Burdett Trust for Nursing

pathway
Healthcare for homeless people

Towards System Leadership -

defining the role and potential of nurses working in homeless hospital discharge

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Key messages from this report

1. **The Band 7 nurse hospital-based role that focuses on improving hospital discharges for people experiencing homelessness is a clinical nurse specialist role**

The Band 7 role meets the criteria for a clinical nurse specialist job title, in that there is a distinct expert knowledge and skills base that the nurses utilise to deliver specialist care. Expertise spans patient engagement, physical health, mental health and addictions, safeguarding, mental capacity and cognition, harm reduction and motivational practice, concordance, and health and housing rights. The nurses are also involved in defining quality care, and also influencing the health wider systems they work within to deliver quality care.

2. **The role is not just about the discharge of people experiencing homelessness, but has a much wider potential reach and impact**

The role is not just about effective hospital discharge. For an individual patient it is also about front-line engagement (within a multiple complex needs context), maximising the benefit of the admission for the patient, and assisting patients to get equitable and effective treatment and follow-up. For the wider system it is about influencing the system to be more inclusive, compassionate, accessible, and flexible to all people with complex needs - these nurses are changing hearts and minds every day, in order to deliver a wider culture change. Finally, the role is about ensuring the system is working correctly in line with best practice, clinical guidance and legislation, and that the gatekeeping practices often brought to bear with this group of patients are not allowed to prevail.

Overall, these nurses have the potential to have much wider system influence if they are supported to do this. If the role was invested in and developed, inclusion health consultant nurses could ensure inclusive care was delivered across all organisations in the future.

3. **The hospital-based role is distinct from homeless health practitioners that work in the community**

Although the knowledge and skills base for the nurses working within the community and hospital is similar, the hospital-based role is less about 'hands on' care and the treatment of specific clinical conditions, and more about complex case management, working with people in crisis, challenging stigma, and changing hospital systems so that they work better for disenfranchised people. However, being less 'hands on' does not make it less clinical, and the role demands a very high degree of clinical acumen.

4. **Community homeless health practitioners and nurse champions / link nurses within hospitals are also working hard to improve outcomes and deliver system change in this area, but often with limited resource directed towards this**

Several participants on this project were not employed full time in roles that were directed at improving hospital discharges for people experiencing homelessness. However, they were all senior nurses, with directly relevant specialist expertise, and they were also making an

impact through advocacy, partnerships and teaching. Their input to the project was invaluable, and their participation was vital in considerations of best practice and quality.

5. A clinical network is needed to support this clinical speciality

There are currently a relatively small number of nurses (25-30) working in this emerging speciality, who are generally quite isolated within their organisations (although it is likely there will be more in the future). A huge amount of very real challenges for these practitioners have been articulated in this report. They are delivering highly skilled advocacy and fighting the system every day, which is mentally exhausting.

These nurses need to be able to link up regularly to trouble-shoot challenges, and to be able to support each other to avoid burn-out, but also to share current best practice, and develop the evidence base for practice. However, most organisations will not provide time or resources for them to network outside their organisations without a clear imperative or incentive for doing this. This is a challenge that needs overcoming.

6. There needs to be development of a greater evidence base

Most patients seen by these nurses have multiple complex needs, and the number of patients being seen is unpredictable, and in most cases increasing (e.g. due to a background increase in the numbers of homeless people). As such it is impossible to maximise the benefit of the admission fully for all patients in all cases, and generally the emphasis in all services has been on the immediate management of risk. However, after this, whilst many similarities in practice do exist, other aspects of practice have developed locally in line with practitioner 'gut feelings', and it is actually unclear in many scenarios what best practice actually is.

There is a need to develop more evidence into the priorities interventions e.g. how much time should be spent teaching staff and or link nurse programmes, and what is the impact of wider staff teaching on patient outcomes vs delivering an individual one to one intervention. There is also a need to test out specific ways of working e.g. does routine follow up of patients (not standard in most services due to capacity) improve outcomes. There is another key question regarding the extent to which these services should be integrated and/or whether there should be any service boundaries at all - and how nurses should work within that. These nurses are extremely well placed to cross boundaries and work in both primary and secondary care, which would seem to be of considerable benefit to patients in some cases.

As this is an emerging clinical discipline, and many of these nurses are isolated, extra support needs to be mobilised to help these nurses develop the evidence base. Indeed, many of these nurses could be encouraged to make formal research applications regarding the development of practice in this area, in order to help define the discipline for the future.

