

# **Hastings Homeless Service**

**Conquest Hospital  
partnership development  
pilot project:**

**July 2008 – August 2009**

**Improving access to health care and support for  
homeless and vulnerably housed people.**

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## Introduction

In July 2008 St John Ambulance Homeless Service (SJAHS) received funding for one year from Hastings and Rother Primary Care Trust via the Seaview Project, with the broad remit of providing a service to homeless and vulnerably housed (HVH) clients who were not accessing the SJAHS based at Seaview's premises at Southwater Road, St Leonards-on-Sea.

Having carried out a revised needs assessment of local services, it was agreed that this funding would be deployed for the development of the Homeless Service's then newly formed partnership with the Conquest Hospital, in order to improve the discharge and follow up care and support of HVH patients leaving hospital, whether from A&E, the wards or Woodlands, the mental health unit.

It was agreed that information on clients and the service provided would be compiled in a report into the needs of homeless people leaving hospital in Hastings, with the aim that the findings would: a) inform future local service provision and b) provide valuable information and principles to homeless services working in other areas of the country. This report details those findings.

## Homelessness, health and hospital discharge

Homeless people are known to have rates of ill health several times higher than the general population, have lower life expectancy (Crisis, 1996), are 40 times more likely not to be registered with a GP and are four times more likely to use A&E (Crisis, 2002).

The problems associated with homelessness and hospital admission and discharge are outlined in a recent article by Tansley and Gray (2009). They report that homeless people's multiple health and other needs are often not fully addressed, leading to hospital readmissions, lengthy hospital stays, self discharges, and failure to find appropriate accommodation.

National guidance on homelessness and hospital admission and discharge concludes, 'Most homeless people....have poorer health than the general population. People living in temporary or insecure accommodation have difficulty accessing primary care which means that they often do not seek treatment until the problem is at an advanced stage. Once admitted to hospital, they can present a complex medical and social picture' (Department of Communities and Local Government et al, 2006). The guidance states that homeless people often self discharge due to sometimes unrecognised mental health or substance misuse problems, or anxiety about losing insecure accommodation.

## St John Ambulance Homeless Service Hastings (SJAHS)



**SJAHS treatment-room at Seaview Project day-centre**

SJAHS delivers a nurse led drop-in clinic at the Seaview Project day centre to provide advice and treatment for health care issues, independent nurse prescribing for minor ailments and a podiatrist for treatment of foot problems. The service also offers advice and support, provided by a team of volunteers, and can help clients to access mainstream health and housing services. The Seaview Project is a day centre in St Leonards-on-Sea for local vulnerable people.

The St John Ambulance Homeless Service mission statement is as follows: *'The Homeless Service aims to deliver a high quality primary health care and first aid service to homeless and vulnerably housed people, by providing a nurse-led, client focused, health, educational, informative and practical outreach service'.*

## The pilot project

A 14 month trial (July 2008 – August 2009) of a healthcare, support and advocacy service was carried out for patients who are about to be discharged from hospital, and who are:

- in need of ongoing health care
- but who have difficulties in accessing services due to homelessness or inadequate housing
- may not be registered with a GP
- and who fall outside existing SJA Homeless Service provision.

The aim of this pilot was to address inequalities in health care provision by improving appropriate access to health care services for homeless people and those in temporary accommodation, and to prevent the problems associated with the admission of homeless people as described above by Tansley and Gray (2009).

The partnership project with the Conquest Hospital is referred to throughout the rest of this report as the 'pilot project' or simply 'pilot' or 'project'.

Information on clients using the service has been collected, collated and analysed in order to report on and make recommendations for future service delivery. Zoe Redman was employed as Assistant Co-ordinator for one year from the end of October 2008 to take this pilot project forward and compile the findings.

The work of the project detailed in this report, with homeless patients in the Conquest Hospital, formed part of the overall Homeless Service, working closely with the Conquest and other agencies, as well as the patients/clients themselves, in order to assess their needs prior to discharge and plan how best to meet these needs. This involved advocacy, referral to other agencies, accompanying the clients to appointments and general support.

Once the service was established, the assistant co-ordinator (who was employed for 16 hours per week) received referrals from the Conquest Hospital by telephone and visited clients in hospital before discharge in order to establish their needs and whether the pilot project could offer a service. Once the assistant co-ordinator had full details of the clients health needs she was then able to assess the clients' other needs and tailor the service offered by the pilot project accordingly. The service provided included accompanying clients to the housing office in order to make an application for housing, referring to other agencies, for example substance misuse services, ensuring clients attended follow up appointments with their GP.

The pilot project also provided discharge packs for homeless clients leaving hospital, which contain basic supplies including isotonic drinks, space blankets, shower gel, sunscreen and information about local services.

## Referrals

During the period July 2008 – August 2009, 28 referrals were received, shown by month in Table 1. Five of these referrals were for information purposes only.

Date	Jul 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09
Referrals	4	0	0	1	3	2	2	1	4	2	4	1	2	2

*Table 1: Numbers of referrals received from the Conquest Hospital, by month*

A more detailed record of referrals can be found in Appendices 1 and 2.

## Development of the project

One of the key factors in the successful working of the pilot project has been the development of effective working relationships with other agencies. The project has worked closely with the discharge nurses – primarily Jenny Penfold – and A&E at the Conquest Hospital, Hastings Borough Council (HBC) Housing Services and Seaview Project, in order to provide the best possible outcomes for clients, with regard to housing, social care and health care needs.

