Healthy London Partnership

Health, housing and social care integration for people experiencing homelessness: needs identified in an inpatient audit

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Supported by and delivering for London's NHS, London Councils, the Office for Health Improvement and Disparities, and the Mayor of London

About Healthy London Partnership

Healthy London Partnership (HLP) formed in 2015. Our aim is to make London the healthiest global city by working with partners to improve Londoners' health and wellbeing so everyone can live healthier lives.

Our partners are many and include London's NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, the Office for Health Improvement and Disparities, and London Councils.

All our work is founded on common goals set out in Better Health for London, NHS Five Year Forward View and the Devolution Agreement.

About this document

This document is intended to be used by our partners across health, housing, social care and voluntary community and social enterprises (VCSE). The report aims to show what action can be taken as integrated care partnerships to support timely and safe discharge from hospital and improve out of hospital care (OOHC) for people experiencing homelessness in London.

Acknowledgements

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Executive summary

People experiencing homelessness and multiple disadvantage frequently die young, often from preventable and treatable conditions. They experience significant barriers to accessing health services, so regularly have unmet health and care needs, resulting in high rates of urgent and emergency care.

This report describes the findings of an audit conducted across 19 London hospitals of people experiencing homelessness who were inpatients at one point in time. It was conducted to understand and quantify the needs of people admitted as well as gaps and barriers to safe discharge from hospital.

As highlighted in recent NICE guidance, hospital admission can offer a critical opportunity to provide comprehensive needs assessments and interventions that can significantly improve health and social care access and outcomes. This requires integrated multidisciplinary health and social care services that are trauma-informed, provide person-centred care and recognise the need for often long-term wrap-around support. Considering the often-early onset of frailty and multimorbidity, NICE also highlights the need for care packages that are based on needs rather than biological age. In addition, NICE state that intermediate care should be provided for people experiencing homelessness who have healthcare needs that cannot be managed in the community but do not need inpatient care. This is particularly important considering the bed pressures that hospitals are experiencing.

Reducing inequality is a goal across health, housing and social care. To tackle inequalities, we need to improve visibility and a shared understanding of the barriers and gaps within the system. For strategic planning across sectors, NICE recommends the need for improving data collection and reporting.

The audit

In the absence of data, we undertook a snapshot audit over one week in February 2022 and investigated the health, care, support and accommodation needs of people identified as being homeless who were in hospital at that point in time. Accident and Emergency (A&E) departments were not included.

The audit is of a scale and detail that has not previously been undertaken in hospitals across London. It represents data from 15 Acute, three Mental Health and one community hospital in which there were 150 in-patients identified as being homeless at that one point in time. Homelessness for this report includes individuals not having a home, living in poor or unsafe conditions, sofa surfing, staying in a hostel, night shelter, temporary accommodation, squatting, and rough sleeping. This report focuses on an in-depth analysis of 104 of these inpatients. The depth of information gathered was only possible due to hospital and ‘out of hospital’ inclusion health teams. These specialist teams are often multidisciplinary and aim to support people who are socially

