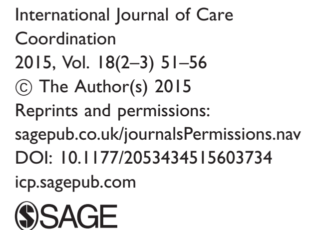
Check for updates

Research Paper

International Journal of Care Coordination

International Journal of Care Coordination
2015, Vol. 18(2–3) 51–56
© The Author(s) 2015
Reprints and permissions:
sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/2053434515603734
icp.sagepub.com



A codex of care: Assessing the Liverpool Hospital Admission and Discharge Protocol for Homeless People

Martin Whiteford and Glenn Simpson

Abstract

There has recently been an upsurge of interest in the relationship between homelessness and hospital discharge policies and processes in England. In this paper, we investigate the significance of these developments by assessing the Liverpool Hospital Admission and Discharge Protocol for Homeless People. Drawing on in-depth qualitative interviews with hospital-based clinicians and community-based health and social care practitioners, we identify four central features of the Liverpool protocol: (1) local prioritisation, (2) good systems of communication, (3) partnership working and (4) access to appropriate post-discharge care and support. Overall, we contribute to the literature of care coordination by filling a gap in the knowledge base in relation to the multiple and complex needs of homeless people, while delivering important insights into the delivery of integrated care.

Keywords

Communication, homelessness, hospital discharge, knotworking, partnership working

Introduction

In policy and practice circles in England, there is increasing recognition that homeless people, particularly rough sleepers, present significant challenges to public health and social care systems.[1–5] A national health audit drawing on the experiences of 700 homeless people across England carried out by Homeless Link,[6] the national umbrella organisation for homeless organisations, noted that homeless people use acute health services at a disproportionate rate to that of the general population. The audit observed that over a 12-month period, only 7% of the general population will have an inpatient hospital stay. It estimated that the average length of stay of 7.2 days for homeless people, compared to 2.1 days for the general population. This is often attributed to the complexity of homeless people's presenting health needs (multiple morbidities) rather than to delayed discharge. The annual cost of acute care services for homeless people has been estimated to be at least £85 million per year.[7] These factors are considered at a policy level to represent an unnecessary cost burden and reflect inappropriate access to care.

In 2012, Homeless Link and St Mungo's,[8] a leading homelessness charity, were commissioned by the Department of Health to provide a detailed overview of hospital admission and discharge policy and practice for people affected by homelessness in England. The report highlighted an uneven picture. Examples of good practice were buttressed by accounts of inadequate support. It documented, for instance, how more than 70% of homeless people were 'discharged back onto the streets, furthering damaging their health and all but guaranteeing their readmission'.[8(p.6)] Key findings of the study included homeless people are routinely discharged from acute hospitals into the community without their housing or health needs being satisfactorily addressed, housing should be viewed as a critical component of a 'safe discharge' and coordinated discharge practice can reduce costs for the NHS and improve the health and well-being of homeless people.

These findings subsequently played a pivotal role in the Department of Health's decision to establish the

University of Liverpool, UK

Corresponding author:
Martin Whiteford, University of Liverpool, 1-5 Brownlow Street, Liverpool L69 3GL, UK.
Email: martin.whiteford@liverpool.ac.uk

Homeless Hospital Discharge Fund 2013–14.[2] The £10 m grant fund sought to enable 52 voluntary sector organisations working in partnership with the NHS and local government to develop and foster new forms of integrated care services. This development, alongside wider policy measures pertaining to hospital readmission rates and a new statutory duty placed on Clinical Commissioning Groups to reduce inequalities in health outcomes and access to health services, has thus brought the specific issue of hospital admission and discharge policies and processes for homeless people into greater prominence.

Notwithstanding the notable exceptions of Homeless Link and St Mungo's[8] summary report on hospital discharge arrangements and Homeless Link's[9] detailed evaluation of the 'Homeless Hospital Discharge Fund', there has been no serious attempt to critically consider how different professional groups understand and implement hospital discharge protocols for homeless people in England. This stands in contradistinction to a small but significant corpus of research emanating from North America exploring and elucidating the transition from hospital admission to medical discharge right through to the provision of community-based care and support for people who are homeless.[10–12]

Noting this lacuna, we take inspiration from Yrjö Engeström's practice-based theory of collaboration and learning.[13–15] Knotworking, with its roots in activity theory, refers to 'tying, untying and retying of separate threads of activity'[13(p.346)] in pursuit of a collaborative enterprise. For Engeström, interprofessional collaboration is considered to be a fluid and responsive process which is actualised through the co-configuration of a relatively loose network of actors and activity systems. Knotworking knots are understood to connect groups, tasks and tools across complex organisational boundaries in order to address temporary, goal-orientated problems or tasks. Under such conditions, negotiation becomes a central coordinating mechanism of knotworking. For Engeström, 'collaboration between the partners is of vital importance yet takes shape without rigid predeterminated rules or a fixed central authority'.[15(p.44)] This directs our attention to the way in which responsibility becomes 'distributed' rather than structured according to the logic of a central knot. In effect, this means that no single individual or organisation can assume a preeminent position nor evade responsibility for contributing to the collective endeavour.

