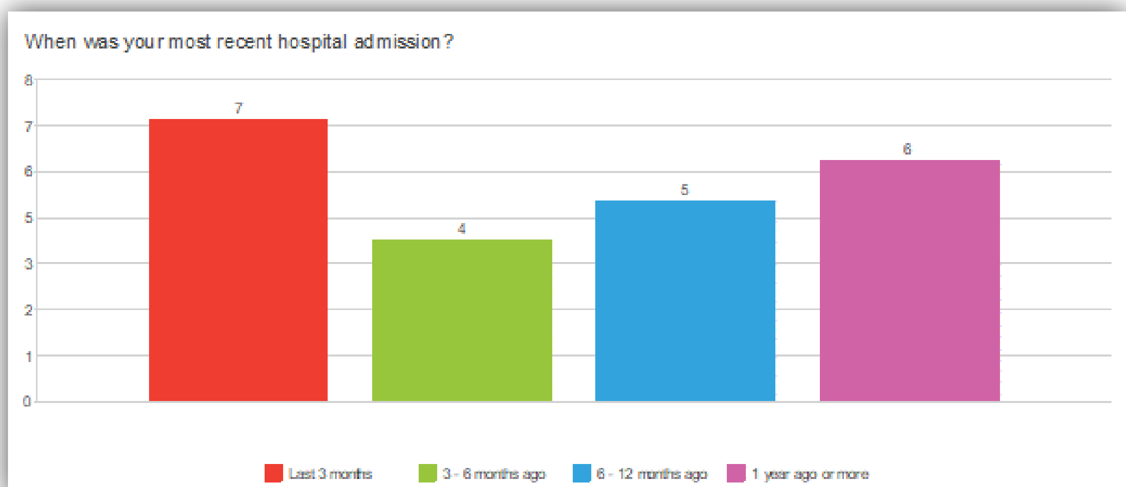
Mental health support		
Clients can get stuck between diagnosis of substance misuse and poor mental health; often being told that they can get mental health support when they have addressed their substance misuse. I understand it is hard to work with these complicating factors, but it needs to be recognised that separating them out as distinct problems make no sense as they are intrinsically combined and need addressed together.	Many of the service users feel like they were not heard at crisis, and believe they need to keep self-harming, often increasing what they are doing, to get admitted or help with their mental health.	It is nigh impossible for us to access mental health support for any of our service users struggling with mental health issues.
Discharge and Duty to Refer		
Often single vulnerably housed or homeless people have no support networks. They are in hospital alone and some support groups like day centres and charities only see them after discharge. They are often discharged without support; they have no food at home or heating and lack the means to adequately care for themselves. The hospital should be asking if individuals have organisations that they rely on and contacting the organisations to offer support before and after hospital discharge. This will help prevent readmissions.	My clients are often discharged without any transport home. This has put one client in debt, as she had no idea about buses and just ordered a taxi. Others have walked miles to get home. I think transport should be offered as a matter of course for vulnerable adults who do not live locally and have no other way to get back.	There is not the money nor the understanding currently in place to help people and treat them in the way that we should be treating them.
It would be good to know the procedure so I can advocate for the people I support.	What the duty of care is and also what can be offered / provided by the NHS or other agencies.	I would like to know the full protocol.

Staff attitude and understanding		
One thing that has shocked me is how, sometimes, homeless people are treated with no compassion, grace or understanding. Not all homeless people shout and scream the ones that do may well be scared or lost a grip of reality. The impression from staff I have got on occasion is that the treatment given is a waste of NHS time. I have known guest be in hospital overnight or couple of nights and they are not spoken to except for medical reasons. I have also witnessed kindness and compassion.	Staff can be quite judgemental when they become aware that someone is living in a homeless hostel. I have actually witnessed downright rudeness. This further deteriorates once substance issues are disclosed.	