It is important to note that nurses are the one common denominator within the homeless hospital discharge interventions around the country, and are therefore arguably the best discipline to be leading this research.

7. Standards for practice also need development

Although this project has produced draft voluntary standards for homeless hospital discharge practice based on the previous voluntary standards for practice published by the Queens Nursing Institute, this is just the start of a potential process that could lead to later ratification with some thought. Via a wider steering group and process it might be possible to work towards a statement of voluntary standards for all homeless health nurses that includes both community and in-hospital nurses. This would perhaps help the Queens Nursing Institute support this process – because it is important to note the Queens Nursing Institute supports community nurses, and whilst homeless hospital discharge teams are arguably a community in-reach intervention, most of the nurses involved are actually hospital employed.

8. There is a potential need to develop bespoke Continuing Professional Development content in this clinical area

Although the Faculty of Homeless and Inclusion Health has now stimulated the introduction of two Inclusion Health Masters modules (one at UCL and one at Edinburgh), both focus primarily on the social determinants of health, the structural causes of homelessness, the impact of homelessness on health, and discussion on system-based solutions. Neither provide clinical content focused on e.g. the prioritisation of clinical interventions in this context, motivational practice, promoting concordance, the assessment of cognition, the management of frailty, working effectively with clients with complex trauma / personality issues, being an effective clinical advocate, or common clinical conditions (e.g. liver disease). There is a potential need for a clinical course at post-graduate / Master level that covers this content, that would potentially be relevant to anyone working in a complex needs setting.

However, when considering the clinical expertise that is required to work effectively in this area, there could be an argument for develop a specialist practitioner programme which pulls together some elements of existing specialist practitioner programme areas, but adds new areas. For example, a programme might have the core areas: inclusive practice, mental health, addictions, chronic disease management, public health screening, migrant health.

9. A Continuing Professional Development directory should be created on-line

On a more immediately deliverable note this project has identified quite a lot of continuing professional development content that is relevant to the sector and is freely available on-line. However, it is not coherently assembled, and therefore quite hard to find for any individual. A useful intervention might be to create an on-line hub with links to useful CPD, e.g. either via the Pathway or Queens Nursing Institute website. This could be shared widely via the Faculty of Homeless and Inclusion Health, Queens Nursing Institute Homeless Health Initiative, London Homeless Health Programme and London Network of Nurses and Midwives Homelessness contact lists to benefit as many nurses / other practitioners as possible.

10. There should be a rebranding of this role

Although nurses working with people experiencing homelessness in hospitals and the community often have the word 'homeless' or 'homelessness' in their title it is important to note that homelessness is a state, not a trait, or indeed a clinical condition, and this could be construed as labelling. It also doesn't really underline the ambition for the role, and in a hospital context often ends up with the nurse being seen as a housing worker.

This inherent labelling is an issue that has already being addressed in part. 'Inclusion health' has recently been defined as 'a social justice movement that aims to prevent and address the harms of extreme inequity through research, service and policy', and gives examples of people that would come under an inclusion health agenda – people that are homeless, prisoners, migrants, drug users, sex workers. As such both community and hospital nurses working with people experiencing homelessness could be branded as inclusion health practitioners, and the job descriptions produced for this project have been branded as such.

However, another option would be for these nurses to be called complex needs practitioners. This would certainly be descriptive of the seniority of the role, and the depth of knowledge and skills required.

11. Pre-registration health practitioner courses need clearer content in regard to inclusion health

The direct interface between these nurses and mainstream practitioners has thrown a clear light on the need for curriculum content for pre-registration courses to involve pragmatic content around actually addressing inequalities in health, not just explaining the social determinants of health. These nurses see a high level of inadequate knowledge and skills related to rights and access to healthcare, NHS charging, cultural competence and inclusive practice generally. Engagement with providers of pre-registration health practitioner education is planned via the Council of Deans of Health and Medical Schools Council, however a further work to support the development of basic core curriculum e.g. 'the ten things everyone should know' would be required, and needs steering and funding.

12. The Royal College of Nursing should consider whether non-medical prescribing is essential for advanced nurse practitioner accreditation

Many of the nurses on this project would not meet the criteria for Royal College of Nursing advanced level practice credentialing, despite obviously being advanced level practitioners, because they do not have a non-medical prescribing qualification which is an essential requirement. However non-medical prescribing would not be of any use to these practitioners, as one of the main focuses of this work is engaging people appropriately with other services. This is not a role of diagnosing or working with undifferentiated conditions (for which prescribing would be appropriate), and yet it still requires very advanced level clinical skills.

