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NHS Fife & Shelter Scotland approach to supporting homeless patients attending hospital

What have we learned from the intervention pilot that can be used to inform future models?

Place, Home and Housing

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NHS SCOTLAND

Contents

Intervention overview

Healthcare Improvement Scotland were approached by Shelter Scotland and their colleagues in the Fife Health and Social Care Partnership (HSCP), to carry out a cost-effectiveness analysis of an intervention being conducted in the Victoria Hospital, Kirkcaldy (NHS Fife).

The main component of the intervention comprised two full time staff members being employed by Shelter Scotland whilst based at the Victoria Hospital. The staff members liaise with both clinical staff to assess and provide support to patients who are homeless or at risk of homelessness prior to discharge (and follow up with them post discharge if necessary), as well as local authority staff to help facilitate the provision of suitable accommodation. 91 patients were supported by the intervention between January 2018 and February 2020.

To supplement this approach, Healthcare Improvement Scotland interviewed staff from across the partners involved in the project to understand the experiences of stakeholders. The purpose of this report is to present the key findings and learning of this work, understand the challenges and barriers that exist, and what we can learn from this to inform the design of future intervention models.

Project methodology

Between October and November 2020, we spoke with a range of stakeholders involved in the NHS Fife & Shelter Scotland intervention project based in the Victoria Hospital, Kirkcaldy.

- Six semi-structured interviews were carried out with participants from NHS Fife, Fife Council and the Shelter support team with experience of working within the intervention project when it was based in the A&E department of the hospital. We were unable to conduct interviews with members of the intervention team that were based in the discharge hub as they were no longer in post.
- An additional semi-structured interview was carried out with a patient supported by the intervention team.
- The interviewees were approached with a request to discuss their experiences and opted in to the process. The interviews were transcribed and thematically analysed.

What worked well?

Participants in the interviews highlighted a number of key areas where the project worked well that should be maintained and developed for any future implementation of the approach.

1. Blended intervention team

The intervention team consisted of a housing professional and a health professional. This was seen as beneficial by stakeholders as it meant that both medical and housing issues could be addressed by the team. The health professional had an understanding of how to navigate the NHS and in particular, the Victoria Hospital, and was able to pass this knowledge on to the housing professional. Similarly, the housing professional was able to educate the health professional on housing issues and the signs of potential homelessness or insecure housing situations.

Recruitment for the posts were carried out in partnership by a representative from both Fife Council and NHS Fife ensuring that the relevant skills across housing and health were identified to maximise the potential reach of the team.

> ***A team of health and housing is key, the project needs the best of both worlds. There needs to be a person with medical experience and a person from housing support. As much as we could we adapted and went forward, not so much with homelessness cases coming in but by passing advice back and forth to each other.***
> Shelter Scotland Support Officer

2. Awareness raising

The intervention team raised awareness of the service throughout the hospital by producing promotional materials (posters, leaflets, introduction to homelessness document). The materials also contained contact details for the intervention team. Additionally, the team also undertook face-to-face promotion around the hospital and this helped to familiarise staff with the services and the staff involved.

> ***I've realised that this project made me think more about homelessness, homelessness isn't just not having a house it's all the wider permeations beyond that, it's not just one thing and all the things are intertwined, it was useful for me to think about that wider picture.***
> NHS Fife Clinician

Creating an understanding of the wider issues faced by people experiencing homelessness helped generate greater empathy amongst clinical staff and more referrals to the service.

3. Accessibility and relationship building

Situating the service within the A&E department of the hospital meant that the service was visible and easy to access for clinical staff and the intervention team were able to build relationships with reception staff to spot the signs of homelessness or insecure housing situation and refer the patient to the intervention service.

> ***We built relationships with the reception staff who developed an understanding of what cues they could look out for – such as 'I'll just leave my mums address', then they would come to me and say I think they need help because of X, Y, Z.***
> Shelter Scotland Support Officer

Clinical staff are bound by time pressures meaning that they are often unable to engage in lengthy processes and form filling. The ease of access to the intervention team who were situated in a room within the ward meant that face-to-face discussions could happen immediately to support the patient's wider needs beyond the presenting medical issue.

> ***The intervention team were accessible, no drawn out processes or forms to fill in to access them. Ease of access is important, as a clinician I don't have a lot of time to fill in forms so knowing that the team are around and I could just call them worked.***
> NHS Fife Clinician

Being situated within the same department helped to foster relationships through face-to-face interactions with doctors and nurses that helped to generate trust and understanding across all partners.

4. Advocacy and connection to other services

Providing support and advocacy on a range of patient needs provided reassurance to both patients and clinical staff that wider health and wellbeing needs including Housing could be addressed. The intervention team were equipped with the knowledge of how to help people engage with other services such as Mental Health and Alcohol & Drug services helping to alleviate pressure on clinical staff. The intervention team were also able to get patients with no access to a GP service registered and this in turn helped people to connect with other health and social care services in order to have their wider health and wellbeing needs addressed.