Patient survey - 23 survey responses were received



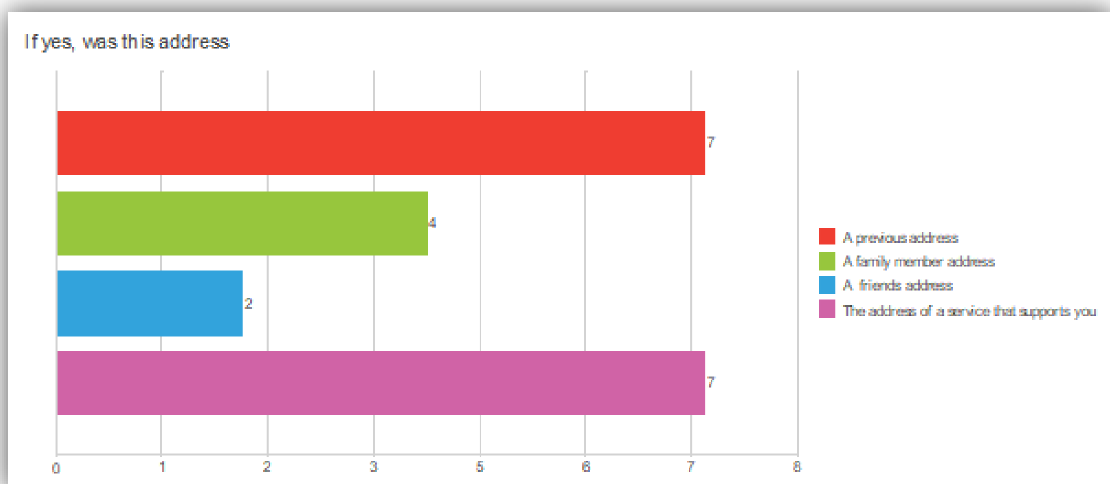


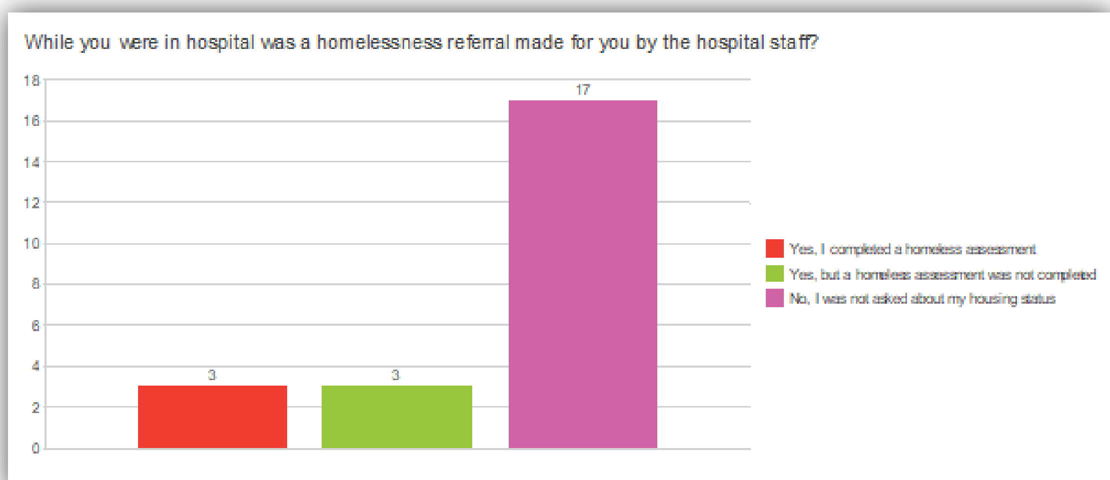


Physical health		
I had a miscarriage in December. I was there for a few hours and discharged. My partner was with me but was not allowed in the hospital so had to harm himself in order to bet into A&E because it was a freezing night and he had nowhere to go.	I was admitted to A&E as an emergency as I had fallen and broken my ankle. I was seen in A&E. I told them I was homeless, but I was told I could not stay in hospital and that there was nothing they could do for me. I was not offered any help at all and was discharged back to the streets.	The patient is my baby son who was born with a disability and was in hospital for a long-time age she was born for various problems. over 4 years he has many admissions, but the hospital has been very good with him. he has not been in for seven months now but sees other people for his disabilities.
Alright.	Its ok, better with new adult area.	Shocking.
Was in Glenfield hospital, service was good. I broke my ribs when I fell downstairs so had plates put in.	I had injured myself and needed x-rays and scans so was in for one night. They didn't want to admit me and only did because I had nowhere to go.	Ok. I was admitted for a problem with my leg and stayed in for 3 days. it was ok no real issues.
Quite good.		
Mental health		
When I was admitted for my physical pain it was ok but when I was assessed for my mental health they didn't do anything or put any support in place.	I was admitted for self-harming following an incident at the hostel I was living in having come out of prison. I was in overnight and was helped to get a place at the Falcon Centre where they have been fantastic, only been here 4 days but was ready to top myself so they have saved my life.	The services that were to support me with my mental health after I was discharged were explained to me clearly so fairly good.
My mother has been in hospital several times and gets good care in the Bradgate Centre.		

Discrimination		
I have asthma and have had a few admissions with this condition. I am a recovering addict and at the last two times I was admitted I was not allowed to have my script at the hospital, so I discharged myself. I ended up using drugs on one occasion because I left hospital too late to get my script. Hospitals in my experience don't like dealing with homeless people and treat you as if getting ill is your own fault. they want rid of you as soon as possible in case you cause trouble. it's not great, you don't really want to stay their either even if it is somewhere warm to stay. I have never stayed more than a couple of days even if I have still been feeling ill. Inclusion Healthcare treat you better because they are used to dealing with homeless people.	I have had numerous admissions over the years and some of the times I have been seriously ill and almost died. I believe that you are discriminated against by the staff when you admit to being homeless and are treated with suspicion as if you are going to steal something or take drugs or something. therefore, you don't always want to admit to being homeless. I have never been helped by anyone in respect of my housing situation whilst in hospital and have never been followed up after discharge either. I have generally been well cared for in hospital, but I do believe you are treated differently if you are homeless.	I and my long-term partner both have life limiting long term illness and don't expect to live to old age. I have been in hospital many times over the years and sometimes it has been fine and sometimes it hasn't because you are definitely treated differently if you are homeless. Nursing staff immediately think you are going to be violent or difficult and treat you like that. Even if you go to the toilet or outside for a smoke you are questioned closely as if you have been taking drugs or something. it is not good being treated like that. sometimes I have given a false address just so that they don't think you are homeless, and you get treated better and not so discriminated against.
Repeat attendance		
I was admitted via ambulance for severe stomach pain. I was seen and sent out the first 2 times and admitted after the 3rd when they suspected appendicitis I was in for 3 days after finding an infection.	I had covid symptoms but was twice sent home and the 3rd time I was kept in. I went to hospital by ambulance who said I had a critical temperature, but hospital sent me home. the hospital wouldn't keep me in saying I was well, but they couldn't find what was wrong.	