Our understanding of the Liverpool Hospital Admission and Discharge Protocol for Homeless People[16] draws in part on Engeström's metaphor of knotworking. What remains stable and durable in this context is the Department of Health's stipulation that lead managers for hospital discharge in acute hospitals and local authority adult services should ensure that hospital discharge policy includes guidance that homeless people are identified on admission and their pending discharge notified to relevant primary health care and homeless service providers.[17(pp.74–75)] This provides the direction for shaping and structuring admission and discharge planning for homeless patients.

In leaning on Engeström's formulation, we understand knotworkers to be engaged in a shared activity that relies upon improvisation and persistence. In seeking to resolve the transitional care needs of homeless patients, knotworkers are forced to negotiate administrative and communicative barriers. Practically speaking, discharge planning involves the participation of different professionals at different times.[18] Thus, a male patient with a personality disorder and history of exclusions from hostels and entrenched rough sleeping may expect to receive care and support from a vastly different set of knots of expertise and resources than, say, a female patient recently made homeless with stage 4 liver disease. Viewed through this lens, the sequential steps contained within the Liverpool protocol can be seen to give rise to various forms of tying, untying and retying of otherwise separate threads of activity that *can* and *should* coalesce around coordinated care.

Methods

The study relied upon purposeful sampling. This strategy enabled the research team to draw on their combined theoretical understanding and local knowledge to identify research participants best able to inform the study. We draw on semi-structured interviews with hospital-based clinicians ($n = 7$) and community-based health and social care practitioners ($n = 11$) intimately involved in the care and support of homeless people in Liverpool. All interviews were carried out face-to-face in a private room at the participant's workplace. Interviews lasted approximately 30–60 min. The interviews were guided by a number of topics:

- Knowledge of the Liverpool Hospital Admission and Discharge Protocol for Homeless People
- Understandings of the health, housing and social care needs of homeless people
- Examples of interprofessional learning and practice
- Perceptions of the strengths and weaknesses of hospital admission and discharge arrangements for homeless people in Liverpool

All interviews were audio recorded and transcribed verbatim. Data were analysed using thematic analysis as described by Boyatzis.[19] The Atlas Ti qualitative software package was used to assist with code development and identification of themes. According to

Boyatzis, a theme can be defined as a 'pattern in the information that at minimum describes and organises the possible observations and at maximum interprets aspects of the phenomenon'.[19(p.161)] Themes were discussed and rechecked by the research team to ensure consistency and comprised: local prioritisation, good systems of communication, partnership working and post-discharge care.

Ethical approval was obtained from the University of Liverpool (UoL000956) and the National Research Ethics Service (13/NW/0375). Research was conducted between March 2013 and March 2014.

Before we proceed to identify the constitutive elements of the Liverpool protocol, we need to set the scene and consider the local context in which integrated discharge arrangements for homeless people operate, so as to better appreciate its scope and significance. In the following sections, quotations are used to illustrate key research findings. We conclude by summarising the strengths of the Liverpool protocol and by gesturing towards some of critical gaps that remain in care coordination for homeless people in Liverpool.

Context

Since its inception in 2008, the Liverpool Hospital Admission and Discharge Protocol for Homeless People has received national recognition as an important exemplar of care coordination for a group who routinely experience multiple and complex needs (i.e. homelessness, mental ill-health and drug and alcohol misuse) and ineffective service use (e.g. unplanned use of acute services and intermittent engagement with preventative and recovery services). In narrow terms, the stated purpose of the Liverpool protocol is 'to prevent homelessness on discharge from hospital'.[16(p.1)] In broader terms, it seeks to emplace both vertical integration (of primary and secondary care) and horizontal integration (across health, housing and social care). As such, the Liverpool protocol codifies a series of sequential steps that are considered necessary in order to meet and manage the discharge needs of homeless patients, and in so doing genuflects towards the following processes and considerations:

(I) **Process within ED** – identify patient's housing status
(II) **Process on admission to ED or hospital ward** – identify patient's housing status/substance misuse issue and make appropriate referral (with patient's consent)
(III) **Process for discharge planning** – if a patient consents a referral should be made to housing options and/or social services.
(IV) **Other issues if patient is admitted to a hospital ward** – patient required to undergo multi-disciplinary team meeting unless discharge plan already in place.
(V) **Issues to be considered before discharge** – suitability of accommodation, availability of transport and access to GP.
(VI) **If patient takes own discharge** – inform specialist primary care service for homeless people/patient's own GP and, if applicable, hostel.