> ***As a doctor from a medical point of view I can say 'you're fit to be discharged but I'll get someone who can support you with all the other issues impacting on your health' and that being face-to-face there and then is a far better opportunity than me saying 'I'll get someone to phone you or make appointment for you.***
> NHS Fife Clinician

Service User story

We interviewed Client 'A' about his experiences of being supported by the intervention project.

"The team were a big success for me, having someone you can trust who is interested in you and what you need. The whole team, the way the medical staff, general nurses and occupational therapy made a difference even just in their encouragement, someone telling you that you are doing well." – Client A

Client A had been in hospital for an extended period of time and was engaged with by the intervention team following a referral to the intervention service from the ward. He was homeless having been evicted from his previous tenancy and was extremely anxious as to what his housing situation would be upon his release from hospital. 'A' had experienced homelessness for most of his adult life and fully expected to be discharged back to emergency accommodation such as a B&B. 'A' also experienced issues with drugs, alcohol and mental health and feared these would be exacerbated by a return to emergency accommodation. The intervention team picked up the case and began liaising with housing services and other support agencies to ensure suitable housing and support was in place upon 'A's discharge from hospital. 'A' remained in hospital for a further 4 months recovering from a number of physical health issues.

During that time, the intervention team advocated on 'A's behalf, keeping him informed at all times and were able to secure a suitable property that met his needs. The team also engaged with wider support agencies and secured the provision of a 'Link Living' carer and access to a dedicated drug and alcohol worker to help him sustain his tenancy and continue to support him to remain drug and alcohol free.

Upon release from hospital, 'A' successfully moved into his new property and has maintained this for a sustained period of time. Having access to suitable accommodation has allowed 'A' to start to rebuild his life and he is now engaged in education and community activity, attending classes on entrepreneurship and business. 'A' described the support he received as invaluable and in particular valued:

- **Encouragement, understanding and support provided by both the medical and intervention staff.**
- **Empathy that can be provided by staff with lived experience of homelessness.**
- **Being kept informed of progress.**
- **Helping him to think about his ambitions for the future.**
- **The visits and social interaction, feeling like someone cared.**

"Being here in my home I'm able to build stuff up, I've been able to get my own TV and I can have clothes that aren't getting lost all the time, I've lost a lot of stuff over the years." – Client A

What were the challenges and areas for development?

Although people's experiences of the project were largely positive, some challenges existed that require to be considered when implementing a similar model in the future.

Access to Mental Health and Drug and Alcohol Services

Patients who were identified as homeless or at risk of homelessness often required access to Mental Health and Alcohol and Drug services. Access to these services were not readily available and required referrals to be made and appointments set for a later time. The intervention team supported patients to gain access to these services however it was felt that it would be more beneficial to have immediate access to these services on-site increasing the likelihood of engagement.

"Previous to this project, if a person was in crisis in homelessness we would have contacted social work and get them seen by alcohol services, but alcohol services are opt-in so the patient has to make their move to go into those but if they don't have the resilience or support to make that appointment they tend to spiral further down with their issues."

NHS Fife Clinician

Partnership working arrangements

Changes to staffing arrangements meant that mechanisms for more structured partnership working developed as part of the project inception did not continue as planned.

Working arrangements between the partners could be strengthened to include regular operational meetings that track progress against an agreed purpose and set of shared outcomes. This would provide the opportunity to discuss individual cases, assess the effectiveness of the approach, discuss challenges, and generate ideas for improvement.

"It felt as though barriers came up because of the challenges each service faced so an understanding at the outset of what each service can do and the challenges we all face would be better."

Fife Council Housing Officer

Staff across the project expressed a desire to get to know their counterparts better through regular formal and informal contact. It was felt that more regular interaction between partners at an operational level would help people to understand the challenges and limitations faced by each, helping to build trust and understanding.

Managing expectations

"I think we needed more of a partnership approach, it was difficult when temporary accommodation was required against the hospital's target timelines when a person is medically ready for discharge."

Shelter Scotland Support Officer

Staff reported a tension between the time taken to secure Temporary Accommodation and targets for NHS turnaround times when the patient was medically ready for discharge. Often people were placed in emergency accommodation such as B&B's rather than temporary or permanent accommodation given the tight timescales to rehouse someone following discharge from hospital.

Stock availability is often limited and the size, type and location of property a patient requires may not be available. Giving the intervention team access to details on stock availability and turnover could help to support conversations with patients around expectation and suitability.

Operating model

The project operated on a Monday to Friday, 9 am to 5 pm basis. Staff felt that many of the patients that would benefit from the intervention were more likely to present at A&E in the evenings or at weekends. The intervention team had planned to trial some evening and weekend work but were unable to commence due to COVID-19 and the associated restrictions.

"When people go into hospital overnight we would go to see them in the morning. But if a person is kept in the waiting room there is the risk that they will walk out, there were times when we were told someone was in the waiting room but when we went they had already left."

Shelter Scotland Support Officer

Involving relevant stakeholders from Housing

Housing staff involved did not have responsibility for allocating properties, acting as the 'middle man' between the intervention team and their allocations department. There were no changes to the allocations process for those supported by the intervention meaning no improvement in length of time to be accommodated.