When you were admitted to hospital were you asked to provide an address?
20
1
2
0
2
4
6
8
11
13
15
17
19
21
Yes
No
Don't remember

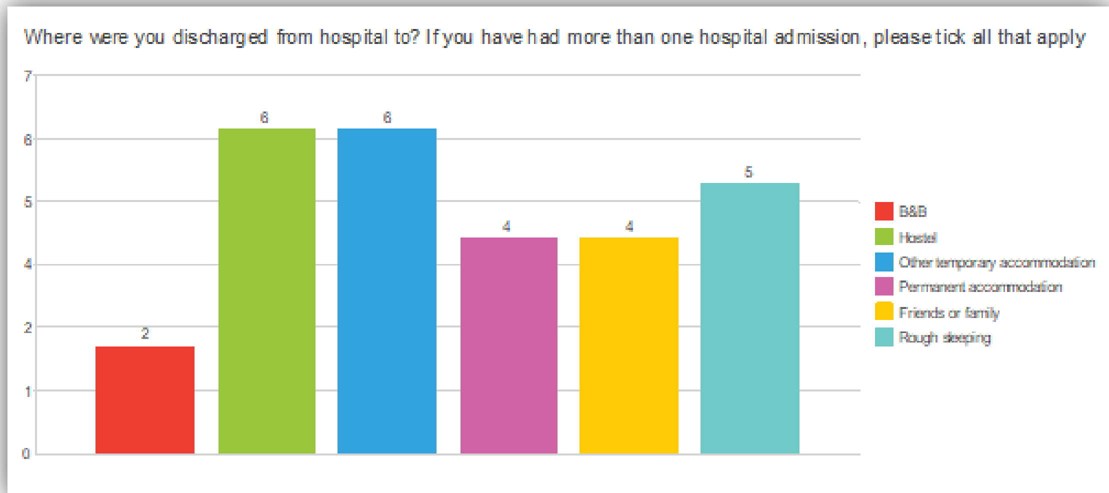

If yes, was this address
7
4
2
7
0
1
2
3
5
6
7
8
A previous address
A family member address
A friends address
The address of a service that supports you

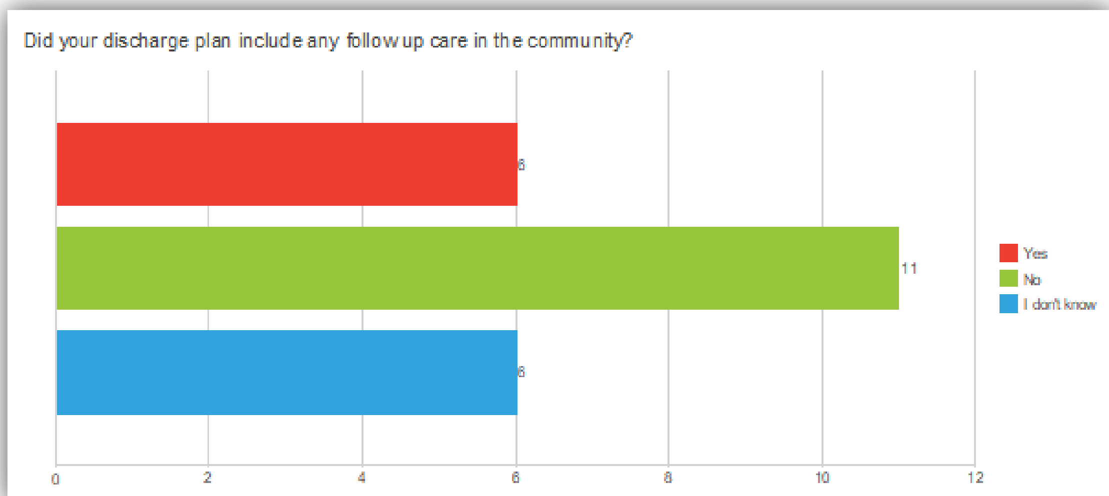

While you were in hospital was a homelessness referral made for you by the hospital staff?
18
16
14
12
10
8
6
4
2
0
3
3
17
Yes, I completed a homeless assessment
Yes, but a homeless assessment was not completed
No, I was not asked about my housing status

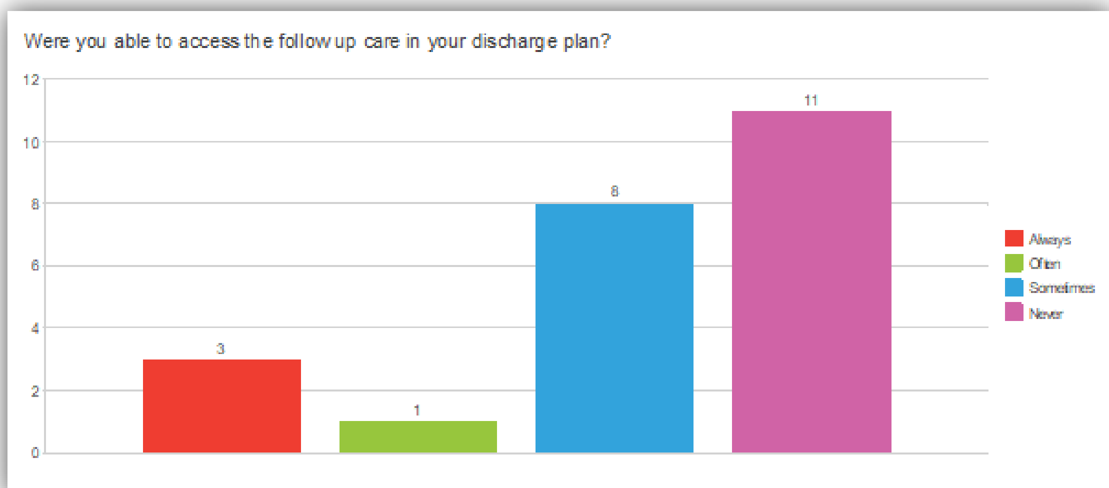
Q8. Please describe any actions that were taken to resolve your housing needs while you were in hospital. Please include any other agencies that were involved in your care or support