In operational terms, the Liverpool protocol is embedded within the adult safeguarding team at the Royal Liverpool University Hospital. The team is composed of a variety of disciplinary expertise – an adult safeguarding lead, homeless link nurse and substance misuse nurse – and three housing outreach workers (voluntary sector support to secure accommodation on discharge) funded by Liverpool City Council. Patients are identified via intelligence gathering across the hospital and through referrals from the emergency department and crisis team. Practical support can involve helping patients to access supported accommodation and welfare benefits and, where appropriate, through making referrals to an enhanced GP service for homeless people, structured drug and alcohol treatment programmes and social services provision. At base, then, the Liverpool protocol is predicated on the understanding that the health, housing and social care needs of homeless people need to be considered at the point of admission, during treatment and after discharge.

Local prioritisation

The Liverpool protocol derives much of its operational reach from the institutional patronage it receives from Liverpool City Council, Liverpool Clinical Commissioning Group and the Royal Liverpool and Broadgreen University Hospital Trust. Consequently, it is seen as being integral to wider efforts to prevent homelessness and reduce hospital readmission rates:

> [We have] familiarity with the processes and obviously hospital discharge is a priority. (Local housing official)

From a clinical perspective, admission to a hospital ward was viewed as a critical opportunity to engage with a homeless patient's holistic needs rather than just their presenting condition:

> We try and support homeless patients knowing that they are going to be a bit more chaotic than your everyday patient. We don't just address the abscess that they have come in with. We address the drug issue; we

address the mental health issue if there is one. We are only the starting point and we still have a long way to go. (Safeguarding lead)

There was a strong sense of the importance of establishing clear discharge pathways:

> Our policy states that on the day of admission patients must be referred to the appropriate teams, whether it be substance misuse, alcohol specialists or homeless outreach. Previously if you were medically fit you were gone. But now if we know there are other issues around trying to get them into rehab or detox we keep them on the ward. We don't bed block because we can't do that, but we're given time to do what is needed... Our aim is to get every homeless person or hostel dweller on a discharge pathway from the day of admission, so that you don't get problems at the eleventh hour when the doctor turns up on a Friday and says: 'oh, you can go now'. (Homeless link nurse)

This shared commitment to enhancing homeless people's health and housing outcomes is aided by the nurturing of effective channels of communication.

Good systems of communication

Previous work has emphasised the importance of communication in the discharge process.[20] Hwang and Burn's[21(p.1545)] narrative review of health interventions for homeless people demonstrates that communication between acute care services and community-based providers is essential to ensuring continuity of care.

The transformation of the Liverpool protocol from a static and immutable 'thing' to a conscious way of thinking and acting is constantly brought about through acts of communication. Its growing effectiveness was felt be coterminous with improvements in communication, thus:

> It's not like the old days when people were sent here in a taxi from the hospital. Those days have gone. There is now a lot more communication about what's going on. (Voluntary sector manager)

From the vantage point of primary care, a homelessness nurse described how collaborative networks contribute to better care coordination:

> We communicate with [housing outreach worker at the hospital] about these patients. We know that people go into one hostel and the move on to another hostel, so we try and keep up communication between the hospital and GPs. We have fortnightly A&E meetings at the surgery so that everyone is aware of patients [who have been admitted and/or discharged from hospital].

The consolidation of effective communication was, in many important respects, viewed as a 'relational' rather than 'systems' outcome. A good example of the centrality of communication was evident in the issuing of discharge letters:

> Usually if we get a discharge letter it is one of the routine ones that tend to come about two weeks after the patient is discharged. Obviously with our patient group it can be more complicated and not as straightforward [as dealing with the general population], especially if they're rough sleeping or sofa surfing. On a Friday afternoon we have had a ward call up and say: '*so and so might be discharged today. Can you sort it out?*' On a Friday afternoon it can be [difficult] to get done... but to be honest I have not had a telephone call like that in quite some time. (Homelessness nurse)

An important counterweight to the problems associated with the electronic issuing of discharge letters was apparent in the adoption of closer partnership working arrangements.