Working in conjunction with HBC Housing Services and the Conquest Hospital, the project has been involved in the development of joint working protocols, one for use by staff working in A&E and one concerning the discharge of homeless patients from the wards. These protocols aim to assist staff to identify homeless people and to adopt a referral process for homeless people to present to Hastings Borough Council and St John Ambulance. The protocols aim to provide a client-centred approach, to improve joint working between agencies and to provide accessible primary health care, support and advocacy for homeless people presenting at A&E and being discharged from the wards.

In addition to the proactive efforts of SJAHS to develop an inter-agency partnership to improve practice, this collaboration is also a direct response from statutory services to national guidance, *Hospital Admission and Discharge: People who are Homeless or Living in Temporary or Insecure Accommodation (Department of Communities and Local Government et al, 2006)*.

The aims of the guidance are to enable timely, appropriate and safe discharge, and reduce readmissions, length of hospital stays and self discharge, by guiding professionals in how to set up a local protocol. The guidance emphasises partnership working as a key element in the process, the value of which cannot be overstated. The development of the joint working protocol locally in Hastings and the outcomes of partnership working as described in the rest of this report, exemplify the kind of good practice recommended in the guidance.

## A&E patients

The development of the joint working protocol for the management of homeless people at A&E (in the Conquest Hospital) has led to the devising of a single housing assessment and referral form. This form is faxed by A&E staff to HBC Housing and SJAHS in order for these services to assess the client and offer appropriate housing and health services.

One of the aims of a single assessment/referral form is to reduce administration time for busy nursing staff, thereby promoting effective and efficient referrals to take place and helping to ensure that all homeless patients are indeed referred to both organisations.

Secondly, the joint referral form ensures that both agencies receive the same information for each patient referred and are able to work effectively together to consider solutions to housing, social and health care needs, which are often, inevitably, strongly intertwined.

By the end of the project period, the joint working protocol for A&E had been finalised and was ready for use by A&E staff.

### **Inpatients**

A joint working protocol for the discharge of inpatients from the wards has also been in the process of development by East Sussex Hospitals Trust (ESHT), Hastings Borough Council Housing Services and St John Ambulance Homeless Service. The finalisation of this document has been delayed by the identification of the need to widen the protocol to include the whole of ESHT, for example, for patients being discharged from Eastbourne District General Hospital (EDGH) as well as the Conquest Hospital.

By the end of the project period, a meeting had taken place between several agencies from both Eastbourne and Hastings, including those named above, EDGH staff and East Sussex Social Services, in order to agree the terms of the protocol, and it is hoped that this will be finalised and ready to implement by early 2010.

Meanwhile, in the absence of a joint assessment/referral form for ward patients, all referrals for homeless inpatients at the Conquest Hospital are made by Jenny Penfold, Discharge Nurse, to both HBC Housing Services and SJAHS by means of each agency's own referral pathway.

As a result of the established relationship between HBC Housing and SJAHS, in some instances a patient will be assessed jointly on the ward by staff from both services. In other cases the patient is assessed by each agency separately, either because it has been agreed that this would be more appropriate or because of logistical difficulties in arranging a joint assessment.

In both scenarios, with the patient's consent, their case is discussed by the two agencies, to enable joined up working and holistic assessment to take place. The assessment takes into account housing, social and health care needs together.

### **Other departments**

As the pilot has progressed, relationships with other departments at the Conquest Hospital, notably the Rapid Response and Assessment Team (RRATS) and social services have been established, and referrals have subsequently been received directly from these teams.

From 1 August 2009, a new discharge team has been in place at the Conquest Hospital, to work with vulnerable patients. The pilot project was invited to meet the team, as it is anticipated that referrals will be received from them in future. Information, referral forms and discharge packs have been provided to the team.

## Issues identified during the project

### Lack of referrals from A&E

One of the first issues to emerge towards the beginning of the project was the lack of referrals received from A&E. Referral forms, information about St John Ambulance Homeless Service and discharge packs had been provided to A&E, but no referrals were being received. Following a meeting with A&E's lead nurse to discuss this, it was agreed that all homeless people seen would be referred. The project also agreed to provide training to A&E staff to promote understanding of homelessness, and to raise awareness of the service and the referral process.

A training programme for A&E staff was devised and delivered to 15 staff over four monthly sessions between April and July 2009. The training was well received, although this did not immediately lead to any referrals being made. In an attempt to exclude the possibility that homeless patients were being seen but not referred to SJAHS, it was then agreed with Jenny Penfold, Discharge Nurse, that a book would be placed in reception for staff to enter details of homeless clients seen. The referrals would then be made by Jenny Penfold.

During discussions with nursing and reception staff, they reported that street homeless people are not attending A&E, or are not disclosing that they are homeless. Reception staff confirmed that they are aware of the referral process and that homeless patients had not been seen in the preceding months.

Crisis, in its study *Critical Condition (2002)*, found that homeless people are four times more likely than the general population to attend A&E. **Locally**, however, because of the established, accessible health care service provided by SJAHS for homeless people at Seaview, it seems very probable that homeless patients are rarely seen by A&E staff at the Conquest Hospital.

This observation is reinforced by the fact that for much of the period of the study there were relatively low numbers of street homeless people in the Hastings area. Discussion with Dave Lawrence, Seaview's outreach worker for rough sleepers, confirms that the number of known rough sleepers in Hastings and St Leonards fluctuates weekly, but at the end of August 2009 the number stood at 10. A number of these clients are known to SJAHS and attend the clinic at Seaview.

Following on from this work, the first referral from A&E was received in August 2009 for a client who became homeless whilst in hospital (see Findings for descriptions of homelessness).

By the end of the project period, SJAHS staff were confident that A&E staff were fully informed about the project, the wider work of SJAHS and the referral pathway to the Homeless Service and to HBC Housing Services, established within the joint working protocol.