- 17 comments 2 themes

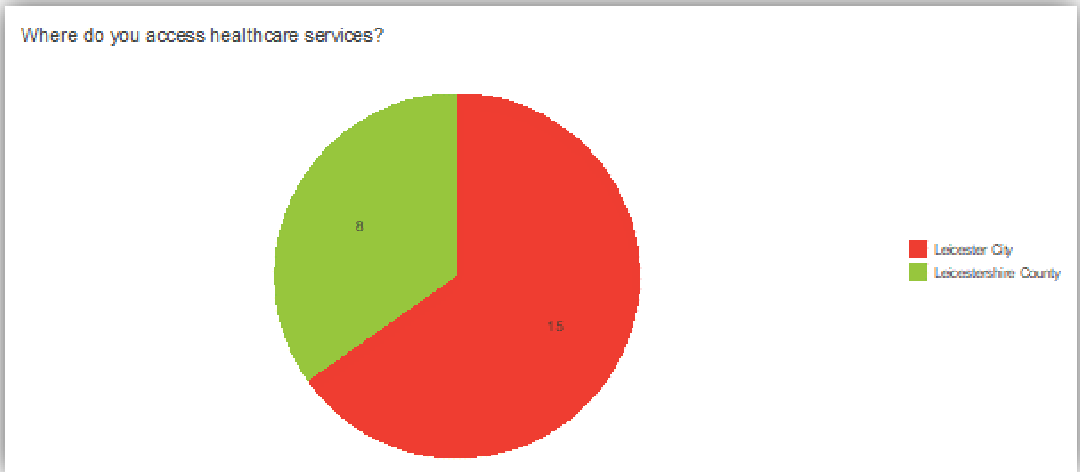
Housing needs not addressed		
My housing needs were not discussed on any occasion I have been in hospital even though I and my partner have a life limiting illness and I also have a physical disability. neither of us have ever seen anyone in hospital about our housing situation or given any help. We have been on the streets previously but are now in temporary accommodation.	None whatsoever. I was not asked about my housing status, but I gave them the information because I had nowhere to go but back to the streets. No help was offered. They clearly wanted rid of me and were quite hostile towards me, I believe because I was homeless.	I don't recall being asked about my housing. I have had a lot of problems getting housing to accept me onto the list as I didn't have a local connection, but they have finally accepted me on the list but told me I won't get a property for at least 12 months.
In all the times I have been in hospital I have never received help with my housing. the help I have now comes from Turning Point who have helped me to make housing applications and provided temporary accommodation.	None. I was not in long enough and they wanted me gone as soon as possible. I got no after care and no means of getting from Nuneaton to Hinkley so had to 'jump the train'.	They asked me my housing situation and I explained that I was living in my car but there was nothing followed up from that conversation.
This has never been addressed with me either in a ward or in A&E. I have no recollection of ever being given any support with housing.	No action taken.	None.
Not asked.	No.	Nothing.
Duty to Refer		
I was seen by someone at the hospital and as a result got offered temporary accommodation. I now have settled status and have just been allocated a flat which I should move into in a few weeks. The bridge is helping me a lot with benefits and getting furniture and I still attend here as I have support and friends.	We were given a temporary flat by social services, and we are still in it waiting for our asylum application to be settled. We don't know what will happen then, but we know we will have to move at some point.	I was discharged from hospital but told I did not meet the housing criteria as I have no local connection. However, the Exaireo Trust took me on and have provided temporary accommodation and support which has been fantastic.
One roof gave me advise for my homeless situation as I become homeless whilst in hospital. They found me accommodation.	I was not in hospital long but was referred to and accepted by the Falcon Centre so was really lucky.	

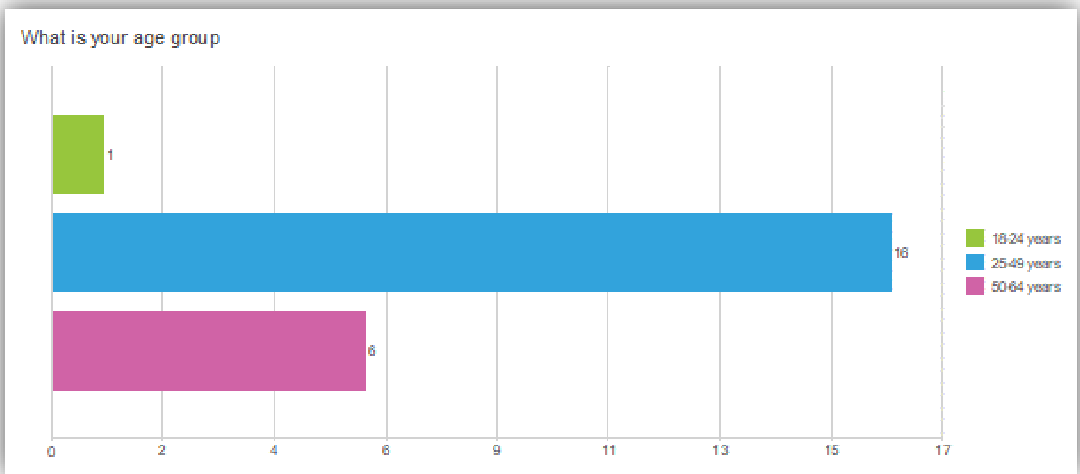

Where were you discharged from hospital to? If you have had more than one hospital admission, please tick all that apply
7
6
5
4
2
1
0
2
6
6
4
4
5
B&B
Hostel
Other temporary accommodation
Permanent accommodation
Friends or family
Rough sleeping

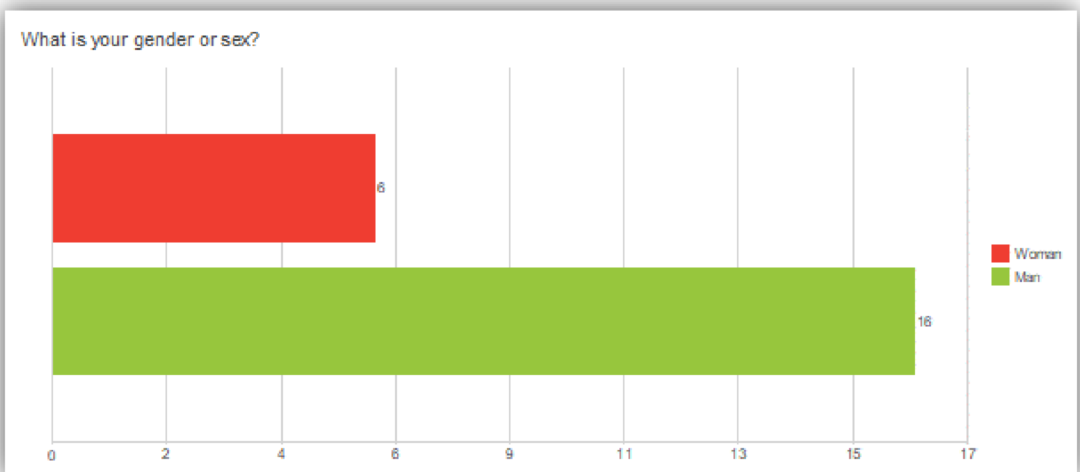

Did your discharge plan include any follow up care in the community?
6
11
6
0
2
4
6
8
10
12
Yes
No
I don't know