In summary this group of passionate, autonomous nurses with exceptional clinical expertise, who have the ability to inspire the wider health care system to always provide the best care possible, but they need ongoing support.

What now?

In an ideal world this group of nurses could now be facilitated to bid for further funding (potentially in a partnership supported by Pathway and the Queens Nursing Institute). Priorities for a second stage project include:

1. Deliver further leadership training to these nurses, and support the continuation of the clinical network
2. Further develop and ratify standards for practice for these nurses
3. Engage the National Institute for Health Research with a view to encouraging and supporting nurses to do research and understand best practice in this area
4. Publish and on-line directory of existing CPD
5. Scope options for a continuing professional development course and or specialist practitioner programme
6. Develop pre-registration core curriculum content for health practitioners that could be offered free to educational institutions

Introduction

This paper outlines the work of a 15-month project to define the role and potential of nurses working in homeless hospital discharge.

The project was hosted by the Pathway charity and funded by the Burdett Trust for Nursing. The Queens Nursing Institute, Royal College of Nursing and London Homeless Health Programme (Healthy London Partnership) were involved on the steering group. The Queens Nursing Institute also provided ongoing expert advice outside the steering group, as did a representative from the Pathway Education committee. The project lead was Samantha Dorney-Smith, Nursing Fellow, Pathway, who was previously the lead nurse for the Pathway homeless hospital discharge based across the Kings Health Partners collaborative of hospitals.

The original stated objectives of the project were to:

- Develop a 'clinical nurse specialist' role description, competency framework and recommendations around Continuing Professional Development
- Understand best practice across the UK through shadowing and observation
- Develop a dialogue with service users about best practice
- Build a supportive network of nurses in this emerging clinical area
- Develop leadership skills in these nurses
- Think about the future of the role.

The project mostly considers the work of inpatient based nurses holding a specific specialist title, and in a role entirely devoted to improving hospital discharges for people experiencing homelessness. However, the project also involved nurses based in community settings who were also working to improve homeless hospital discharge arrangements, and nurses without specialist roles, but who were acting as nurse 'champions' in their systems.

This report summarises the findings of the project, and provides recommendations for the future development and support of the role. All nurses in these types of role nationally (not just nurses in Pathway teams) were involved.

Project outputs contained in the report include:

- a detailed description of role, a summary of best practice and local innovations,
- an articulation of the challenges faced by these nurses.
- a job plan,
- suggested job descriptions,
- an analysis of the continuing professional development needs of the role
- key performance indicators for the role that were developed by the nurses and a service user feedback form.

It is hoped that the report will be a resource for nurses currently in this role, and that it will act as a springboard for further work to support these nurses in the future.

N.B. Two of the nurses or their services were nominated for national awards during the period of the project, Helen Phelan and Lucy Harrison.

Project activities and methodology

The project was funded by the Burdett Trust for Nursing from January 2018 and March 2019. Activities undertaken to support the project were:

- Nurses working in homeless hospital discharge interventions and their managers were contacted from January 2018 to secure their involvement
- Leadership facilitator Jan King was engaged in January 2018 to help design the workshop programme content
- 3 full-day workshops for nurses were facilitated in London in June 2018, October 2018 and January 2019. Around 20 nurses attended each workshop from England and Scotland. Content focused on a variety of key issues including sharing best practice and innovation, developing key performance indicators and monitoring processes, obtaining service user feedback and defining competencies. Outside speakers were involved.
- Workshop 2 focused entirely on quality improvement and Experts by Experience were involved in the design and delivery of the workshop, although they played an important role in all three workshops.
- Shadowing visits to 14 different sites were undertaken (for either 1 or 2 days in each case) to observe and understand practice. Notes were taken throughout including key quotes from nurses.
- During these visits' interviews were also conducted with the nurses with a set of routine questions regarding length of time qualified, core qualifications, highs and lows of practice etc.
- Communication with other nurses about their roles happened by phone or email outside workshops.
- A task and finish group with Experts by Experience was delivered to develop a suggested service user feedback form that might be used within services.
- Multiple engagements with educationalists and educational standards setters were undertaken e.g. at the RCN, QNI, NMC, UCL, University of Edinburgh, the Academy of Royal Medical Colleges
- A literature review was undertaken regarding the history of homeless hospital discharge practice.
- Three steering group meetings were held in February 2018, July 2018 and March 2019.