Partnership working

The management of the health and social care needs of homeless people cuts across several organisations, professional groups, policy domains and data collection and sharing mechanisms. Expediting hospital discharge and care pathways is achieved through the activation of interprofessional collaboration, thus:

> What actually works is the relationships rather than the protocol [per se]. I can ring the discharge team and say: '*what's going on with this patient? We have a bed, but it won't be available* [for a day or two]. *Can you speak to the consultant*? *What can you do here*?' (Voluntary sector manager)

This is to understand that the Liverpool protocol is constituted in and through interpersonal relations. It is also based on a number of spatial proximities:

> We can [quickly organise] a multidisciplinary meeting. It is all about relationships and networking with [primary care] and the [voluntary sector]. We are all within a stone's throw of each other; we all know the same people and we all work with the same patients. I think if anyone was trying to copy this model they would have to make sure that they have good relationships because that's the root of our success. (Homeless link nurse)

The institutional and relational characteristics of the Liverpool protocol are in turn actualised through the acquisition of post-discharge care.

Post-discharge care

Local understanding of the interdependence between housing and health is reflected and reinforced by Liverpool City Council's funding commitment to the provision of a number of 'ring-fenced' hostel beds for the exclusive use of homeless people discharged from hospital coupled with the introduction of an electronic assessment system to improve access to short-term housing related services. There was a strong feeling that these initiatives, albeit important, are largely inadequate in meeting the needs of people with chronic medical conditions and complex social care needs:

> I don't think that there has been a single person that I haven't offered accommodation. But I don't know if 100% of the time if it has always been the appropriate accommodation . . . I think that it is about negotiating with [the relevant housing providers] to try and get people up the list so that they can be accommodated when they leave the hospital. Homeless people should be prioritised even when they're fit for discharge because of their health and social care needs. (Housing outreach worker)

A similar sentiment was expressed by a homelessness nurse:

> We are seeing more alcohol-related problems [among our homeless patients]. For instance, when a patient is discharged with chronic liver disease a consultant will often phone us and say that there is nothing more that we can do for the patient. They then go back into the environment of a hostel and become physically unwell. The first thing that the key-worker does is phone 999 to take them back to A&E. They go through the system again and get spat out again. It is difficult to break that cycle.

The 'gap' between the ambition of the Liverpool protocol and the reality of the local service infrastructure was particularly problematic when managing 'end-of-life' issues:

> Our members are changing slightly in the fact that we are getting very, very complex people and with very, very complex health issues that we have never dealt with before. We are getting people at the end of life, [and] hostels have never managed that complexity. (Hostel manager)

The foregoing comments serve to problematise the reach and scope of the Liverpool protocol by pointing to the continued importance of housing, care and support in the community.

Limitations

This was a small-scale investigation into how statutory and voluntary sector organisations coordinate pathways of care for homeless people in Liverpool. Research findings must therefore be viewed as exploratory and confined to the localised experience of Liverpool. The study was also weakened by its failure to capture the full range of organisations and individuals involved in interpreting and operationalising the Liverpool Hospital Admission and Discharge Protocol for Homeless People. Despite widespread recognition of the close association between homelessness and mental health (see Rees[22] for a useful overview), we were unable to recruit mental health professionals (e.g. psychiatrists, clinical psychologists, mental health nurses, mental health social workers) to the study. It is arguably the case that this omission leads to a partial and incomplete picture of the structures, systems, processes, relationships and resources that undergird hospital discharge arrangements for homeless people. In acknowledging and accepting this limitation, we asked those with epistemological privilege – in this instance the participating hospital-based clinicians and community-based health and social care practitioners – to judge and confirm the validity of the methods and the validity of the interpretation running through this study.[23(p.193)]

Discussion

In assaying the Liverpool Hospital Admission and Discharge Protocol for Homeless People, we have found the metaphor of knotworking to be a particularly useful heuristic. We would further suggest that it has enriched our understanding of the way in which a complex constellation of organisational actors connect and coordinate care for homeless people through the principal vessels of interprofessional communication and interprofessional collaboration. In a fundamental sense, though, the Liverpool protocol is simply a guidance document which seeks to outline the most appropriate and effective steps to be taken in ensuring the safe discharge of homeless people from acute hospital settings. Properly understood, though, the Liverpool protocol is performatively brought into being through the collective actions of a relatively small, but strongly linked, group of health and social care practitioners. It is in this sense that frontline professionals act as both *care navigators* and *homeless*

champions. The crucial ingredients of the Liverpool protocol can thus be understood in terms of an 'ethics of care' and recognition of the efficacy of care coordination.