Were you able to access the follow up care in your discharge plan?
12
10
8
6
4
2
0
3
1
8
11
Always
Often
Sometimes
Never

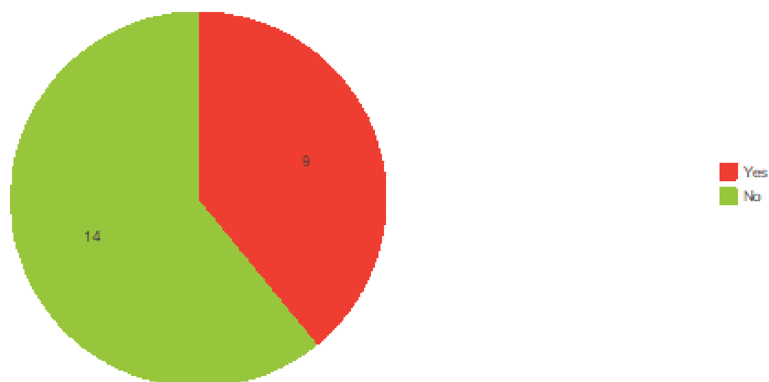
Community services		
They gave me information packs for mental health crisis numbers to ring and signposted me to the crisis cafe.	Pretty simple, they gave me a call to access another service to carry on the care of my hand.	I go to the assist practice, and they are very good. I get medication from them for my mental health.
I can access GP service through Assist Practice. the service has been very good and not difficult to access. I don't know if a letter went there about my hospital stay because no one told me.	I had a lot of help with my housing from the hospital and am very happy. I was registered with the assist practice but now am with another GP which is ok but not as good as they don't always listen to you.	I was going to the assist practice, where there are plenty of appointments but now I have signed on with a GP practice but haven't had an appointment yet.
I am now registered with a GP and have an appointment today as I have mental health problems and need medication.	I will access services at the GP practice over the road. the Staff here sort all of that out for you. They are great.	I haven't really needed it. but my GP practice is pretty good, and I can get an appointment if I need one.
I have had problems getting a GP over the years but have one now and it is working ok.	Easy to access but long wait.	Fair.
Lack of planned aftercare		
I have never to my knowledge had a discharge plan. I have been treated by Inclusion Health Care but not as a result of the hospital referring me. Care can be difficult to access because of the stigma attached to being homeless.	My follow up care is what has been instigated by me or the accommodation I have been staying in through inclusion healthcare. I now have a GP as I am in temp accommodation and that is working ok at the moment in that I can get my prescriptions ok.	I was aware of inclusion healthcare and went to them for some pain killers because the hospital would not give me any assuming I abused drugs because I was homeless. Even they will only give you certain painkillers and nothing with any opioids in them.
I did once have a nurse to dress a wound on my leg at inclusion healthcare and they were very good mostly though I have not had any follow up after being in hospital or told by the hospital that I would have any follow up.	Easier to use 111 for aftercare now as GP is too hard to get into. The only issue with this is it is all over the phone.	Shocking.
Non-existent.		


Where do you access healthcare services?
8
15
Leicester City
Leicestershire County

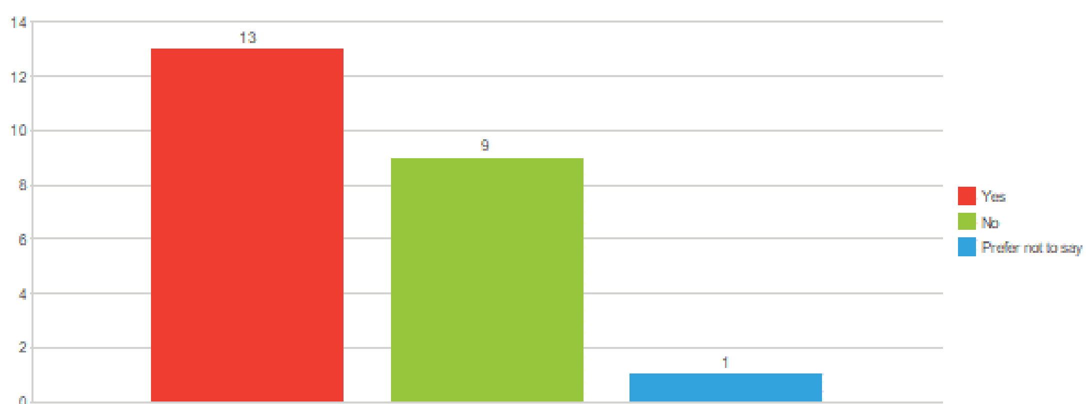

What is your age group
1
16
6
18-24 years
25-49 years
50-64 years
0
2
4
6
9
11
13
15
17


What is your gender or sex?
6
16
Woman
Man
0
2
4
6
9
11
13
15
17

Do you have a disability?



Do you have a long term condition?



