**Title**

Homelessness, hospital discharge and challenges in the context of limited resources: a qualitative study of stakeholders’ views on how to improve practice in a deprived setting

**Abstract**

Hospital discharge for people experiencing homelessness is a perennial challenge. The Homeless Reduction Act (2017) (HRA) places new responsibilities on hospitals, but it is unknown whether this has affected discharge practices. This qualitative study explores stakeholders’ views on the challenges around hospital discharge for people experiencing homelessness, in the context of a deprived English city.

Semi-structured interviews were conducted with 27 stakeholders. Participants were purposively recruited from local authority, third sector, and the National Health Service. Interviews were transcribed and thematic analysis conducted.

Analysis generated three main themes. First, a need for better planning and communication with the third sector, particularly around medication, prescriptions and information sharing. Second, the need to improve awareness and ‘upskill’ hospital staff to work more effectively with people experiencing homelessness, including understanding their needs, the wider support available, and HRA requirements. Third, there were calls for (re)investment in a different approach to better support this population, based on outreach and flexibility. The need for improved partnership working and investment was emphasised. Whilst recognising the challenges faced by hospitals, especially within the context of funding cuts, this study highlights the need to recognise the third sector’s contribution in supporting people experiencing homelessness in the community. Developing site-specific checklists for practice before discharge (and as early as possible) may help to ensure appropriate measures are in place. Improving legal literacy in the context of what an appropriate discharge is for people experiencing homelessness may help develop staff confidence to challenge the focus on ‘quick’ discharges.

**Key words:** homeless persons; patient discharge; health services; healthcare disparities; social welfare; qualitative research.

**What is known about this topic**

* For people experiencing homelessness, there are multiple barriers to accessing primary and mainstream healthcare, which then leads to presentations at hospitals
* Hospital discharge is historically poor for this group, which can contribute to a ‘revolving door’ of hospital admissions
* There is optimism that the HRA (2017) provides a new opportunity to address homelessness, placing new responsibilities on hospitals (and other public authorities) and a focus on joint working

**What this paper adds**

* Highlights some of the challenges for hospital discharge and homelessness in the wider context of a deprived city, where funding cuts have been severe, and appropriate accommodation is limited
* In this context, third sector organisations (i.e., not for profit and non-governmental, social/community services, including charities, and social housing associations) are going above and beyond to support people experiencing homelessness, including after discharge; this needs greater recognition and improved communication from hospitals
* There is a need for more awareness, training and upskilling within hospitals to better understand the implications of some discharge practices for people experiencing homelessness. Improving legal literacy (of safeguarding and The Care Act 2014, as well as the HRA (2017)) in this context may help develop staff confidence to challenge the focus on ‘quick’ discharges for this cohort.

**Introduction**

People experiencing homelessness have higher rates of morbidity and mortality than the rest of the population (Fazel et al., 2014) which underlines the health inequalities experienced by this population globally. The rapid increase in homelessness in the United Kingdom has been driven by austerity, welfare cuts, lack of affordable housing and sustained cuts to local authority support services (Hewett, 2019). These issues have been compounded by COVID-19, which has seen a growing number of people at risk of, or experiencing, homelessness for the first time (Boobis & Albanese, 2020). In 2010, the Department of Health (2010) estimated that the homeless population use up to around four times more acute hospital services than the general population, costing at least £85 million per year. That was before almost a decade of austerity that saw year-on-year rises in rough sleeping (Ministry of Housing, Communities & Local Government, 2019). Accident and Emergency (A&E) attendances of people experiencing homelessness have trebled since 2010/2011 (Lacobucci, 2019). Emergency Department attendances for people experiencing homelessness tend to be triggered by physical health issues, predominantly infections and exacerbations of long-term conditions (Morton, 2017).