It is anticipated that some, albeit perhaps infrequent, referrals will be received from A&E in the future for local homeless patients who do not attend Seaview or who are new to the area.

## Lost clients

At the beginning of the pilot, there was an issue with clients being lost during the referral process.

Some homeless patients were being referred to the pilot project relatively late into their admission, and were discharged before SJAHS staff had been able to visit them for a pre-discharge assessment on the ward.

Although clients discharged before being seen by project staff were signposted to Seaview, some chose not to attend and so were not seen by Seaview staff or in the SJAHS clinic at Seaview. With no address or phone number, it was not possible to gain further contact with these clients.

All referrals were faxed, and in some cases there was a delay in the faxes being picked up, with project staff being out of the office for up to two consecutive days, resulting in clients being discharged before they had been seen by the project.

To address this, the referral process was adapted, with referrals being initially made by telephone to a mobile of one of the SJAHS staff, and followed up by a faxed referral form.

In addition, discharge nurses initiate referrals as early on as possible in clients' admission.

Both of these amendments to the referral process have ensured a quicker response from the project, and all clients are now seen prior to discharge.

The pilot project stipulated that its staff will respond to referrals on the same or next working day. The discharge nurses agree a date and time for the client to be seen on the ward, and also advise the project of the client's expected discharge date.

# Findings

## 1 Housing status

Of the 28 referrals received, 16 of the clients were street homeless prior to admission, two had become homeless whilst in hospital, one was sofa-surfing and nine were vulnerably or inappropriately housed. Chart 1 shows the percentage for each of these categories.

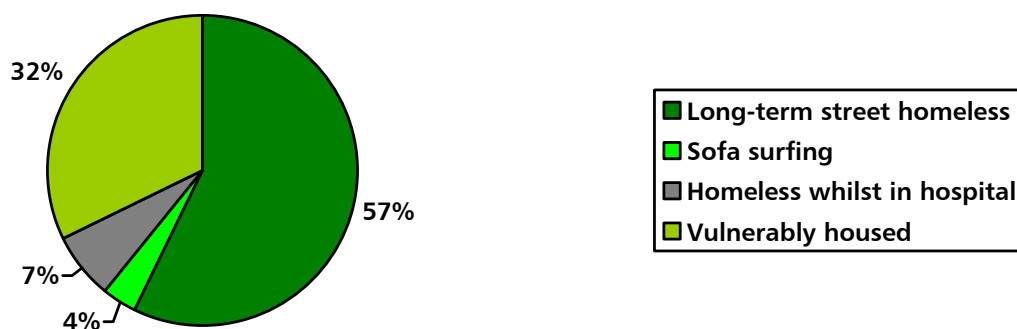


Chart 1: Housing status of clients referred

Both of the clients who had become homeless whilst in hospital were unable to return home due to family conflict. Although, in such cases, the Borough Council would not necessarily have a duty to provide accommodation, the clients in question needed intensive support and input from services, as they were particularly vulnerable and would have been street homeless without service intervention.

The issue of being intentionally homeless, that is, being assessed by HBC Housing Services as being responsible for making themselves homeless, was an issue faced by many of the clients and, significantly, every client affected by alcohol or drug misuse was assessed as being intentionally homeless (15 clients).

## 2 Age, gender and ethnicity

The age range of the clients referred is shown in Table 2.

Age	18-24	25-34	35-44	45-54	55-64	65+
Number of clients	2	2	6	9	6	3

Table 2: Age range of clients referred to pilot project

The majority of the clients referred – 19 out of 28 (68%) – were male: comparable to the ratio of male to female clients seen in the SJAHS clinic at Seaview. All the clients referred were of white British ethnicity.

### 3 Reasons for admission

There was a wide range of conditions which resulted in these clients being admitted to hospital. Details of these can be found in Appendix 1.

However, there were common themes which emerged, notably alcohol and drug misuse. It is also important to note that these clients often had multiple health issues.

Chart 2 shows the *primary* reason for admission. However, many of the clients had more than one health issue, and mental health problems- which may not have been a reason for admission- but were often a factor for these clients.

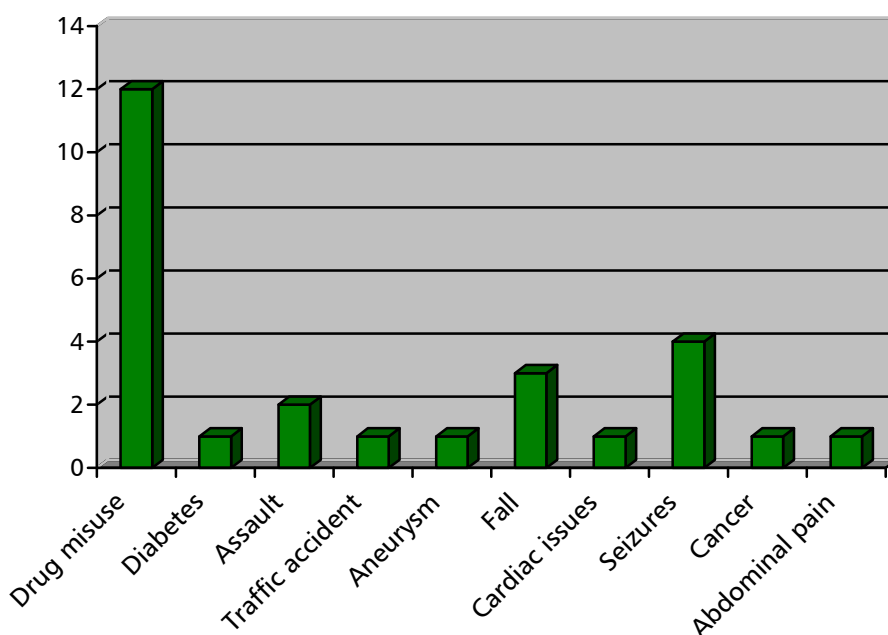


Chart 2: Primary reason for hospital admission

Five of the clients referred (18%), reported that they had been diagnosed as suffering from depression, one with bipolar disorder and one with schizophrenia.