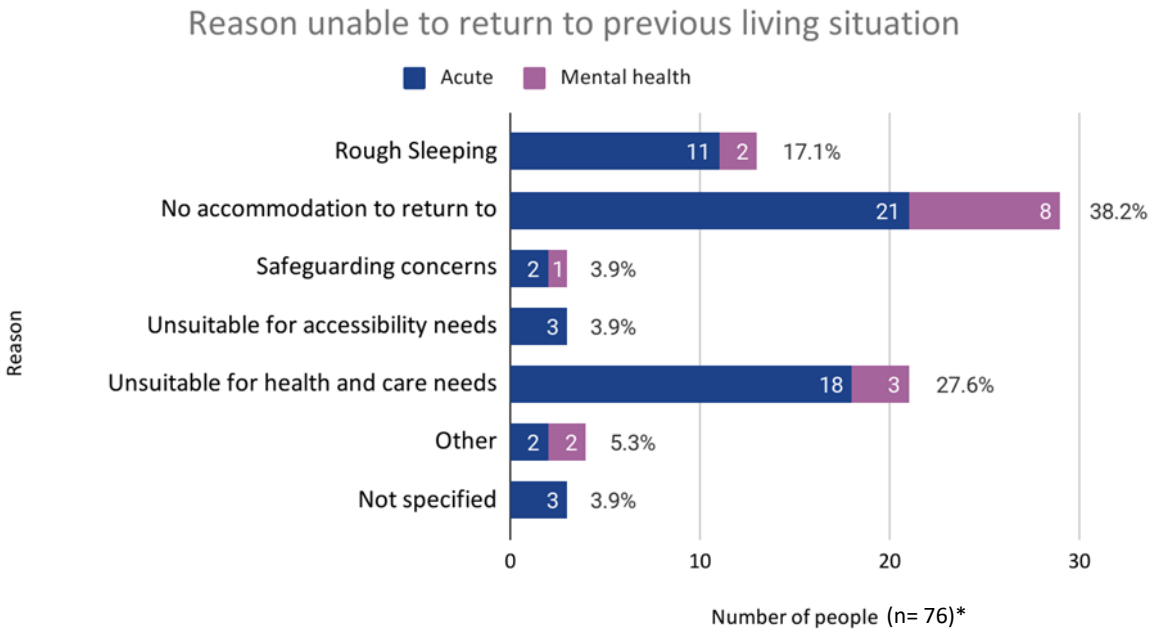
excluded, who typically have multiple risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and who are not consistently visible within healthcare datasets.

Key findings

The audit found those experiencing homelessness have high levels of complexity of health and support needs, with the vast majority of people unable to return to their pre-admission living situation. There was a mismatch between the type of projected accommodation and support needed compared to what was available, often resulting in discharges that were suboptimal and/or delayed. Among delayed discharges, there were also people awaiting assessments or decisions from local authority housing and/or adult social care services. For those whose eligibility for public funds was identified as being restricted, the barriers to accessing accommodation and support were even greater with considerable delays in establishing whether they would be supported under the Care Act.

Unable to return to previous living situation

The majority (91.6 per cent) of people were unable to return to their pre-admission living situation for a range of reasons including, rough sleeping, they had no accommodation to return to (due to having been evicted or the host was unwilling to take them back), or the accommodation was unsuitable for their existing and new health and care needs (and would likely result in a suboptimal discharge). See graph below. Those who could return had been admitted from hostels.

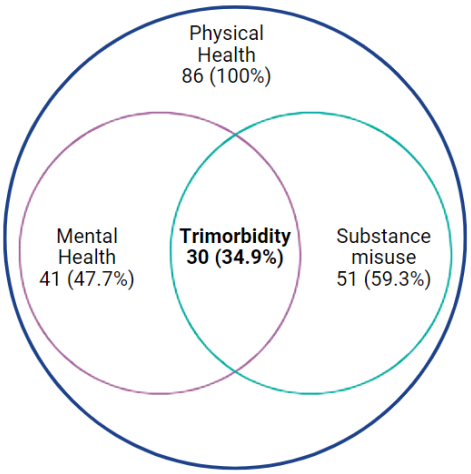


**This question was added at a later date and so responses were not captured from the total cohort.*

High level of complex needs

There were extremely high levels of complexity across the cohort. Out of the 86 individuals in Acute hospitals the following was found.

- Almost two-thirds (64 per cent) had three or more physical health co-morbidities; the highest number of comorbidities being eight.
- A large proportion had mental health and/or substance misuse issues, and over a third (34.9 per cent) had tri-morbidities.
- More than half (54.7 per cent) were believed to have care needs.
- There were concerns about cognitive impairment and/or aspects of mental capacity in 30.2 per cent.