Chronic homelessness is characterised by the combination of physical and mental illness with addictions (Hewett & Halligan, 2010). This health need is compounded by difficulty in accessing primary and mainstream care (e.g., Elwell-Sutton et al., 2016; Wilson & Astley, 2016; Parsell et al., 2019; Hodson & Glennerster, 2020). Historically, discharge protocols for this population have been poor (Albanese et al., 2016). Homeless Link & St Mungo’s Broadway (2012) reported that more than 70% of homeless people had been discharged from hospital back to the streets, without addressing their housing or underlying health problems. Effective hospital admission and discharge for this population have been found to be cost effective through reduced length of stay in hospital, if their housing status is addressed early, and through reduced readmission to hospital if discharged at a suitable time and to appropriate accommodation for recovery (White, 2011). Hospitals have a key role in referrals and effective collaboration with homelessness service providers in helping to address revolving door admissions (Barrow & Medcalf, 2019). Hodson and Glennerster (2020) argue that professionals should be slower to discharge people experiencing homelessness (than the general public), because discharge can undermine their dignity and health.

The need to maintain resources in specialist care and find ways to combat stigma and discrimination, such as a greater focus on safeguarding have been emphasised (Cornes et al., 2019). Since the Care Act 2014, any individual with any level of need for care and support has a right to an assessment (Cornes et al., 2018), with a clear message that safeguarding is everyone’s responsibility, including local authorities, the National Health Service (NHS), commissioners and providers, housing, third sector, community organisations and uniform services (Preston-Shoot, 2015). Nevertheless, Martineau et al.’s (2019) analysis of Safeguarding Adult Reviews related to homelessness found reports of poor co-operation between authorities, poor hospital discharge arrangements and a lack of supported accommodation. This was alongside a reluctance to recognise homeless individuals as requiring safeguarding measures, and a preoccupation with housing rather than assessing their care and support needs accordingly.

The Homelessness Reduction Act (HRA) (2017) set out a range of new duties to focus on prevention and early intervention of homelessness, and joint working. It requires public authorities (including hospitals) to make a referral, with the individual’s consent, to the Local Housing Authority (LHA) if an individual is homeless or at risk of becoming so (the duty to refer). The LHA is then required to assess the person and take reasonable steps to work with them to help secure accommodation (the relief duty). There has been optimism about the opportunity the Act presents (e.g., Massie et al., 2018; Hewett, 2019), and that it could be instructive for other countries (Paudyal & Saunders, 2018). Nevertheless, its implementation presents challenges for healthcare providers, including hospitals (Paudyal & Saunders, 2018). The HRA came into force in April 2018 (and the duty to refer in October 2018) and little is known about how, if at all, this new policy has affected hospital discharge processes specifically.

More co-ordination is needed to facilitate effective partnership working, given the separate service systems involved, such as hospital and housing (Canham et al., 2019). Projects based on a partnership approach produce better outcomes for people experiencing homelessness and it is important that future models consider a whole-system approach (Albanese et al., 2016; Hwang & Burns, 2014). Jenkinson et al. (2022)’s research in Toronto emphasised the need to locate the hospital discharge process within the context of the larger system; without this broader understanding of the system, there is a risk that solutions will not be ‘contextually-relevant’ for different hospitals or service settings.

In recognition, this qualitative exploratory study aimed to explore the views of stakeholders across the system who work with people experiencing homelessness around hospital discharge (either directly or indirectly), in a specific setting (detailed below). Initially, this preliminary qualitative data collection was intended to inform the development of a whole-system tool to improve discharge processes for people experiencing homelessness.

**Method**

Study setting, participants and recruitment

This qualitative study was conducted in a deprived city in the West Midlands of England. Categorised as one of the 20% most deprived districts, the health of the local population is generally worse than average, including life expectancy, and rates of statutory homelessness (Public Health England, 2019). As Marmot et al. (2020) emphasise, whilst large funding cuts have been enforced across England, deprived areas and those outside London and the South East experienced larger cuts which has undermined their capacity to improve social determinants of health (i.e., the conditions in which people are born, grow, live, work and age).