Many other clients reported feeling depressed and anxious as a result of being homeless or vulnerably housed, and suffered from low self esteem. Many of these clients were also socially isolated and lacked the support of family and friends.

Clients affected by alcohol or drug misuse, which resulted in admission following overdose or collapse, underwent detoxification, but were also treated for resulting conditions such as liver disease or deep vein thrombosis (DVT).

Although clients were signposted to the Seaview Project and to the SJAHs clinic at Seaview for follow-up support if required, only two clients attended, both of who were already known to the Seaview Project.

#### 4 Local connection

Local connection is a term used by housing services and is one of the criteria used to assess whether the local council has a statutory housing duty towards an applicant.

Chart 3 shows the local connection status of the clients referred to the pilot project. The majority (75%) of clients had a local connection to Hastings. The two clients (7%) whose local connection was unknown, were clients that were not seen by the pilot project, but were lost in the referral process as noted previously.

Five clients (18%) did not have a local connection and this presented additional challenges when working with these clients.

There were several reasons why referrals were received for clients that were not local to Hastings, most notably being that in March this year, the Conquest Hospital had several admissions from Eastbourne District General Hospital (EDGH) when some of the wards at the EDGH were closed.

Another client had been visiting friends in Hastings and had been involved in a road traffic accident, and one client was from Bexhill-on-Sea.

For those clients without a local connection wishing to stay in Hastings, the pilot project was able to continue working with them following discharge, providing support and helping with access to statutory housing services, usually housing advice, and offering follow up healthcare.

Following discharge to Eastbourne Housing Services, one client was successfully referred to Eastbourne PCT Homeless Service, and feedback was received stating the client had engaged with that service.

The pilot project can only work with clients while they remain in Hastings, and once they return to their local area, the involvement of the pilot project ceases.

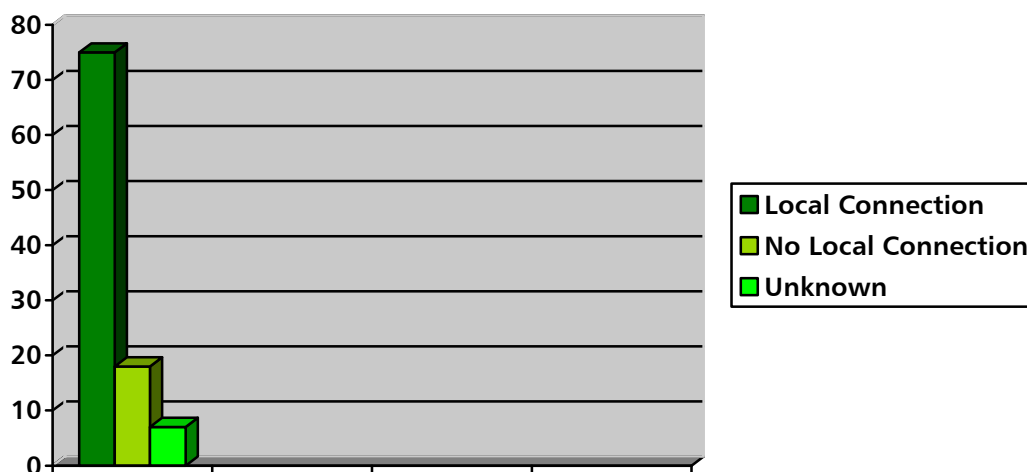


Chart 3: Local connection (%)

#### 5 Signposting to Seaview Project

All clients were signposted to Seaview by either the discharge nurses or the pilot project. Only three clients subsequently attended Seaview, two of whom were already known to both Seaview Project and SJAHs.

For those clients referred by discharge nurses and not seen by the pilot project, the reasons for not attending Seaview Project are unknown.

When signposted by the pilot project, clients often stated that they did not see themselves as being part of the homeless community; for others, day centre services were not something they wished to attend. Although this potentially limits the follow up care provided by the project, as SJAHs services are primarily delivered from within Seaview, this obstacle was overcome by offering alternative arrangements, such as meeting clients at GP appointments or HBC Housing Services for advocacy or support as appropriate.

## 6 Service provided

Clients were seen by project staff prior to hospital discharge to assess their needs and plan discharge and follow up care to be provided. This was carried out in conjunction with the discharge nurses, other agencies such as HBC Housing, social services, and the clients themselves.

Tansley and Gray (2009) assert that clients' housing status and vulnerabilities, and any key working required, should be identified at an early stage, preferably on admission. As the pilot progressed, referrals were received earlier on during a client's admission, providing all agencies involved with more opportunities to engage with the clients and complete more comprehensive assessments of their needs.

The nature of being homeless often means clients have difficulty in accessing mainstream health and social care, and the project is able to aid this process, by advocating on their behalf, attending appointments with clients at HBC Housing and referring them to other agencies (see Chart 4 for number of clients who received advocacy service).

In one instance the project helped a client register with a GP. One client was accompanied to appointments with her consultant and another was offered a blood test at the SJAHs Clinic at Seaview, (he did not attend).

In all these cases support was offered with ongoing (chronic) healthcare needs. All clients are made aware that they can access the SJAHs clinic at Seaview for ongoing health needs and support if necessary.

Although the pilot did not provide as much follow up care of *physical* health as had perhaps been anticipated at the start of the project, many clients required emotional support and mental healthcare, provided by the assistant co-ordinator, who is also a registered mental health nurse.

