North Somerset Council

REPORT TO THE ADULT SERVICES AND HOUSING POLICY AND SCRUTINY PANEL

DATE OF MEETING: 6TH MARCH 2015

SUBJECT OF REPORT: HOSPITAL DISCHARGE - HOMELESS PEOPLE

TOWN OR PARISH: DISTRICT WIDE

OFFICER/MEMBER PRESENTING: MARK HUGHES

KEY DECISION: NO

RECOMMENDATIONS

That the Panel consider and comment on the information provided regarding the arrangements for discharging homeless people from hospital.

1. SUMMARY OF REPORT

At the ASSH Panel meeting of 21 November 2014 a Health Watch report concerning homeless people was discussed. The report summarised research undertaken into the experiences of homeless/vulnerable service users in Weston-Super-Mare in relation to hospital discharge from Weston General Hospital. In summary the report identified 3 key issues:

- The need to improve hospital discharge arrangements to ensure that the needs of homeless/vulnerable people are identified prior to discharge and arrangements put in place to meet those needs for example: access to accommodation and support services.

- To improve the arrangements for handling homeless/vulnerable people who present at the emergency department but do not require hospitalisation

- To improve the arrangements for provision of follow up care and/or treatment.

The Panel requested that officers look into the findings and provide a report to this meeting.

Following the ASSH Panel meeting discussions have taken place between representatives from Weston General Hospital, CCG, North Somerset Community Partnership, Adult Social Care, Housing, Supporting People, The Home from Hospital Service and Red Cross. These discussions have the highlighted services currently available for homeless people and areas for further development which are set out below:

2. POLICY

The Corporate Plan sets out a priority of "Work(ing) with communities to better meet housing needs". The Council's Housing Strategy sets out the priority outcomes and key actions for housing in North Somerset.

3. DETAILS

Service provision

A range of services are currently provided for homeless people leaving hospital to assist their discharge and provide access, either directly or through out of hours arrangements, to key services for example statutory homelessness, social care:

- **Home from Hospital (HfH)** Service provided by the Home from Hospital Partnership (lead provider – Alliance Homes). The purpose of the service is to promote timely and effective hospital discharge, to assist where possible the patient flow and to reduce the chances of readmission. During the hospital stay HfH staff engage with patients to establish if there are any social issues which may: have led to the admission, prevent discharge, result in readmission or will reduce the chances of them living independently in the future.

  Where needs are identified the HfH service works with other service providers to ensure as far as possible the identified needs are met. The service provides quarterly monitoring reports and in the most recent report included case studies to highlight homelessness and housing issues faced by patients. The monitoring report identifies the positive outcomes that the service is currently delivering for this client group.

- **Assisted Discharge Service** — the CCG commissions services at both Weston Hospital and the BRI provided by British Red Cross. The Weston Hospital service is a 12 month project that is currently being evaluated. It focuses primarily on the Emergency Department and aims to resettle and re-able patients and avoid them needing to be admitted to hospital. This includes helping to facilitate discharge from the hospital where a patient has no medical need for admission but non medical needs which are preventing a safe discharge.

  Discussions with Red Cross have identified a range of positive outcomes that the service is currently delivering for homeless service users. The team are collocated with the Admissions Prevention Team and there is an agreed referral route through to the Home from Hospital team for follow up action where a homeless person is discharged from hospital. As this service user group are often not registered with a GP there is close liaison with the Community Outreach Practitioner Service. The service provides quarterly monitoring reports and in the most recent report included statistics identifying work with referrals that have addiction, mental ill-health and homelessness issues and the positive outcomes achieved.

- **Aftercare - Community Outreach Practitioner Service** – this service is commissioned by the CCG and provided through the Community Partnership. The aims of the service are to provide immediate clinical support to people who have

been identified as not registered with a GP practice and who experience long standing health issues as a result of their lifestyle (which may include being homeless) and avoid the need for these service users to visit the emergency Department. The service was introduced following the closure of a drop-in clinic located in Weston-super- Mare. The nurse practitioner is working with a range of agencies to engage with homeless people about their health needs, including through the provision of a number of drop-ins. Through this route Homeless people who have recently been discharged from hospital are able to engage with after care services. This is an important service in ensuring homeless people are able to access a GP and in arranging access to more specialised services e.g. Podiatry.

- **Health Trainers** – this service has strong links with "Somewhere To Go" and Weston Hospital and works closely with Community Outreach Practitioner Service.

Service Development

Discussions with service providers and commissioners have identified a number of areas where we can continue to improve the services provided for homeless people using hospital services as set out below:

- Training will be provided for hospital Pathway Facilitators, ward sisters and the Emergency Department matron on the services available for homeless people and how to access these services including through the Home for Hospital and Red Cross. Home for Hospital staff will provide induction training for all new student nurses and other new appointments to ensure their awareness of this service.

- Improved links will be developed between the statutory homelessness, Home from Hospital, Red Cross and community based services.

- The Community Outreach Practitioner Service will be linked in with new and existing services being commissioned for rough sleepers through Strategic Housing (HomeChoice and Housing Advice Service) in partnership with Bristol City Council. These services are being funded through the successful bid (£250,000) by North Somerset, Bristol and BANES to the DCLG to enable services to be developed for single homeless people and rough sleepers.

- Senior Nurses who provide mentoring will promote the Home from Hospital service.

- A guide for rough sleepers is being developed and will be distributed to partners

4. CONSULTATION

The information in this report has been provided following consultation with service providers and commissioners. Each of the service providers has a range of arrangements in place to engage with service users.

5. FINANCIAL IMPLICATIONS

Improving the arrangements for hospital discharge will reduce pressures on Weston General Hospital. Some of the service developments identified in the report will be funded through NS/BCC/BANES joint single homelessness rough sleeping funding obtained through the DCLG.

6. RISK MANAGEMENT

There is a risk if hospital discharge arrangements for homeless people are not improved that discharge times will increase and there will be increased presentations to both health and homelessness services.

7. EQUALITY IMPLICATIONS

Continued partnership working will help ensure that the health and housing needs for this vulnerable group are met.

8. CORPORATE IMPLICATIONS

The provision of services for homeless people supports the delivery of the Councils Housing Strategy and Corporate Plan.

9. OPTIONS CONSIDERED

Not applicable

AUTHOR

Mark Hughes Head of Strategic Housing

BACKGROUND PAPERS

Health Watch North Somerset Report – Special enquiry on hospital discharge July 2014