Participants were stakeholders with knowledge and expertise of working with people experiencing homelessness around their discharge from hospital (n=27). Table 1 shows the sample spanned local authority (n=7), third sector (n=12) and NHS (n=8). The sample comprised 20 females and seven males. Purposive sampling was used to select information rich cases (Patton, 2015). This was achieved through the steering group, which included representatives from the funder, local authority and NHS. The group also shared the invitation via email with relevant networks. Stakeholders who could not be recruited for interview were invited to participate in the workshop to ensure a range of views informed the recommendations.

Data collection

Data were collected from April 2018 to June 2019. Semi-structured interviews (n =20) were conducted, comprising 14 face-to-face interviews (at their workplace or the University) and 6 telephone interviews. Thirteen interviews were one-to-one, and seven were joint interviews with two participants from the same organisation/department (conducted at their workplace). The semi-structured interview allowed ‘scope to digress, investigate further, probe and illuminate’, and adapt to what participants shared (de Viggiana, 2020, p.127). An interview topic guide was developed with the steering group and to ensure key topics were covered, whilst focusing on participant expertise. Interviews were audio-recorded and transcribed.

Ethical approvals

Ethical approvals were granted by the University Ethics Committee (for non-NHS participants) and the Health Research Authority (IRAS number - 241750) for NHS staff. Researchers obtained informed signed consent from participants prior to interview.

Data analysis

The analysis process followed Braun and Clarke’s (2006; 2020) phases of (reflexive) thematic analysis: familiarisation and writing familiarisation notes, inductively coding the data (using QSR NVivo), developing and reviewing themes, refining, defining and naming themes, and producing the report. Thematic maps were used to explore the patterns and how they fitted together. Interviews and data analysis were conducted by two female, Caucasian researchers; one with qualitative research experience on homelessness and stakeholder interviews (1st Author; MPhil); the other with experience of mixed method evaluations (2nd Author; PG Cert.). To finalise themes and co-create recommendations, feedback was obtained through a workshop with 20 stakeholders from the NHS, local authority and third sector (in June 2019). This included support workers and commissioners, spanning social care, housing, discharge, track and triage, and primary care. This comprised some interview participants (n=11), wider stakeholders (n=6), the research team (n=2) and funder (n=1). The workshop was used to co-create recommendations.

**Findings**

Three themes were developed (see Table 2). To protect participant identities, quotes are labelled with an ID code grouping them into: local authority (LA), third sector (TS), or NHS.

**Theme 1: A plan in place: The need for better planning and communication with the third sector**

Having a plan in place was considered essential for a good discharge. Participants identified numerous challenges in services working together around hospital discharge processes. Most related to the perceived lack of planning, communication and co-ordination, often exacerbated by the need to ‘free up beds’ within hospitals. There was recognition that the NHS is under pressure, creating urgency around patient discharge:

“We know there is pressures with the NHS, and we understand that it’s more about juggling priorities, but I think too often, too readily, they want to discharge people at the earliest opportunity.” (LA1.1)

For people experiencing homelessness, this tended to mean that “there [is] nothing in place” (TS3)upon discharge, particularly in terms of accessing medication and prescriptions. This often resulted in services having to complete or chase up what they felt should have been done in hospital or could have been planned for better with earlier communication. These services were often third sector, and representatives talked about having to “drop everything to sort things out” (TS11.2). However, working in this way created more pressure on those services:

“Sometimes the communication from the hospital is not ideal as we don’t actually know when people have been discharged, so sometimes we will only find out on the day. Or they will turn up at the service and say, ‘we have been discharged from hospital and I need to pick my medication tomorrow’, and we don’t know anything about it.” (TS12)

In the climate of limited resources, the emphasis is on ‘firefighting’ and it was considered that a more planned approach would help to ease this reactive way of working. In the absence of appropriate support from statutory organisations, there was a clear perception that third sector organisations are going beyond their remits to help and advocate for people experiencing homelessness:

“We are already working well outside our remits, we are masking a lot of the problem. I will tell you what we are very verbal about it at meetings, but I think it is masking it.” (TS5.2)

There was a perceived expectation that third sector would “sort it out [and] step in where the system is failing” (NHS1). Some stakeholders felt that the third sector deserves more support and respect for its role with people experiencing homelessness. It was suggested that other sectors could benefit from working more closely with them:

“Well their involvement is on a very 1-2-1 basis and they probably know these individuals very well because of their involvement. It’s kind of not recognised because they haven’t got a I don’t know professional position.” (LA3.1)

Another challenge for services working together related to data protection and patient confidentiality, resulting in services being unable or reluctant to share information about discharge and subsequent appointments. In turn, this put onus on the individuals to contact services to inform them that they have been discharged (i.e., after the event) and require access to follow on support:

“So much information is lost isn’t it between services and like I say, somebody might be discharged with another service involved and we have got no contact with that service. Again you’re relying on the customer then to go ‘this person getting involved with me now’” (TS6.1)

Stakeholders frequently described professionals and organisations as working in silos. They reported that a partnership approach that is multi-disciplined and co-ordinated, involving services communicating and sharing information effectively, could help improve hospital discharges for this population. Given the multiple and complex needs of this group, spanning health, social care and housing, there was a recognised need to improve partnership working to support people experiencing homelessness generally and in relation to hospital discharge.

**Theme 2:** **A (safe) place to go? Training to improve awareness and ‘upskill’ hospital staff**

Having a safe place to go once discharged was considered essential to support the patient’s recovery. Stakeholders advocated training, raising awareness and “upskilling” (TS12)hospital staff to better equip them to understand complex needs and to work effectively with this cohort. This included better understanding the support currently available in the wider context (including temporary accommodation), and the requirements of the HRA.

Underpinning much of this was a perceived lack of such understanding, which exacerbated issues that patients experiencing chronic homelessness face. Stigma against this group was described as “the elephant in the room” (TS5.2)*,* recognised by stakeholders from across local authority, NHS and third sector, who perceived that some professionals could be reluctant to engage with and treat some people experiencing homelessness:

“If I'm honest, [some professionals] still have so much prejudice against homelessness and the way those people look and present themselves and perhaps behave, that any excuse to turn them away is a good one. Which I'm very ashamed of but I think it's the truth.” (NHS1)

Stakeholders called for training to improve communication with people experiencing homelessness around discharge, with numerous examples of where this had been lacking; for example:

“They [hospital staff] advised this gentleman [that he was going to be discharged sooner than expected], which he was extremely upset about and became quite agitated and as they termed it, ‘verbally aggressive’, but that was in response to being told in his mind ‘well you are not as important as the next person’” (TS3)

There was confusion around which roles and support services had been decommissioned, which were still operating, and their remits. This was highlighted as an important gap in knowledge that needed to be addressed so that hospital staff could work more effectively with other services:

“I think better liaison with the services and communicating as well, so making sure that everyone knows that those are services are out there” (NHS7)

This was echoed by another NHS stakeholder, who highlighted that it can be difficult to find out who to contact:

“When we have somebody with a housing issue or a homeless person in, it's difficult to find out your first point of contact, so what other agencies are out there that could support. I don’t know if *(agency)* can do any emergency housing, I don't know what other services there are, other than [the council’s housing service]” (NHS6)

It was raised that previously, the Homeless Matron (theme 3) was a key contact for hospital staff to liaise with if a quick response was needed; however there is now “no go-to person that can respond quickly” (NHS7).