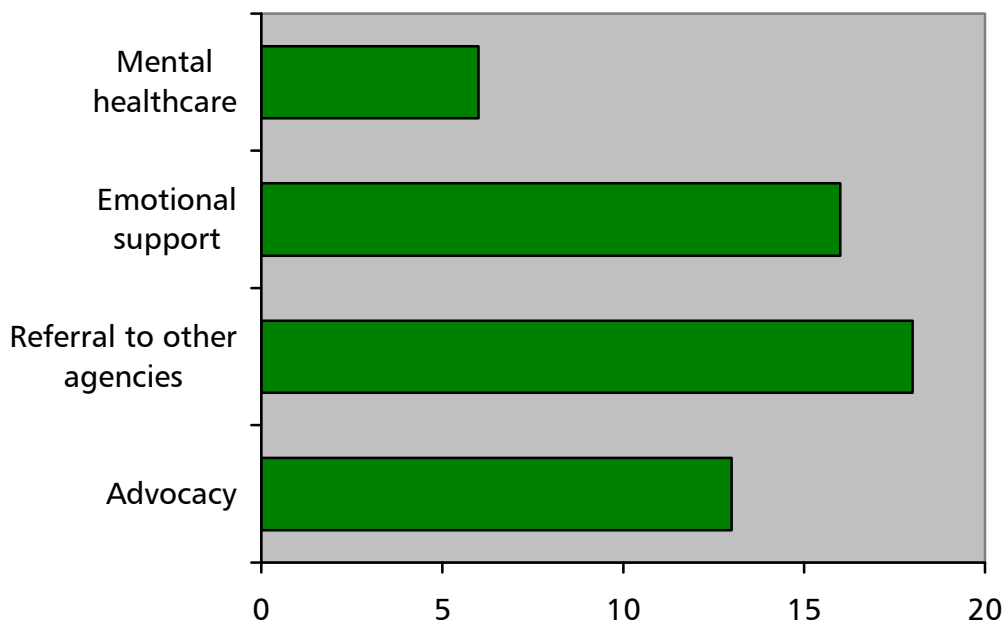
Many of the clients reported feeling depressed, anxious and stressed, and lacked self esteem and confidence. Offering a client-centred approach, by providing these clients with the opportunity to speak and express their needs and wishes, and helping them to feel empowered to make informed choices, was an important part of the healthcare process.

For many of the clients, having someone to talk to and listen to them played a vital part of the role of the project. The value of listening is often underestimated, in this context not only helping improve clients' self esteem and wellbeing, but also enabling project staff to assess the clients' own perceived wishes, needs and aspirations. This in turn enhances concordance between staff and clients, empowering clients to make reasoned choices and take control of their own lives.

The work of the project with clients being discharged from hospital is generally short term (under two weeks), although on one occasion work with the client was longer term (spanning approximately four months), in response to the particular ongoing health and housing needs of this individual. Much of the work involves joint working with other agencies, which is crucial in ensuring the clients' needs are met, as illustrated in the case studies below.

12 of the clients had been admitted with alcohol or substance misuse related issues, and these clients were signposted to Substance Misuse Service or Action for Change (a local alcohol misuse support service). One client was assisted in completing a referral form for Action for Change (however, he did not attend this service after discharge). No direct referrals were made to either agency, in accordance with clients' wishes.

Chart 4 shows the range of assistance provided by the pilot project. In most cases clients inevitably required more than one type of input from the pilot. For example, clients requiring advocacy often needed emotional support too. This is reflected in the numbers recorded on the chart.



*Chart 4: Range of assistance provided*

## Case studies

Please note: all names have been changed to protect client confidentiality in accordance with the Data Protection Act 1998.

### Study 1

Nelly, a rough sleeper well known to both Seaview and SJAHS, was admitted to the Conquest Hospital in November 2008 for surgery to remove an abscess and was subsequently diagnosed as having squamous cell carcinoma. The project staff provided emotional support as well as practical help such as the provision of clothing, courtesy of Seaview.

Following her discharge in January 2009, Nelly was accompanied by project staff to HBC Housing Office for advice and support, and was placed in B&B accommodation. In February, HBC Housing, working in conjunction with the pilot project, was able to secure Nelly long term sheltered housing. The project continued to work closely with Nelly and the housing association landlord for several months, in order to support her to maintain her tenancy.

After she moved into the sheltered accommodation, Nelly underwent cancer treatment as an in patient. With her consent project staff maintained contact with her consultant and continued to offer support and advice upon her discharge.

The project also worked with Seaview staff to access funding to furnish her flat and helped Nelly to obtain a bus pass.

Initially, when the original referral was received and Nelly was discharged, it was at times difficult to engage Nelly as she would often miss appointments and disappear for days. However, with persistence it was possible to establish a rapport with her, and help her to access other services which led to the securing of long term housing prior to the commencement of her treatment.

The pilot project worked with Nelly from the time she was admitted to hospital in November until March when her case was taken on fully by Seaview. Working with Nelly was an intensive process, particularly during January and February when she was moving into her flat, and during this time she was receiving a service from the pilot project as well as a floating support service from Seaview.

Throughout this period all the services involved continued to communicate well, which proved to be an excellent example of services working effectively together to reach the best possible outcomes for the client.

## Study 2

Paul was being discharged from the Conquest Hospital on a Friday afternoon in October 2008 following admission after collapsing, with a number of gastric and cardiac problems. He was known to the Conquest discharge team from a previous admission earlier in the year when he had been homeless. Paul had moved into a flat shortly before this current admission, however, he had no furnishings, no fridge, and had no support. It was speculated that the lack of food hygiene due to absence of a fridge may have contributed to his health crisis.