PATIENT DEMOGRAPHICS

- 8 people accessed healthcare service in Leicestershire county
- 15 people accessed healthcare services in Leicester city
- 1 person did not disclose where they access healthcare services

- 6 of the people we spoke to reported themselves to be female
- 16 people reported themselves to be male
- 1 person chose not to disclose their gender

- 1 person was 18 - 24 years
- 16 people were 25-49 years
- 6 people were 50 – 64 years

- 9 people reported that they have a disability
- 14 people reported they did not have a disability

Summary

It can be seen from the feedback from both staff and patients that perceptions of both hospital care and follow up care were mixed with several themes emerging. Most respondents felt that hospital stays are negative because of the way they are viewed by hospital staff as homeless people, which they felt was reflected in the care they were given which was described by some as discriminatory. This is also supported to a large degree by the views of staff supporting them after discharge. There were very positive comments about the support given by the staff in their accommodation, but few were able to recall any discussion about or the existence of an on-going follow up care plan following discharge. A significant issue that came out of the staff survey was the lack of any involvement in discharge planning of staff who support people day to day and who have a significant role in ensuring patients can access the on-going community services they may require on discharge. This was seen as a significant gap in the planning of care of patients being discharged from hospital.

Most access to GP's was reported as positive particularly Inclusion Healthcare who most respondents spoke highly of. People who live in the Leicestershire districts were also able to access GP services and the comments were mostly positive about the experience. The main issues identified here was access to appointments for people with limited phone credit waiting in long queues to try to get through to the GP for an appointment.

Few people who responded to the survey were aware of any post discharge care plan in place so either this was not communicated to them, or they did not require ongoing support after discharge. The staff survey responses however do not really support this view with many reported on-going health issues post discharge. Again, lack of involvement of staff in their accommodation was seen as a real issue as it is them that often have to support their residents with very little information to go on.

Support with housing assessments received mixed reviews with some having received housing assessments and being helped into temporary accommodation but others reporting no help or involvement with accommodation needs whilst as an in-patient or in the ED. There was clear evidence form the survey feedback that several patients are discharged from both wards and ED without any discussion about their housing status. This conflicts with the views of the staff who work in the hospital setting who reported that more people than not are identified, assessed, and helped than those who are not. Our survey responses do not support that assertion. A conclusion that can be drawn from these findings is that communication in ways that are meaningful to this cohort of people is an area that needs to be addressed to overcome these issues.

Feedback from drop-in services – group discussions

We spoke to over 60 people attending the various drop-in services we visited both in the city and in the county. These were a mixture of men and women of mixed ages. Most attendees were either living in temporary accommodation awaiting permanent housing or had been through the process and were now settled in long term accommodation but still accessing support services for various reasons. Not all met our criteria to complete the survey but gave us feedback of their experience of accessing both accommodation and healthcare over the period of their homelessness and move into temporary accommodation.

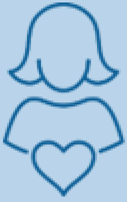
We spoke to a group of asylum seekers at a weekly support group at The Bridge. Many of them had been waiting five or more years to have their asylum claims heard. Most of the people we spoke to had accessed healthcare through the Assist Practice and were wholly complimentary about the service, in terms of access and quality of provision from the healthcare staff. Most had no problems accessing the service, appointments etc., had good comments about the quality of staff and the hands-on care they received. Many of this group we spoke to had experienced issues with mental health triggered by the traumatic experiences they had suffered on their journey and the lack of certainty about their asylum status and length of time waiting. There were fewer positive comments in this area especially around the lack of face-to-face contact and any real therapeutic input to deal with these issues.

One woman we spoke to told us:

I live with my mother in Social Services accommodation. My mother wakes up every morning crying and has stopped leaving home. I have tried contacting the GP but can't make them understand how bad it is and how my mother's mental health has deteriorated. No one has been out to see her, and the GP has prescribed different tablets that have made no difference but still no-one comes to see her. It is affecting my mental health seeing my mother in such a depressed state and not being able to help her. It doesn't help that my English is limited and there is no-one to translate day to day.

Similarly, a male attendee told us:

I have contacts from a Community Psychiatric Nurse and a Psychiatrist, but I have never seen them in person, so I find it very difficult to really talk about how I am feeling because I can't see their face, so it makes me feel uncomfortable. I really think they should allow some face-to-face meetings now; I think I would be much better if I could actually see someone in person.



We spoke to four women who had all used the maternity services, and all were very positive about their experience.

One told us:

My son was born with multiple health problems and learning difficulties. The hospital was excellent and the team there helped me with my housing application and getting the right services for my son to support us when he left hospital. Thanks to the help I received, I am about to move into my first permanent flat and my son has access to additional support at his nursery. I cannot fault the help I have received.

We also spoke to a group of people recovering from addictions who had less than positive experiences both with hospital admissions and with dealing with housing authorities,

One recovering addict told us:

There is a stigma attached to being homeless and how you are looked on by the staff. They won't give you painkillers as they think you are going to misuse them or sell them. It is sometimes so bad that it is better not to admit that you are homeless, that way you are less discriminated against."

"It is very difficult to get on the housing list if you have a drug or alcohol problem as it is assumed you are not going to pay your rent or cause trouble in the neighborhood by having other addicts' round to the house. It takes a long time to convince them that you have turned your life around and give you another chance particularly if you have had rent arrears in the past.

One of the main issues that came up through our group discussions was around the lack of access to dentistry and a lack of awareness about how to access emergency dentistry. Again, there was a perception amongst both homeless people and staff that there was a discriminatory element to this, and that access was denied due to their homelessness and negative perception of them as people.

One man told us:

I have been in agony with my teeth and have tried every dentist in the area but told they are not taking on new patients. All I have been able to do is take painkillers but getting them is difficult because of my problems with addictions in the past. No-one has told me about any emergency dentists available, so I am still ringing dentists each week to try to find one who is taking new patients.

On this occasion Healthwatch was able to provide information on where emergency dentists could be accessed in the city. Overall, there were far more positive comments about services received in primary care and less positive comments about care received as an in-patient. Very few people could recall having any conversation with staff about their housing situation or being asked if they wanted to be referred to the housing authorities for an assessment.