Whilst some stakeholders believed the HRA had increased awareness around housing solutions, packages of care and services available to this population, there was a perception that a lack of awareness amongst hospital staff remained. The need to upskill staff to better understand and fulfil the requirements of the Act was clear:

“The hospitals aren’t clued up on the HRA at all. So they don’t seem to realise the council has got a Duty of Care as well, that’s one of the things we came up with on (hospital ward), we said ‘this is his housing worker, and if you want him out of hospital, you really need to put some pressure on her to find somewhere for them to go’.” (TS11)

There seemed an appetite amongst hospital staff for more training to address this:

“Certainly, I think it's filtering through the hospital. But it would be great if there was someone that could provide more education and training around that” (NHS7)

It was highlighted that whilst there may be procedures in place (e.g., a hospital discharge proforma), they are not necessarily followed in practice. Again, the issue was framed as a lack of time for hospital staff.

Questions were raised about how effective the HRA would be for people experiencing chronic homelessness as “it is just literally make the referral” (TS5.2). In practice, making a referral and ‘discharging to’ seemed to be conflated by some (NHS) participants; for example, the suggestion of having a link worker in A&E “*so they can discharge them to the rough sleepers’ team*” (NHS4). There appears to be a need to work with staff to unpick some of the discharge practices to better understand what the implications may be for people experiencing homelessness. As this quote highlighted, there was discomfort with some practice:

“We discharged him to the [LHA] and that didn't sit very comfortable with myself or the staff on the ward, he had one set of clothes and shoes with holes in, so the staff rallied round and got him some spare belongings and we sent him out with a food parcel and we discharged him to the [LHA] office. We would have liked to have done something more, but he was in a hospital bed and we hadn't got the resources to help him really and there was a demand for his bed.” (NHS6)

Whilst the council service is able to provide temporary accommodation to those assessed as in priority need, there does not appear to be any guarantee that patients discharged to the service would be accommodated immediately. Examples included homeless patients being put in taxis upon discharge and sent to the Council building for accommodation support, including outside of the office hours. There was concern regarding a potential lack of follow up and that information may not be double checked. For example, if a patient had a place in temporary accommodation when admitted, hospital staff might assume they should be discharged back there, without confirming their space is still available.

There was a perceived need for hospital staff to have a better understanding and awareness of “what temporary accommodation consists of” (LA1.1) and the implications for the patient and their health needs:

“That is something that we have tried to explain to the hospital team, because obviously if they talk to us at an early point, then that will help them inform decisions about discharging, because we wanted to educate them on the understanding of what we do. Because when we talk about emergency accommodation, because again we are talking about a roof, it literally is a room in a hotel, where there is no cooking facilities, there is no meal provision…how are they going sustain that accommodation and continue their recovery?” (LA1.1)

The broader issue of a lack of supportive accommodation options (for groups other than older people) was highlighted, for example, those with experiences of homelessness, drug use and complex needs; it seemed the question of whether there is a safe place to go for this cohort was often left unanswered on discharge.

**Theme 3:** **Need for (re)investment in outreach and flexibility for people experiencing chronic homelessness**

Participants acknowledged the challenge for the wider health care system working with this group, particularly in the context of funding cuts and reduced service capacity. The limitations on time and ability to work flexibly that resulted from cuts to service budgets were thought to make it even more difficult for various services to engage effectively with people experiencing homelessness. In addition to the stigma (Theme 2), participants perceived that the current mainstream support is unable to meet the often complex and multiple needs of people experiencing homelessness. Working with people experiencing homelessness necessitated building trust and fostering relationships alongside addressing clinical needs, which requires “a fairly disproportionate amount of time” (NHS4). This tension is not easily resolved with the level of demand faced by GP practices:

“It's not that they don't care, they are just overwhelmed with other stuff”. (NHS 8)

Within this context, there was a perceived “lack of a person-centred support and care” (TS3) for people experiencing homelessness, whereby there was often not the time or will to attempt to understand the patient’s needs, views and experiences. This related to hospital discharge and care more generally:

“She (customer) had the rough sleepers team involved, a resettlement team, a tenancy service, and she wouldn’t engage with any of them because they all work 9-5, she didn’t want it 9-5, it was the night times. So [we] could get a lot of services in there but not enough.” (LA7)