Paul was referred to the pilot project by Jenny Penfold on discharge and provided with hospital transport to the SJAHS clinic at the Seaview Project, where staff met him and assessed his needs.

This 48-year-old man had been experiencing depression, alcohol misuse and significant, associated medical conditions.

The project team liaised with Seaview staff, who – on the same afternoon – helped Paul to follow up an outstanding grant application and to apply for a furniture grant.

Paul also joined Seaview's volunteer scheme and started working in the kitchen at Seaview that Monday.

When Paul's case was reviewed by the project team two weeks later, his self esteem and mood had significantly lifted, he was clearly enjoying working in Seaview's kitchen four days a week, and his alcohol intake had reduced to a minimum. His relationship with his partner had been restored and his flat was furnished with some essentials, including a fridge.

He was now considering applying for paid employment. Paul had also attended a cardiology outpatient appointment and was engaging with their care.

Paul was readmitted to hospital in April 2009, and was again referred to the pilot project. Although no longer homeless, his flat was now unsuitable given his health needs. A referral to HBC Housing was made by the discharge nurse. The pilot provided emotional and social support.

Following discharge, Paul moved flat and began drinking heavily again, disengaging from services. He subsequently began attending Seaview again and was awaiting a date to commence detoxification at Woodlands.

While in this case it was Seaview rather than the pilot project that provided the majority of the support needed, the project provided the link between the Conquest Hospital and Seaview Project which led to – at the time – a significant improvement in quality of life and health. Staff are hopeful that following this positive experience Paul will be able to engage with the detoxification treatment and once again experience an improvement in quality of life and health.

### Study 3

Michael was admitted to the Conquest Hospital in March 2009 following an alcohol related blackout, after collapsing on the street in Eastbourne. He had also had a deep vein thrombosis, which was treated whilst he was in hospital. He wanted to remain in Hastings rather than returning to Eastbourne, in an attempt to help him stop drinking and make a fresh start.

Jenny Penfold referred him to the project, and he was seen in hospital to discuss his options and provide him with information about local services available. While in hospital, Michael was assessed by HBC Housing, and the pilot project also discussed with the Seaview Project the possibility of housing being provided by them. Unfortunately, due to a recent reduction in the number of units of accommodation, Seaview did not have any available at that time.

During this time, Michael's family became involved in the situation, and insisted that he be housed immediately, threatening to complain to the media if he was discharged from hospital as homeless.

Michael's discharge was delayed several times but he was eventually discharged to HBC Housing where he was accompanied by project staff. Michael was assessed as not being in priority need. He advised us that he would be staying temporarily with a friend, and was signposted to various agencies for help with finding accommodation.

Michael was due to attend the SJAHS clinic at Seaview for a blood test but did not attend. He was subsequently alleged to have been seen drinking in Hastings town centre. All attempts to contact Michael were unsuccessful. He was referred to Seaview's outreach worker for rough sleepers, and will be supported by SJAHS if required in the future.

Although it appears that Michael may have returned to street drinking and is again putting his health at risk, working with Michael highlighted, on the one hand, the effective working relationships between the agencies involved and, on the other hand, the observation that clients make their own lifestyle choices which even the most effective partnership working cannot necessarily influence.

## Feedback from clients and staff

The role of the pilot project in working with homeless clients has had a positive impact on discharge outcomes and has played a part in helping to reduce the length of some clients' stay in hospital. This point was acknowledged by Beverley Thorp, Assistant Chief Nurse for East Sussex Hospitals Trust, which includes the Conquest Hospital, during a meeting with her to discuss the work of the pilot project.

Throughout the period of the pilot, feedback has been sought from both professionals and clients in order to carry out ongoing evaluation of the project, to develop and improve the service and ensure it meets both clients' needs and organisational demands.

Informal, verbal appreciation of the service provided by the pilot project has been expressed by HBC Housing Services staff, and written comments received from Jenny Penfold, Discharge Nurse. These, and verbal comments from clients which were recorded in writing by project staff, are detailed below.

### Comments from Jenny Penfold (11 May 2009):

'Every *in patient* that presents as a homeless person is reviewed and supported by you, with their consent before discharge. I can confirm that this assists with the reduction of stress for the patient and to the ward staff. It enables the discharge process to flow smoothly and helps reduce the length of stay.

In most cases you attend the housing office or meet the patient afterwards and are acting as advocates where your help is accepted. Once again there is reduction of stress for the patient and no break in care from hospital to community.

You have regularly helped set up community health care plans when there is no GP, or if a patient needs support attending the GP. This has reduced the length of stay. The feedback allows us to keep A&E informed regarding the possibility of readmission.

We follow up past cases together. If readmission occurs we continue our review together and work to improve the patient's situation. There is a good exchange of information between us.'

### Verbal feedback from clients:

Below are some comments from clients, regarding the service provided by the pilot project:

'What would people like me do without people like you?'

'Thank you for your time, and your patience. Without your help I would not have been able to get my flat.'

'It was nice to feel someone listened to me and asked what I wanted.'

'It was good to have someone to talk to, I can also come and see you at Seaview, but it would have been nice to have visits at home too'.

The feedback from Jenny Penfold highlights the importance of joint working to ensure clients receive the necessary follow up care. The client feedback shows that the service is valuable to them and the importance of advocacy to these clients.

## Analysis

### Health needs and healthcare

Follow up healthcare for ongoing *general* health issues has been offered in many cases, but has formed a relatively small part of clients' needs and of the service provided.

*Mental* health problems, while not a major primary cause for hospital admission, have been a significant, co-existing or contributory factor in the difficulties faced by clients during the pilot period. The provision of emotional/mental health support for clients, most of whom have some degree of multiple, complex needs, has played a vital role in service delivery.