- Significant safeguarding concerns were present in 29 per cent including domestic violence, “cuckooing” and self-neglect.

Out of the 18 individuals in the Mental Health cohort, the following emerged.

- Over one-third (38.9 per cent) had substance misuse issues (dual diagnosis).
- Half of people (50 per cent) had additional physical health conditions (including hypertension, heart disease, vascular dementia, sickle cell anaemia, leg ulcers, kidney stones and chronic musculoskeletal problems).
- Nearly one in six (16.7 per cent) had tri-morbidity.

Projected accommodation and support needed for a safe discharge

The teams were asked to outline what was needed for a safe discharge, most likely to support improved longer-term outcomes. There was a clear need for trauma-informed services that could provide short- or long-term support for a range of physical health, mental health, psychological and addictions needs. Many of these services were not currently available.

- Only one person needed ‘just’ accommodation (low-level accommodation) with access to routine primary care and outpatient services.

Short-term intermediate care:

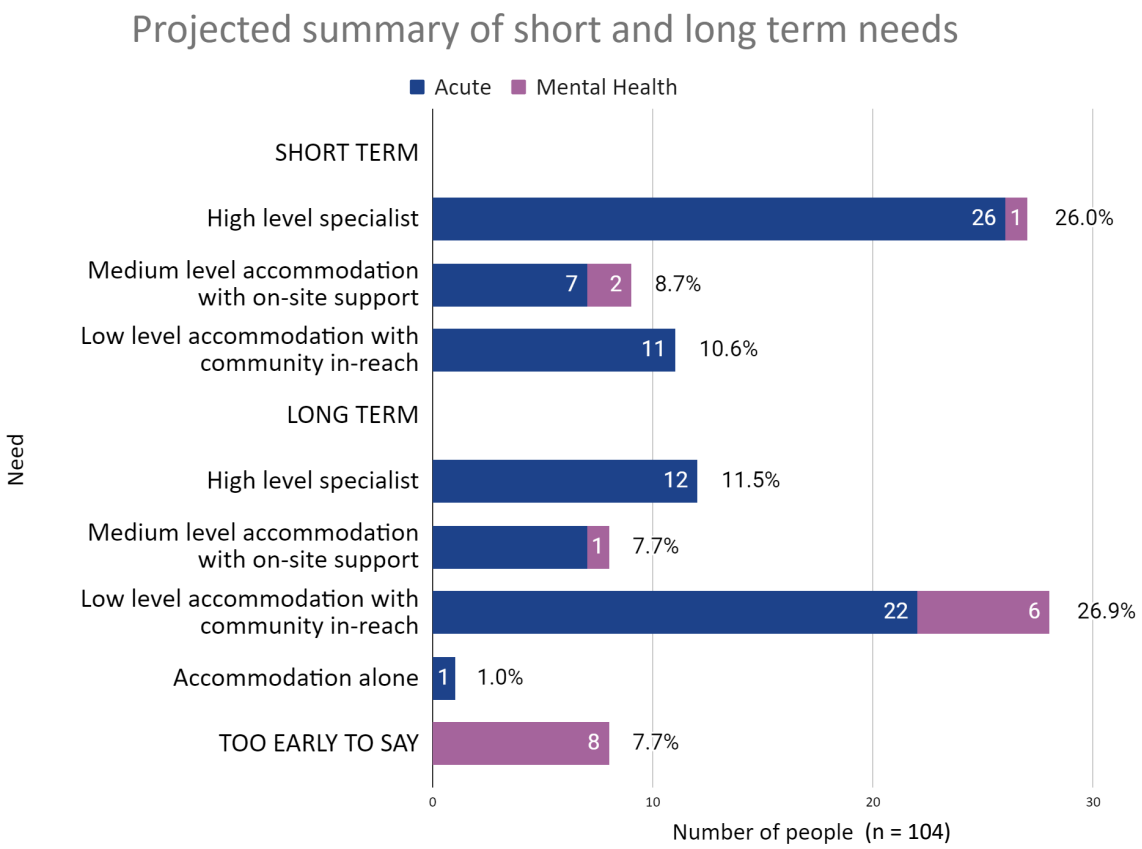
- 45.2 per cent were identified as requiring short term intermediate care/step-down initially. This was because they either had needs that would:
    - change with further treatment (for example, following rehabilitation),
    - their needs were not yet fully understood (or they were awaiting further assessment) or

- more time was needed to explore or resolve immigration issues.