Outreach was considered vital, and there was concern that resources to work in this way were being cut:

“So it just disappoints me that the local drug and addiction services have had a funding cut in their new tender, so there is going to be less assertive outreach, but for our customer base that is essential, because actually they are struggling to attend appointments.” (TS5)

Appointment-based systems were recognised as problematic for this cohort. The need for a specialist “homeless health service” (TS1) was underscored, as was the need for staff to be dedicated and committed to work with people experiencing homelessness, with the necessary skills and knowledge, time and ability to develop secure relationships for a more pro-active and preventative approach:

“I think they are viewed as a difficult group … I don't like any group being called difficult, it's just a different skillset and a different thing you have to deal with” (NHS8)

The combination of drug use and mental health was regarded as challenging to manage within the current system. Most participants discussed a previous (decommissioned) role of Homeless Matron which they perceived as effective. This success was attributed to the outreach approach, accessibility of the care, the focus on managing conditions and prevention before issues were exacerbated and required urgent attention, and the strong relationships developed with people experiencing homelessness:

“…[the homeless matron] used to have a clinic in (hostel), she used to go to the needle exchange, she’d go to the soup kitchens that are run in the evening and she would run her clinics from there… it was very accessible to them [people experiencing homelessness]; they were going there anyway” (NHS5)

The flexible and informal nature of the support was framed as fundamental to its success and it was highlighted that the processes and procedures in place “enabled, empowered” (LA4) the role to be performed in that way. Again, this demonstrates that working effectively with people experiencing homelessness is a specialism within the wider healthcare system, and requires different, more flexible, approaches and standards. All stakeholders expressed hopes that the role would be reinstated (it has since been). Recognising that the current system does not work for people experiencing homelessness, stakeholders called for more investment in a different approach:

“If you want to do something different, then you need to stop cutting-I know the purse is tight and as a local authority officer it’s very difficult for me to say because I know the local authority have to do the best for the public purse.” (LA7)

**Discussion**

Hospital discharge for people experiencing homelessness in this city was framed in a context of high levels of deprivation, prejudice and stigma. Ultimately, a good discharge was considered as having a plan in place, and a safe place for the patient to go to continue their recovery. However, this study highlights that for patients experiencing homelessness, this was difficult to achieve for various reasons. Some of which related to attitudes and practice within the hospitals, and the lack of specialist understanding about this cohort and their needs. As will be discussed, others related to the wider system and the context of cuts to funding within this city, which has undermined the local authority’s ability to address social determinants of health (such as appropriate housing) (Marmot et al, 2020). Thus, this study reiterates the need to locate hospital discharge for homeless patients in the wider context (Jenkinson et al., 2022).

Our findings emphasise the critical contribution of third sector and community organisations, going ‘above and beyond’ in the support they provide people experiencing homelessness. This was framed in the context of cuts to statutory services, and the third sector having to react and respond to failures in other parts of the system. Identifying and supporting mechanisms that facilitate partnership working (between hospitals, local authority and third sector) are vital in the context of the Care Act (2014) and the HRA (2017). However, our findings suggest that there seemed to be reluctance and concern over sharing information with the third sector. This echoes research from Toronto that found the legal context of health information protection created barriers to knowledge sharing between hospitals and shelters, excluding shelter workers from discharge planning (Jenkinson et al., 2020). The development of a ‘release of information’ form may aid communication between partners, and ultimately improve care for people experiencing homelessness during the transition from hospital (Canham et al., 2019). This would undoubtedly relieve some of the added pressure that ‘firefighting’ has on the third sector.