Despite the low volume of direct general healthcare administered by the pilot project, health needs - both *mental* and *physical* - have in all cases been an important part of the overall, holistic assessment carried out by project staff. It is understood by those working with homeless people that there is an important, complex interplay between housing, health and social issues, all of which need integrated consideration.

In addition, some of the advocacy provided by the project has been related to clients' physical health needs, as illustrated in the case studies, and it seems likely that there will, in future, be patients referred who require direct follow up healthcare by SJAHs.

For all these reasons, it has been entirely appropriate that the project has been nurse led throughout, in order to ensure skilled communication with clients, thereby achieving an informed and comprehensive assessment of needs and effective identification of services required on an individualised basis.

Although the project's service provision has included mental health support for patients referred from general wards, no referrals were received from Woodlands, the mental health unit attached to the Conquest Hospital. Some liaison was made with Woodlands, including a positive meeting with the unit's modern matron, who welcomed the work of the pilot project. However, it was established that Woodlands has a broad multi-disciplinary team including a dedicated housing worker, and there is not therefore a need to refer homeless patients to the project. However, further liaison with Woodlands is planned for the future, in order to explore whether SJAHs may yet be able to provide a supportive role to their clients on discharge.

### Housing needs and homelessness

The housing needs of homeless and vulnerably housed patients who have been referred by the Conquest Hospital to the project during the pilot period have been varied, complex and often difficult to resolve.

Obstacles to being housed by HBC Housing Services have included lack of local connection and being assessed as intentionally homeless. As stated in the Findings section, all clients affected by alcohol/drug misuse (15 clients in all) had been assessed as being intentionally homeless. Intensive advocacy has, nevertheless, led in four cases to clients being successfully re-housed. This reflects HBC Housing Services' commitment to the government's drive to eradicate rough sleeping - 'No One Left Out' (DCLG, 2008) - and their proactive efforts, such as referrals to supported housing organisations and support with bidding on the Choice Based Letting Scheme, to achieve housing solutions for vulnerable rough sleepers with complex needs in spite of these obstacles.

Other clients from areas outside Hastings were referred back to the housing services in the area of their own local connection (in most cases Eastbourne).

In all these cases, the pilot project has highlighted the need for effective multi-agency working when dealing with clients with multiple and complex needs, including housing, as these needs cannot be met by one agency.

Furthermore, advocacy is significantly more effective in the context of established inter-agency partnership-working, as has been demonstrated by the advocacy work carried out by the pilot project, in particular when liaising with HBC Housing Office.

## **Support and advocacy**

One of the most common themes identified by the project has been the feeling of isolation and lack of social support experienced by clients and their need for access to advocacy and support. This is needed not only in order for clients to be referred to other agencies, but also for clients to talk and be heard, which in turn helps increase their self esteem and confidence in their ability to make informed choices.

A large part of the pilot project's work has filled this identified gap in services, much of which has involved liaison with statutory and other housing services to enable clients to obtain housing and in some cases to sustain tenancies in the longer term.

For many of the clients, the housing application process can appear overwhelming and confusing; the pilot project was able to provide advice and accompany clients to appointments where appropriate.

The St John Ambulance Homeless Service is well placed to offer this advocacy role, as it brings both medical understanding and mental health support to holistic assessment of needs and to service provision.

In addition, although multi-agency working is important to ensure clients receive the best possible outcomes, it is equally important that clients do not feel overwhelmed by service involvement. In offering both healthcare and advocacy together, the pilot project has provided continuity of care before and after discharge: a combination that may not be offered by another agency.

The new discharge team at the Conquest Hospital will be providing support and advice to HVH clients on the day of discharge, but this will be limited and the team will not be working with clients beyond discharge.

Similarly, Home Works- the new floating housing support provider in Hastings and Rother boroughs- may be able to work with some of the clients currently referred to the pilot project, but do not work with street homeless clients. Their remit is essentially support to sustain tenancies, rather than assistance in obtaining a tenancy in the first place, so they will only work with clients who are already housed.

If the provision of this service were discontinued, there is a risk that clients may not have their advocacy and support needs met and may fail to receive the help they need with finding adequate housing and support on discharge from hospital. This may well lead to unnecessary and costly delays in the discharge of HVH patients, blocking beds needed by other patients.

## **Flexibility**

Working with this client group can be challenging and time consuming, as clients often have multiple and complex needs. It can be difficult to establish a rapport due to clients' often chaotic lifestyles and lack of engagement.

In order to establish a beneficial relationship, it is important to offer a service which is flexible in order to meet the clients' varied needs. This flexibility involves, for example, availability for client assessments at the Conquest Hospital at short notice and for appointments at a range of agencies or venues, also often at short notice.

It is also necessary to recognise that the clients' priorities may not be their health or lack of somewhere to live, and to respect their right to make choices regarding their care. In such cases the pilot project has been able to support the client by providing information and advice, to enable them to make informed choices.

The work of the pilot project has been sometimes limited by the client themselves, who may decline care or choose not to maintain involvement with the service. The wider St John Ambulance Homeless Service remains accessible to such clients, who may choose to engage again in the future.

Staff who are experienced in working with homeless people or with those who misuse substances are best placed to understand and practice this principle of empowering clients to make their own choices.

## Conclusions and recommendations

### In summary

The referral process has evolved and improved as the pilot has progressed, to better meet the needs of clients. As a result of this, every client who agrees is seen by the project before discharge, which enables a rapport to be established, an assessment of the client's needs to be carried out, and a plan for discharge put in place which often includes input from the pilot project.

