North Somerset Council

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REPORT TO THE DISCHARGE OF HOMELESS PEOPLE FROM HOSPITAL (ASSH) WORKING GROUP

SUBJECT OF REPORT:

This report highlights the response to the recommendations made by the Homeless People from Hospital Working Group.

RECOMMENDATIONS

1. There was a need to embed the homeless pathway via training and awareness building, focussing on the two principal gateways: admissions/wards and the emergency department, and that particular attention needed to inform locum and agency staff

2. The homelessness pathway needs to be triggered at the earliest possible point to allow sufficient time for Home for Hospital to undertake assessments and make referrals to appropriate agencies and thereby ensure sustainable discharge

3. There was a need, therefore, for a review of the recording of homelessness in the hospital admissions gateway. This should include the sharing with the working group of discharge data showing the numbers of patients registered without registered GPs or places of abode and the numbers of 'frequent flyers'; and

4. There was a need to consider extending the Red Cross contract to include homeless support in order to provide and improved service at the Emergency Department (A&E) gateway.

1. SUMMARY OF REPORT

1(a). **Embedding the homeless pathway through training**

North Somerset now has an Integrated Discharge Team, which consists of North Somerset Community Partnership, North Somerset Council, Weston Area Health Trust and links well with Mental Health (Avon Wiltshire Partnership). The Integrated Discharge Team is the concept of a group of professionals from both Social Care and Health who are co-located within the Hospital and collaboratively work together to ensure the safe and timely discharge of patients. The Integrated Discharge Team is the first place for escalation of any barriers to effective patient flow. The team will

enable face to face discussion of barriers and blocks to flow between organisations on a daily basis

The Integrated Discharge Team provide a service where the main aims are

1. That Discharge Planning begins at the point of admission.

2. To provide ward staff with support, advice and training regarding discharge planning of both simple and complex patient discharges.

3. To work collaboratively with community agencies such as Intermediate Care, Continuing Health Care, Therapists, Social Services and Community Clinical Leaders to ensure those patients' needs have been correctly assessed and are appropriately met on discharge.

4. To ensure the development of existing discharge services and transfer of care into community settings by developing key relationships with Mental Health, Alcohol Liaison Nurses, Nursing and Residential Homes and Community Nursing and Therapy Services.

5. To provide all groups of staff with education and training with regard to discharge planning.

6. To develop and produce discharge information and literature for our patients regarding the discharge process to assist them and prevent delays in their discharge.

7. The assessment of complex patients' including patients with social care needs such as homelessness, prior to discharge.

2(a). **Home from Hospital**

The Integrated Discharge team work closely with Supporting People services who help people with a range of different issues, including helping to plan and budget, help to avoid becoming homeless or looking for new accommodation, help to access and engage with other key services such as health, education, social services and help to improve independent living skills.

The aim of all Supporting People services is to help people to be able to build their skills and confidence in order that they can, as much as possible, to live independently in the community in independent accommodation. Supporting People is a working partnership of local government, service users, health, probation and support agencies, it involves a system of planning, monitoring and funding for housing-related support services.

3(a).**Hospital Admissions Gateway**

We have since subsequently looked at our systems and record the number of admissions from no fixed abode into hospital

4(a). **Expanding the Red Cross Service**

The service provides an assisted discharge from A&E service to resettle and re-able patients and avoid them being admitted into hospital. However the Red Cross can- not provide a service to patients that do not have an address to discharge to:

The objectives of the service is to

- Facilitate the smooth transition of patients from hospital to home
- Support people for up to two days following discharge from A&E
- Help prevent readmission to hospital due to inadequate support at home
- Communicating with neighbours and relatives about the patients discharge
- Provide emotional support and companionship
- Remind individuals to take their medication on time if appropriate
- Monitor patient's wellbeing and highlight suitable health professionals of any change in condition.

The type and range of services that the Red Cross can offer consists of the following:

- Transporting the patient home where required
- Making a short risk assessment (including fires and falls)
- Low dependency support of a practical and supportive nature
- Practical help may include: shopping, collecting prescriptions, preparing a meal and providing general support in the home
- Offering companionship and emotional support to both users and carers
- Follow up telephone calls the following day and further home visit if necessary to ensure patient is safe and well
- Offer advice on other organisations and services which may help both users and carers in gaining ongoing support.
- A typical level of support would be, 2 hours resettlement and a follow up phone call the next day. Although each case will vary.

2. POLICY

This response is in light of the report of the discharge of homeless people from hospital (ASSH) working group.

3. DETAILS

This report responds to a national Health watch investigation into hospital discharge, Healthwatch North Somerset published a special enquiry focussing on the experience of homeless and vulnerably housed users of hospital services. This 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 ASSH Panel considered these findings alongside service improvements proposed by service providers and commissioners at its meeting on 6th March 2015.

4. EQUALITY IMPLICATIONS

The purpose of the report is to respond to individuals, who are not registered to a GP due to nature of lifestyle ie homeless or of no fixed abode.

AUTHOR

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BACKGROUND PAPERS

Discharge WG findings report V2.doc