There are examples of people being discharged back to the street, that have fallen through the net for one reason, or another given the support offered by the HHET and the Homeless Outreach Team. There may be several explanations for this, for example, the time lapse between in-patient episode and recall of the experience. People being perceived as not cooperating may be another factor and lack of recall due to other issues such as addictions, mental health issues lifestyles etc.

The comments expressed however are echoed by staff working in facilities that support homeless people which adds credence to the experiences of patients and therefore should be taken seriously. There is clearly a job to be done in terms of bridging the gap between what patients and staff who work with them experience and what staff providing the service perceives.

Access to mental health services was also raised in the group discussion. Several people mentioned the difficulty of getting help with their mental health problems, some felt this was due to long waiting lists and others who had had previous involvement with the service but had been discharged spoke of still feeling vulnerable mentally but deemed to be well enough to no longer need the service. This was also supported by staff at the services.

One staff member commented on the survey:

It is nigh impossible for us to access mental health support for any of our service users struggling with mental health issues.

Several of the staff members who responded to the question about whether emergency re admissions could be avoided answered 'yes' if better mental health provision and support was available to people following discharge.

LPT provides a homeless mental health outreach service and work with the city councils outreach team to go onto the streets every week working proactively to support homeless people with complex mental health needs.

Unfortunately, despite several attempts to contact the service by email to talk to someone about the service offered, we received no response to our contacts and so were unable to follow up to find out more about the work they do.

Conclusions

Leicester City Council and Leicestershire District Councils have an extensive range of services to support homeless people across the city and county. The services are underpinned by the Leicester City Homeless and Rough Sleeper Strategy and the Leicestershire Housing Services Partnership.

There is an array of services and support for homeless people from hostel accommodation, B&Bs to drop-ins, outreach support to rough sleepers, day services, activity groups, tenancy support etc. We were informed on several occasions that no homeless person in Leicester and Leicestershire should need to be on the streets without appropriate support if they want to access it.

In theory our finding supports this assertion and there is good evidence of excellent collaborative working in all sectors. In addition, these services are enhanced by some excellent healthcare services such and Inclusion Healthcare, The Assist Practice and some good and supportive GP services in the districts that support homeless people to a good standard according to the feedback.

All areas have robust processes in place for referrals to be made under the HRA and arrangements are in place for assessments to take place whilst people are in-patients. The majority of HRA referrals for people in hospital are made through the HHET (Hospital based housing options and housing support workers) and in the main the assessment under the HRA is undertaken by this team.

The view of the team and the patient flow lead is that the system works well in picking up and responding to referrals in a timely manner and in looking at the number of referrals made in 2021 this is supported by evidence. However, this was not wholly supported. Most patients (20/23) said they had been asked for an address but only three people remembered being seen by someone in the hospital about their housing needs.

This is contrary to information provided by the housing team which indicates a need to improve communication or information to patients about what is happening to them. Many patients cited staff attitudes and discrimination due to their homeless status as being a significant factor in the way they are treated as in-patients and this sometimes leads to them not declaring their housing status.

It was acknowledged that there are gaps in the DTR process often due to turnover of staff on hospital wards who have not received training around the Duty to Refer. This may be a contributory factor in the number of people who had not received an assessment.

A need for on-going training was identified and it does seem that the HHET would be best placed to provide this as they are 'the experts' and have a strong presence in the hospital. A rolling programme of training at intervals through the year both forward and ED staff should have a positive impact on this.

Many patients (49%) were not aware of any follow up care plan following their discharge from hospital.

Lack of communication may be a factor in this but also a lack of liaison between the hospital and Inclusion Healthcare. The current arrangements are the same as with any other patient a letter goes from the hospital to Inclusion Healthcare or other GP practice.

However, considering the issues homeless people often have with engaging with services, a more proactive approach may be required to avoid comments such as this from a staff member at homeless support service:

I have worked with people discharged from hospital, with injuries and care needs but they are released as No Further Action. I do not know why, this happens a lot, the guest only knows they have to leave is when they are told to get up and leave.

There is a need identified from our survey to improve the liaison between primary and secondary care to reduce the numbers of emergency admissions and readmissions to hospital. Homeless people often struggle to engage with services for various reasons, so additional measures need to be in place to encourage and enable them to do so.

The reinstatement of the Primary Care Plus Nurse who has a central liaison role with Inclusion Healthcare and UHL will enable patients to be tracked through their hospital stay to keep engaged with them to facilitate a smooth discharge may improve the pathway between hospital and the community for people who are homeless and known to Inclusion Healthcare and those that are not known currently.

Further, the initiative to fund a role through Leicester City Council rough sleepers' initiative, to employ a peer mentor to help people engage with secondary care and work with frequent attenders to the ED department.

Both roles if agreed could produce significant improvements in outcomes for both the hospital and the patients by providing continuity of care, and more effective discharges from hospital. This will however only apply to people in Leicester City so some similar type of improved liaison should be considered for the districts of Leicestershire.

There were other areas of service where gaps were identified.

Access to mental health services were reported as difficult both in terms of getting a mental health assessment, receiving follow up treatment, discharge processes and lack of appropriate accommodation in some areas for people discharged from the Bradgate Unit.

These were reported by patients and by staff who support them in community services. We were also made aware that delays are exacerbated by Social Services eligibility criteria which is so high as to exclude many people who need it from accessing social work support to help them to live in independent accommodation and maintain a tenancy.

A lack of specialist supported housing was identified as a significant issue in the more rural districts of the county and a more collaborative approach with other districts is one way that could be considered to address this issue. However, it was not thought that this was likely to happen any time soon due to the complexities of the political landscape.

There was no doubt that the professionals we spoke to whilst undertaking this project are passionate, dedicated and committed to providing excellent services to homeless people and we would like to acknowledge and highlight the excellent work that they do to make the lives of homeless people in Leicester and Leicestershire better.