Registered Social Landlord's (RSL's) also have the means to assist the project through allocations across the common housing register in Fife. When developing the intervention, it would be of benefit to include both RSL's and relevant Council allocations staff as partners in the project and included in ongoing progress meetings detailed above.

"Allocations team should be a part of it, everyone from advice and assessment side have been involved but the allocations team weren't given any information."
Fife Council Housing Officer

Implications of COVID-19

COVID-19 and the associated restrictions around face-to-face contact meant that the intervention team could no longer operate from within the hospital. This has resulted in a reduction in referrals to the service and it unclear whether this is down to fewer presentations by people experiencing homelessness or pressures within the hospital.

It is unclear how a similar intervention could be undertaken remotely, however there is potential to explore a model where staff can still refer to the intervention team by telephone. There is also the possibility of undertaking a blended approach whereby the health professional within the intervention team can undertake some of the duties on-site and liaise with the housing professional remotely.

Conclusion

The implementation of this model within the Victoria Hospital in Fife was seen as valuable, positive, and of great benefit to staff within hospitals and the patients that present with housing and other social care issues.

The experiences of people involved in delivering the service has identified the key areas to consider when developing a similar intervention model in the future.

Project start up and planning

In order to ensure a continuity of approach and shared understanding of the aims and objectives of the project, partners should work together at the inception of the project to:

- Ensure a blended approach to the intervention team with at least one housing and one health professional.

- Undertake recruitment for intervention team posts jointly with NHS and Council representation on the interview panel.
- Jointly agree a shared purpose, objectives, roles and responsibilities, data requirements and agreements.
- Undertake stakeholder analysis to ensure all relevant partners are involved (such as RSL's, housing allocations teams, mental health and alcohol and drug services).
- Create a shared ambition to ensure patients are housed in suitable accommodation following discharge from hospital
- Develop processes with all relevant stakeholders to reduce the time taken to secure suitable accommodation for the patient

Formalise partnership working arrangements

It is important to put in place mechanisms that help track the effectiveness of the intervention and offer an opportunity for partners to work together to share knowledge, identify challenges and identify areas for improvement.

- Establish strategic steering group with representation from all partners.
- Set-up regular progress meetings attended by the support team, clinical staff, and Council staff.
- Undertake a case management approach to clients supported by the intervention.
- Establish clear processes and ways of working with potential for lead officer roles within housing.
- Use data and measurement to track progress against agreed purpose and objectives.
- Encourage face-to-face informal interactions between partners.
- Use a test and learn approach to improving the service by documenting key challenges / barriers to progress, and learning from experiences

Awareness and education

The success of the intervention relies on the ability for clinical and reception staff within the hospital to identify patients who are homeless or at risk of homelessness and knowing how to refer patients to be supported by the intervention team.

- Ensure the availability of the service (and its contact details) is promoted across the hospital through posters, leaflets, social networks and face to face promotion across wards within the hospital.
- Educate staff on how to spot signs of homelessness or an insecure housing situation.
- Encourage staff on wards to check housing situation and make it easy to refer.
- Invite referrals from wards across the hospital (Housing issue may only come to light later).

Visibility and ease of access

Clinical staff are often bound by time pressures which affect capacity and the ability to provide additional care beyond the presenting medical need. The intervention project can alleviate this pressure but must be visible and easily accessible for staff.

- Where possible, situate the intervention team within (or close to) the A&E department.

- Provide a dedicated room / facility for the service.
- Work closely with A&E reception staff to build understanding and trust to spot signs of homelessness and refer immediately to the intervention team.
- Provide dedicated telephone number for referrals from other wards.

Managing expectations

To support partnership working and understanding, it is important that all partners are aware of the limitations and challenges faced by each of the services. This would allow the teams to work together to provide solutions to issues with an understanding on what is available and what the expectations are.

- Make stock turnover and availability accessible to the intervention team.
- Work with clinical staff to understand NHS target times and identify ways to ensure people are not discharged into unsuitable accommodation.
- Based on availability of stock, NHS target times and the needs of the patient, develop processes that maximise the available options for the patient.

Advocacy and ongoing support

The role of the intervention team encompasses more than just housing advice and is critical to ensuring clients are connected to the support they require. Efforts should be made to maintain contact with housing and other support services to ensure patients are supported throughout the journey.

- The intervention team should be independent of the NHS and the Local Authority.
- Maintain contact with the patient to keep them informed and be aware of any new or changing needs either in the hospital or in temporary accommodation.
- Ensure the temporary accommodation is suitable for the needs of the patient and maintain ongoing contact between the support service and the Council until suitable accommodation is found.
- If suitable accommodation found, efforts should be made by the Local Authority to hold the property (for a reasonable time) to ensure support in place and maintain ongoing contact with the support team (this arrangement could be agreed at the outset as part of formalising the partnership).
- Support staff should continue to maintain engagement after person has been housed to ensure ongoing support.

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