- The intermediate care needs were divided into:
  - high-level, that is, 24-hour health or care staffing (26 per cent),
  - medium-level, that is, 24-hour (non-health) staffing with multidisciplinary in-reach (8.7 per cent) or
  - low-level, that is, unstaffed accommodation but with in-reach support (10.6 per cent).

Long-term needs:

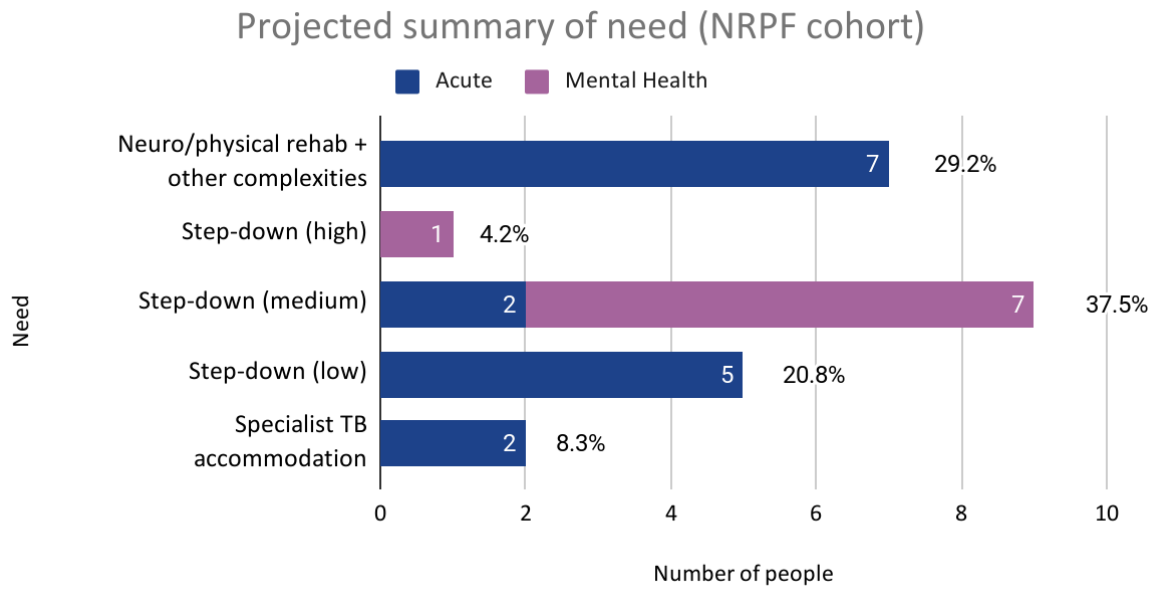
- 46.1 per cent had needs that were unlikely to change in the near future (namely, long-term needs), including:
  - high-level, that is, care home provision (11.5 per cent),
  - medium-level, that is, accommodation with on-site support (7.7 per cent) or
  - lower-level, that is, accommodation with community/in-reach support from a range of services including social care, primary care, homelessness support staff, peer support and voluntary sector organisations (26.9 per cent).



There was more uncertainty around what the most appropriate discharge destination was for teams working within the Mental Health hospitals. However, there was a clear need for placements that could accommodate people with significant mental health needs co-occurring with substance misuse.