The quality of the services we saw and spoke to was demonstrable as was the range and breadth of services available. There is a lot of excellent work happening to support homeless people through hospital discharge and community healthcare, so it is a shame that this is not reflected better in the survey responses. This highlights a need for professionals to regularly review what they are doing and whether what they think they are doing is reflected in the experience of the people on the receiving end. The evidence from people with lived experience indicates that there are gaps, at least in perception in the services available and those received. There was a mix of experiences.

Some people felt judged or stereotyped by healthcare practitioners and this was seen as a barrier in receiving the service that they should have access to. This can be accounted for to some degree by people's memories, and lifestyles but the themes that emerged in the feedback are too common to be wholly explained in this way and were backed up by staff who support them in their day to day lives.

It is acknowledged that when working with people who are homeless, it is at a time when they are at a very low point in their lives where their lifestyle may be chaotic, other influences such as drug or alcohol addiction colour their perception of their experience. In this project though many of these perceptions were supported by the staff who have day to day contact with them. There is enough evidence in the feedback to argue that improvements can and need to be made, whether this is in systems, processes, procedures or communication to make the experiences of homeless patients more positive ones, and some of the very positive work that is happening predominant over the more negative views that currently exist.

Communication, particularly with patients about what is happening to them and involving them as much as possible in the process of assessment and follow up may help to bridge the gap. This may involve looking at the way information is communicated to and with them, finding ways in which patients can feel empowered to be involved in the planning and follow up after their stay in hospital, and to be given information that they can share with the people who support them if they struggle, through their circumstances to fully understand what happening and what the plan is on-going. Involving the people who have day to day involvement in supporting people in their accommodation should be central to this and may also be a way of ensuring that patients discharged either to temporary accommodation or the streets are actively supported to access the ongoing care and support they need.

Recommendations

1

That Duty to Refer procedures at Leicester Royal Infirmary, Leicester General Hospital and The Bradgate Centre are reviewed regularly to ensure that they are still 'fit for purpose' and ensure that there are written procedures that all staff have access to so that they can fulfil their duty effectively.

Action: HETT Leader, Head of Patient Flow and Frequent Flyer Nurse to schedule a meeting to review processes and procedures.

2

That regular training of the Duty to Refer legislation takes place at regular intervals for new staff working on relevant hospital wards to ensure that they are aware of their responsibilities under the Homeless Reduction Act 2017. This could be undertaken by the HHET who are the experts in this area. Training should also include anti discriminatory practice and unconscious bias that can adversely affect how homeless people are treated within the medical system. Homeless patients must feel reassured that they are not stigmatised for their homeless status.

Action: HHET and UHL lead on training to meet to plan a schedule of on-going training for new staff at regular intervals.

3

More partnership working between secondary and primary care and better MDT discharge planning for homeless people when care is transferred from hospital to community services, by utilising the roles of Primary Care Plus Nurse and Peer Mentor in Inclusion Healthcare to make the connections between hospital and community care and ensure that those needing aftercare will receive it in a timely manner.

Action: Secondary care identified leads to review procedures for MDT discharge planning to include Inclusion Health Care and other appropriate people involved with the patient following discharge.

4

Procedures are reviewed to ensure that homeless patients are listened to and involved in the decisions that affect them. This may include considering how and when information is provided and communicated to people and whether, with permission information can be shared with staff supporting patients at their accommodation so that they can be supported to access any on-going care they might need.

Action: Patients given information in accessible form about plans for their on-going care. Where appropriate, procedure in place to involve staff who will be supporting the patient in their accommodation after discharge.

5

Improving access to mental health services for patients with on-going mental health care needs after discharge to ensure that their mental health does not deteriorate through lack of care.

Action: Mental Health service leads to review the processes and procedures for supporting people post discharge including liaison with staff who support patients and housing authorities to determine if discharge from mental health services is appropriate at that time. Also consider ways in which help, and advice can be sought in a time of crisis.

6

To review procedures for referral of patients in mental health facilities under DTR to housing authorities in a timely manner to give the best possible opportunity of planning their housing and support needs in good time before the discharge date.

Action: HHET and Staff at Bradgate Unit to review procedure and to consider earlier involvement of key housing and social services staff to give best possible opportunity for a successful discharge to accommodation to be made.

7

Housing and Local Authorities to look at opportunities for collaborative working with the private/ voluntary sector to provide appropriate halfway/ semi-independent accommodation for people being discharged from mental health units with on-going care and support needs to prevent homelessness due to lack of provision.

Action: Homelessness housing leads to raise this through existing mechanisms and through joint working protocols to see if there are opportunities to address this issue within the statutory/ voluntary/ private sector to meet the needs of people who need supported housing before moving on to independent accommodation.

8

Review communication methods with patients to ensure that information provided is accessible and easy to understand to avoid inaccurate perceptions which feed the cycle of negativity.

Action: All service providers to review communication methods with patients and seek ways in which these can be improved that will lead to patients feeling involved and empowered.

Acknowledgements

Healthwatch Leicester and Healthwatch Leicestershire would like to thank the following people, agencies and organisations for all the help given in undertaking this project and for taking the time to speak to us and provide us with information and access to people and groups which we hope is reflected accurately throughout this report.

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Kyle Richardson - Hospital, Housing and Enablement Team Leader

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Sarah Styles- Chief Executive Officer, Inclusion Healthcare

Helen Payne – Frequent Attender Nurse, Leicester Partnership NHS Trust

Damien Barrow - Outreach Team Homelessness Prevention and Support, Leicester City Council

Rebecca Pawley – Leicester's Homelessness Charter

The Bridge - Homelessness to Hope Leicester

The Falcon Centre - Falcon Support Services

The Exaireo Trust – Housing for the Homeless Loughborough

The Stairway Project - Dear Albert Leicester

Thank you to all the staff and residents who spoke to us and completed our surveys.

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