We would suggest further work with all partners (local authority, third sector and health), to develop a site-specific checklist for practice before discharge (and as early as possible) to ensure measures are in place for accessing following on care and support, including timely communication and information sharing about medication/prescriptions to the patient and wider services. This checklist could also set out the agreed procedures that relate to the HRA. Gallagher et al.’s (2020) work on the ‘Homeless Health Initiative’ emphasised the need to address how compliance with checklists can be improved and how they can be made more robust, for example, by including contact with community inclusion health and street outreach teams. Certainly, in this context of already stretched hospital staff, having extra paperwork to fill in appeared challenging. A partnership approach to developing checklists may help address some of these issues.

Our data highlighted a perception that the NHS may be the more reluctant partner in this context. It was acknowledged that time and capacity are limited within health (as across the board), and that relevant specialist knowledge related to chronic homelessness is also limited within the hospitals. However, there was a clear message that ‘quick’ hospital discharges often occurred with this population, without attempts to look deeper or holistically at their needs, nor having time to substantiate information (e.g., medication, prescriptions and availability of hostel beds). Some NHS participants shared examples of when they felt uneasy about discharges (e.g., of discharging homeless patients to the LHA offices) and there is a need to look further at the implications of this practice and what it means for the health and recoveries of patients’ experiencing homelessness; a referral to the LHA does not automatically mean the patient will be housed immediately, and/or they may be placed in temporary accommodation that could undermine their health and recovery. As acknowledged by participants, hospitals need support with identifying and understanding the wider network of support available for people experiencing homelessness (Paudyal & Saunders, 2018), and so training needs to include up-to-date resources with contact details and remits of the support available (and eligibility) in the local area.

Further training and improving awareness of some of the issues people experiencing homelessness face could help staff to better understand and engage with this population. This type of training could be delivered by ‘experts by experience’ (Wilson & Astley, 2016) which could help build appreciation of the complexities involved. At the stakeholder event, this was linked to a need for more training and delivery of trauma-informed practice, to fundamentally shift the focus from ‘what is wrong with you’, to ‘what happened to you’ (Harper & Cromby, 2020).

Cornes et al. (2019; forthcoming) call for more recognition of safeguarding for people experiencing homelessness, to help to combat the stigma and discrimination they face within the system. We would extend this to highlight a need for wider improved legal literacy in the context of hospital discharge and homelessness. Braye and Preston-Shoot (2016) highlight the three components of legal literacy: knowledge of the legal rules and understanding of how they relate to practice, strong engagement with professional ethics, and respect for the principles of human rights, equality and social justice. Improving knowledge and understanding of relevant legislation (such as The Care Act (2014), the HRA and safeguarding) may help to recognise and reduce unsafe practices of hospital discharge when homelessness is a factor. It may also give hospital staff the confidence and foundation to challenge the pressure for ‘quick discharges’ when there is a lack of a safe place for patients to be discharged to. In addition, collecting and sharing case studies with hospital staff and commissioners about what happens to people experiencing homelessness when they are ‘discharged to’, for example, the LHA, the rough sleepers team, or a hostel, may help to better understand the implications of this practice; given the lack of accommodation in the city, particularly for patients who are homeless with complex needs it cannot be assumed they are all provided with stable accommodation upon discharge. Arguably, there is a need to improve awareness and recognition of housing (or lack thereof) as a health issue in the sector. Such acknowledgement would further strengthen the case for slower discharges for people experiencing homelessness (as called for by Hodson and Glennerster, 2020).

Additionally, identification of housing status, and the lack of a safe place to go, should be done as early as possible (i.e., on presentation) rather than at the point of discharge when it may be harder to find suitable accommodation options (Hewett, 2019). Hewett (2019) suggested routinely asking the question: ‘Do you have somewhere safe to go when you leave hospital?’, which could then prompt an explanation about the HRA referral process and seek the patient’s consent. Training staff to do this effectively would facilitate a proactive and planned discharge, which would also assist other services that may be required post discharge.