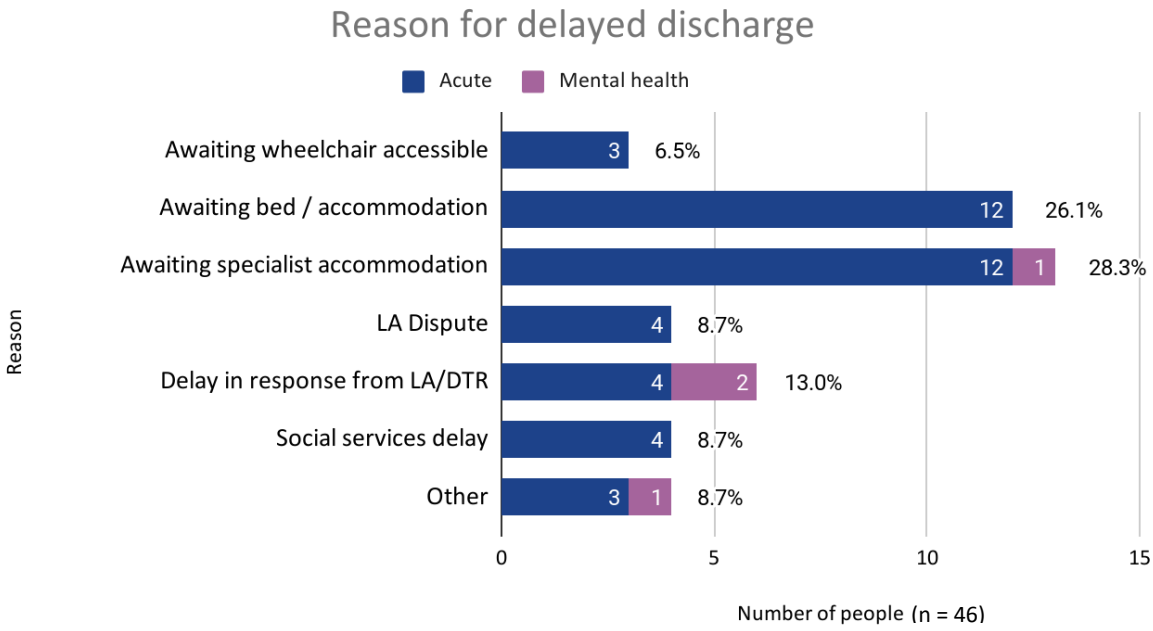
Non-UK nationals with restricted or uncertain eligibility for public funds

There were 24 people who the teams identified as non-UK nationals with restricted eligibility for public funds (16 from the Acute and eight from the mental health cohort), and an additional eight from the Acute cohort whose eligibility was uncertain and still being determined. Of these 32 in total, more than half (56.3%) were believed to have care needs. The graph below shows the projected summary of need for the 24 people reported to have restricted eligibility or no recourse to public funds (NRPF).



Delayed discharge

Due to a lack of safe and appropriate discharge destinations, 44.2 per cent of the 104 people remained in hospital beyond the time needed for that level of care, in other words, their discharge was delayed. Reasons for delay included awaiting different types of specialist accommodation (for example, neurological rehab for someone with mental health or substance misuse issues), or waiting for assessment, outcome and allocation from local authority housing or adult social care teams. 14 per cent (eight) of people delayed were reported to have NRPF.



Unsafe discharges in previous seven days

Additionally, to try and capture the extent of unsafe or unplanned discharges, we asked teams to recall any discharges to the street or discharges they considered unsafe or suboptimal from their inpatient caseload within the previous seven days. The figures are based on the participant's recollection within a specified week and so may not accurately reflect the true number of unsafe discharges within any given week across London. There were:

- 11 unsafe or sub-optimal discharges (which includes three discharges to the street),
- Five self-discharges.

Reasons given for these included pressures for bed availability, challenges dealing with difficult behaviours, lack of options and delays in response from local authority.