The original purpose of the pilot, to provide a healthcare and advocacy service, has adapted to meet assessed needs, focussing particularly on housing-related advocacy, advice and support, in order to fulfil wider physical, mental and social health needs.

A client-centred approach is central to this service. It was found that having someone to talk to and listen improved clients' self esteem and assisted project staff to assess clients' needs.

Working with this client group can be challenging, with issues around non-engagement, failure to attend appointments, and chaotic lifestyles. The pilot project has been flexible in its approach to working with these clients, in order to make the relationships as effective as possible and ensuring that they receive the appropriate care and support.

The effective working relationships with agencies involved in the clients' care are key to ensuring clients receive the best possible follow up care.

Feedback from staff of other agencies and from clients highlights the value of the work being carried out by the pilot project.

### What kind of service is indicated?

The joint national guidance by the Department of Communities and Local Government (DCLG), Department of Health and Homeless Link, published in 2006, for the discharge of homeless and vulnerably housed people, states that services should 'enable timely, appropriate and safe discharge, and reduce re-admissions, length of hospital stays and self discharge, by guiding professionals in setting up local protocols. Partnership working is key to this process' (DCLG et al, 2006).

The collaborative development work by SJAHs with the Conquest Hospital and Hastings Borough Council Housing Services has been an immensely successful example of this guidance in practice, effectively achieving the aims stated above.

It has been clearly identified from the pilot project's 14 months of research and development that its service provisions of emotional and mental health support, advocacy- in particular in relation to housing- and general follow up healthcare, accurately meet previous gaps in local services for homeless and vulnerably housed people when admitted to hospital.

It is also clear from the pilot that this service needs to be flexible. Any agency providing this service needs to have staff available to receive and respond to referrals at short notice, and in many instances to be able to spend protracted periods of time delivering support and advocacy for clients during their stay in hospital and after discharge.

Some referrals are received shortly prior to discharge – for example, because the clients' health needs only warrant a short admission or because they have presented to A&E and have received the treatment they need – and staff need to be able to make time available to spend with clients before or after

discharge at short notice. This may include spending an hour or more with a client at HBC Housing Services, followed by Seaview Project housing services, for example.

### **Who should provide this kind of service?**

St John Ambulance Homeless Service, with its existing role in healthcare, support and advocacy for homeless and vulnerably housed people in Hastings and St Leonards, is ideally placed to continue this work. No other local agency has been identified that would be able to meet the criteria for this service provision.

In addition, SJAHS has been fully involved in the development of the local joint working protocol for the discharge of homeless people, is committed to this collaborative work and is included as a partner agency in the protocol.

As has been stated in the Analysis section, this report recommends that the service continue to be nurse led, to enable skilled client assessments to take place that take full account of health issues and their interactions with housing and other social needs.

The Homeless Service relies on a committed team of volunteers, both nurses and generic volunteers, who assist with current Homeless Service delivery, primarily at its drop in clinics at Seaview. It is proposed that continued support to HVH hospital patients be provided by means of a small number of volunteers who would be trained specifically for the role.

However, initial assessments of clients needs to be carried out by a nurse for the reasons stated above. It would seem unlikely that volunteer nurses would have flexible time available to carry out this role, as at present all volunteer nurses with SJAHS have limited time available due to other work commitments; therefore assessments will be carried out by the Homeless Service nurse co-ordinator.

Following initial assessment of a client by the nurse co-ordinator, ongoing support and advocacy can be carried out by a trained generic volunteer, who would ideally accompany the nurse co-ordinator to the initial assessment and report back to the nurse co-ordinator with subsequent progress of the client.

With monthly numbers of referrals varying from no one to four, and being received at unpredictable times and days, it would not be practical or cost effective to employ a nurse dedicated purely for this reactive and erratic work. The Conquest Partnership service should therefore be encompassed within existing Homeless Service structures.

### **Funding**

Funding for the one year pilot project was gratefully received from Seaview Project, from a Hastings and Rother Primary Care Trust (PCT) grant, to help tackle local health inequalities. This one year period has now been completed.

Given the continued expansion of the work of St John Ambulance Homeless Service in Hastings, of which this partnership work with the Conquest Hospital and Hastings Borough Council is a significant part, and its over stretched resources of staff hours, there is a need for additional staff to be employed in the near future.

This may be in the form of administrative staff, the need for which has already been indicated within the Homeless Service, to release the nurse co-ordinator to give more time to specifically nursing work, whether with clients at Seaview or with HVH patients at the Conquest Hospital and to strategic aspects of service development.

Alternatively, further nursing staff may be indicated in future to assist with service provision across the Homeless Service.

With the current Big Lottery grant that covers the majority of SJAHS funding coming to the end of its period in February 2010, funding is required to enable all aspects of St John Ambulance Homeless Service provision to continue.

Applications are under way for various grants for the continued work of the Homeless Service, but it is especially hoped that the Homeless Service's fulfilment of a number of strategic government aims to address health inequalities locally, through all its service provision including that specified in this report, and its effective inter-agency partnerships, will be recognised by Hastings and Rother PCT commissioners, leading to the securing of further PCT funding.

### **Implications for services in other areas of the country**

The national guidance referred to above (DCLG et al, 2006) is enabling statutory and voluntary services in many areas of the country to develop effective inter-agency protocols that will improve the discharge of homeless and vulnerably housed people from hospital. Some examples of this are described in Tansley and Gray's (2009) article on ensuring safe and appropriate discharge of homeless people.

It is probable that other areas of the country have less well developed strategies in place for the discharge of HVH patients.

It is hoped that this research report will add to the growing body of guidance and good practice that can further shape existing inter-agency partnerships and particularly provide some guidance to those areas that are yet to develop effective protocols.

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