Running throughout our findings was the message that the current system of care and support is unable to meet the needs of people experiencing homelessness. Stakeholders emphasised the need for (re)investment in a different approach, based on outreach, flexibility, trust and prevention. Wider research demonstrates the need for a shift towards integrated healthcare and psychosocial outreach, to improve access to mainstream healthcare for people experiencing homelessness (e.g., Parsell et al., 2019). Stakeholders highlight that appointment-based systems are not accessible for this cohort. Bureaucracy and restricted opening hours alongside stigma and discrimination are known to hinder access to health and social care (Omerov et al., 2020), which our stakeholders confirmed.

In our study, stakeholders emphasised that working with people experiencing homelessness requires dedicated staff with specialist skills who are willing and able (individually and within the system); health-care providers and social services can face difficulties in recruiting such staff (Paudyal & Saunders, 2018). Stakeholders felt that a specialist homeless service was needed, and in many ways, the reintroduction of the Homeless Matron role is likely to provide the specialist skills, capacity, person-centred, flexible outreach approach that was advocated by stakeholders. This role would also be an important contact for hospitals to liaise with about a person experiencing homelessness’s discharge (again, this should be done as early as possible in the process). Ultimately, the provision of a flexible service that treats patients with dignity and respect, and acknowledges the difficulties they encounter, can provide effective care for this population (Morton, 2017).

*Strengths, limitations*

Strengths of this study include the broad range of stakeholders interviewed, and use of a participatory workshop to validate findings and develop recommendations. Limitations are recognised. First, the voices of people experiencing homelessness were not captured, but are needed to play a part in the conversation in how to improve the situation for themselves and other people experiencing homelessness (Massie et al., 2018). Second, we were unable to recruit discharge facilitators from hospitals (although one contributed through the stakeholder event). This study did not investigate views about hospital discharge and gender; given that homelessness is associated with differentiated trajectories for men and women (Bretherton, 2017), this merits consideration. Future research could investigate the role of the hospital discharge teams for people experiencing homelessness specifically or carry out interventions that support this population through the discharge process.

**Conclusion**

This study emphasises the need to strengthen partnership working around hospital discharge and improve links between hospitals and the third sector, who provide valuable support for people experiencing homelessness in the community. There is a clear need for more planning and better communication channels between all partners, ahead of and during discharge processes; identifying mechanisms that support this are vital. Working effectively with people experiencing homelessness should be recognised as a specialism that requires different approaches, standards and training within the wider healthcare system. Training and upskilling staff to improve understanding around people experiencing homelessness, and the wider system of support available (including temporary accommodation) is recommended. Improving legal literacy in the context of what an appropriate discharge is for people experiencing homelessness may help develop staff confidence to challenge practices around ‘quick’ discharges for this cohort. Further work with partners to develop site-specific checklists for hospital discharge, that include agreed procedures related to the HRA (2017) and links to other services, is encouraged.

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**Tables**

Table 1: Breakdown of interviews and total number of participants

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Stakeholder | Breakdown of expertise | 1-1 interview | Joint interview (2 participants) | Total participants |
| Local authority | Adult social care | 1 | 1 | 7 |
| Housing support | - | 1 |
| Commissioning, including homelessness | - | 1 |
| Third Sector | Community alcohol and drug | 1 | - | 12 |
| Hospital to home support | - | 1 |
| Homelessness/housing/complex needs | 2 | 3 |
| Access to services | 1 | - |
| NHS | Primary care | 3 | - | 8 |
| Hospital care – alcohol or drugs | 2 | - |
| Hospital care - palliative | 1 | - |
| Hospital - patient flow (i.e., monitors length of patient’s stay and any delays | 1 | - |
| Commissioning | 1 | - |

Table 2: Findings

|  |  |
| --- | --- |
| **Theme** | **Name of theme** |
| Theme 1 | A plan in place: The need for better planning and communication with the third sector |
| Theme 2 | A (safe) place to go? Training to improve awareness and ‘upskill’ hospital staff |
| Theme 3 | Theme 3: Need for (re)investment in outreach and flexibility for people experiencing chronic homelessness |