Conclusion

People experiencing homelessness often have considerable health, housing and social care needs. Hospital admission is an opportunity to provide holistic assessment to identify what is needed to support recovery. A skilled and multidisciplinary workforce that is familiar with providing person-centred and trauma-informed care, and is trusted amongst this population, can help address these needs to facilitate a safe discharge and access to ongoing support.

Due to lack of available appropriate move-on options, many people are discharged to destinations that are unable to fully meet their needs and therefore potentially unsafe, or will remain in hospital while appropriate options are being sought. Once deemed 'medically fit for discharge', many still require ongoing specialist case working, a period

of rehabilitation, in-reach/community support and/or specialist accommodation. Lack of appropriate options is costly to individuals, in that their health and care needs are often not met, but also to the health and care system. Additionally, timescales that local authority housing and adult social care work towards are different from the often highly pressurised situation in hospitals. A slow response to a request for assessments contributes to longer than necessary stays in hospital. This can be particularly problematic for people with complex immigration issues (such as NRPF).

Identifying whether someone is experiencing homelessness early on in the admission process will enable frontline teams to better plan for that person's care and support needs. Improving visibility of this population within NHS data sets will also help inform commissioning decisions based on demands, gaps and needs.

What's needed to address the gaps found in this audit?

This audit demonstrates the gap between NICE guidance for this population, and what's available in practice. It reinforces the value for a focused homelessness partnership, with leadership and strategic oversight for London. It suggests action is needed to secure the following.

- **A shared, robust and up to date understanding of the population's needs and experiences, to inform commissioning and delivery**.
    - Taking opportunities to understand and capture information about an individual's accommodation status (such as hospital staff asking, "have you got a safe place to be discharged to?").
    - Use of the housing status codes, which already exist in NHS service datasets, as part of routine data collection.
- **A consistent and sustained 'service' offer to individuals to facilitate successful transfers of care from hospital to the community, to prevent crisis admissions ('out-of-hospital care') and improve access to appropriate support and better outcomes**. **A service offer that is consistent with the following elements.**
    - Shaped through co-production with people with lived experience.
    - Person-centred and trauma-informed, with multi-disciplinary teams sharing an understanding of the individual's needs, strengths and aspirations, and how to prevent and de-escalate trauma-induced situations.
    - Makes the best and combined use of professionals' knowledge, expertise, and time including:
        - Bringing together health, housing and social care workforces to better understand and value each other
        - The development of shared protocols, which provide a safe framework for action, to:

            - enable more timely identification of, and decisions on, an individual's housing status, health and care needs, eligibility for housing care and support,
            - prevent self-discharge from hospital, including understanding and managing substance misuse needs.
        - Supports workforce to have access to clinical supervision, reflective practice and training to de-escalate crisis.
        - Offers accommodation options that better reflect the diversity of need and enable personal choice and control, in other words:
            - a range of step up/step down intermediate care solutions, and
            - longer-term solutions, particularly for people with complex needs who have a physical disability and mental health and/or substance misuse issues.
        - Makes the most of opportunities to support people in the community, for example, through peripatetic multidisciplinary team (MDT) support and floating support in temporary accommodation and hostels.
        - Reflects the value of trusting relationships in supporting engagement as an essential part of recovery, through the employment of people with lived experience and VCSE partners.
- **To better support people whose eligibility for public funds is restricted or uncertain, there is a need for the following**.
        - Shared understanding across health, social care and housing workforces of the legislation, policy and practice.
        - More timely identification of, and decisions on, an individual's eligibility for support from adult social care.
        - Access to legal support by hospital teams.
        - Use of available resources and escalation procedures (NRPF Network, Home Office), where appropriate.

Taking this audit further

Scoping work is underway to consider how the findings from the audit can be modelled to quantify what is needed sub-regionally and regionally to address the accommodation and service gaps across London. This work will also consider how many bed days could be potentially saved from reducing delayed discharge.