Our research participants would be the first to accept that the Liverpool protocol is not without its limitations. We have, for example, illustrated some of the procedural weaknesses of the protocol – namely difficulties associated with the issuing of discharge letters and sharing of patient data. Two further concerns relate to the paucity of intermediate care options for homeless patients struggling with substance misuse and/or mental health needs and the complete absence of equitable access to palliative care (see Ubido et al.,[24(p.37)] for an exegesis). It is equally true, however, that the Liverpool protocol has demonstrated significant cost savings to the NHS by focusing on the pin points between a planned hospital discharge, housing need and improved health and social care outcomes.

Acknowledgements

The authors would like to extend their gratitude to the participants and participating organisations for their support and commitment to the study Hospital Discharge and Pathways of Care for Homeless People in Liverpool.

Declaration of Conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The authors are grateful to Liverpool Clinical Commissioning Group for funding the study Hospital Discharge and Pathways of Care for Homeless People in Liverpool (RCF 2012/1301).

References

1. Hewett N, Halligan A and Boyce T. A general practitioner and nurse led approach to improving hospital care for homeless people. *BMJ* 2010; 345: e5999.
2. Department of Health. Homeless Hospital Discharge 2013–14, https://www.gov.uk/government/publications/homeless-hospital-discharge-fund-2013-to-2014 (2013, accessed 10 February 2014).
3. Fazel S, Geddes JR and Kushel M. The health of homeless people in high income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet* 2014; 384: 1529–1540.
4. Medcalf P and Russell GK. Homeless healthcare: raising the standards. *Clin Med* 2014; 14: 349–353.
5. St Mungo's Broadway. *Homeless health matters: the case for change*. London: St Mungo's, 2014.
6. Homeless Link. *The health and wellbeing of people who are homelessness: findings from a national audit*. London: Homeless Link, 2010.
7. Department of Health. Healthcare for single homeless people, http://www.qni.org.uk/docs/healthcare%20for%20single%20homeless%20people%20NHS.pdf (2010, accessed 10 February 2014).
8. Homeless Link & St Mungo's. *Improving hospital admission and discharge for people who are homeless*. London: Homeless Link and St Mungo's, 2012.
9. Homeless Link. *Evaluation of the homeless hospital discharge fund*. London: Homeless Link, 2015.
10. Backer T, Howard E and Moran G. The role of effective discharge planning in preventing homelessness. *J Primary Prevent* 2007; 28: 229–243.
11. Kertesz S, Posner M, O'Connell J, et al. Post-hospital medical respite care and hospital readmission of homeless persons. *J Prevent Interv Community* 2009; 37: 129–142.
12. Sadowski L, Kee R, VanderWeele T, et al. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomised trial. *JAMA* 2009; 301: 1771–1778.
13. Engeström Y, Engeström R and Vähäaho T. When the center does not hold: the importance of knotworking. In: Chaiklin S, Hedegaard M and Jensen U (eds) *Activity theory and social practice: cultural-historical approaches*. Denmark: Aarhus University Press, 1999, pp.345–374.
14. Engeström Y. Knotworking to create collaborative intentionality capital in fluid organizational fields. In: Beyerlein M, Beyerlein S and Kennedy F (eds) *Collaborative capital: creating intangible value*. Amsterdam: Elsevier, 2005, pp.307–336.
15. Engestrom Y. From communities of practice to mycorrhizae. In: Hughes J, Jewson N and Unwin L (eds) *Communities of practice: critical perspectives*. Abingdon: Routledge, 2007, pp.41–54.
16. Liverpool City Council & Liverpool Primary Care Trust. *The Liverpool hospital admission and discharge protocol for homeless people*. Liverpool: Liverpool City Council, 2008.
17. Department of Health. *Discharge from hospital: pathway, process and practice*. London: The Stationery Office, 2003.
18. Varpio L, Hall P, Lingard L, et al. Interprofessional communication and medical error: a reframing of research questions and approaches. *Acad Med* 2008; 83: 576–581.
19. Boyatzis R. *Transforming qualitative information: thematic analysis and code development*. Thousand Oaks: Sage, 1998.
20. Atwal A and Caldwell K. Do multidisciplinary integrated care pathways improve interprofessional collaboration? *Scand J Caring Sci* 2002; 16: 360–367.
21. Hwang SW and Burns T. Health interventions for people who are homeless. *Lancet* 2014; 384: 1541–1547.
22. Rees S. *Mental ill health in the adult single homeless population: a review of the literature*. London: Crisis, 2009.
23. Mason J. *Qualitative researching*, 2nd ed. London: Sage, 2007.
24. Ubido J, Holmes L and Scott-Samuel A. *Homelessness in the Liverpool city region: a health needs assessment*. Liverpool: Liverpool Public Health Observatory, 2014.