Background literature

The first clear reference to homeless hospital discharge policy was in 2003. A Department of Health document 'Discharge from hospital: pathway, process and practice'[1] stated that all acute hospitals should have formal admission and discharge policies to ensure that homeless people are identified on admission, and that the discharge of homeless people should be notified to relevant primary health care and homelessness services.

However, by 2004 there was recognition that further guidance was needed. An expert steering group was then set up consisting of representatives from Homeless Link, the London Network for Nurses and Midwives Homelessness Group, the Department for Communities and Local Government and the Department of Health. Guidance was jointly issued in 2006[2] stating that it was the joint responsibility of hospitals, Primary Care Trusts (PCTs), local authorities and the voluntary sector to put a protocol in place to ensure that no one was discharged from hospital to the streets or to inappropriate accommodation.

Responses to the guidance included a number of perceived best practice protocols such as the Liverpool Hospital Admission and Discharge Protocol for Homeless People, and the Newcastle Hospital Discharge and Homeless Prevention Protocol. At around the same time, in 2009, the first ever 'Pathway model' homeless hospital discharge team (a GP, nurse and peer worker working together within a hospital) was piloted at University College Hospital. However, a survey in 2010 of all Local Authorities in England indicated that implementation of the hospital discharge guidance was far from widespread, with only 39% reporting that they had a discharge protocol[3]. At the same time a national audit of homeless people showed that only 27% of clients had received help around their housing before discharge on their most recent admission to hospital[4].

In 2011, the Government committed to ending rough sleeping in their strategy 'Vision to End Rough Sleeping: No Second Night Out Nationwide'[5]. It contained four pledges including the pledge that 'no one should arrive on the streets'. At the same time a report by the Centre for Health Service Economics & Organisation (CHSEO) in 2011 showed that homeless hospital discharge protocols demonstrated cost benefits through a reduction in 'bed blocking' and 28 day readmission to hospital rates.[6].

This pledge, and lobbying from a number of key partners, led the Department of Health to release a one-off Homeless Hospital Discharge Fund in 2012. A total of 52 projects received a share of the £10 million grant fund available in 2013. This included some projects that had only housing workers, and other projects that had clinician as part of the team. The common denominator of the teams with clinicians was a nursing component, although other teams had a mix of GPs, OTs, Social Workers, housing workers and peer workers (the 'Pathway model' teams).

In a Homeless Link evaluation in 2015[7], data and feedback was obtained from 41 of the projects. Patients managed by these services were reported to be discharged into accommodation 71% of the time (which was a considerable improvement), and this went up to 93% when step-down accommodation was available as part of the package. However, despite this, only 17 out of 41 projects reported receiving extra funding to continue their

project beyond the life of the DH grant, and seven of these received reduced funding from the funding that was given for the pilot. It was important to note though that the teams involving clinicians were relatively more likely to survive, many of which were Pathway teams. Since then Pathway has published papers on the effectiveness of the Pathway approach [7,8,9].

In the background, since 2010, homelessness levels in the UK have gone up, and many specific challenges for people experiencing homelessness have increased[10]. For example, hostel bed closures and welfare reform policies have had an impact, and Universal Credit in particular has been difficult for disenfranchised people. An extension to NHS charging has had an impact on some vulnerable migrants[11]. As such the challenge of effectively managing the care and discharge of a homeless person has increased.

On a more positive note, since October 2018, the Homelessness Reduction Act (2017)[12] has conveyed a 'duty to refer' on Accident and Emergency departments and inpatient settings for patients identified as experiencing homelessness, or being at risk of homelessness within the next 56 days. This requires patients to be referred to a Local Authority for support (with their consent). As the requirement to meet this duty becomes better understood by health organisation leads, it may be that more hospital homeless teams emerge. (The Act was a Private Members Bill that resulted from direct lobbying from Crisis, and also improves the patient level Local Authority response to homelessness applications.)

Finally, the NHS Long Term plan[13], published in January 2019 cited homeless hospital discharge teams (in this case a Pathway model team) as an example of good practice to reduce health inequalities. This strongly suggests that homeless hospital discharge teams are here to stay. It is also important to note that the results of a 3-year National Institute of Healthcare Research study on homeless hospital discharge are awaited.

Nurses are the common denominator of all the current homeless hospital discharge interventions where clinicians are nvolved, and in most cases, they are leading the services.

With this background this project was set up with the aim of:

- acknowledging the key role of nurses in developing this emerging discipline,
- building a network of these nurses, to enable them to develop a shared understanding of their current role, and to enable them to share best practice, and problem solve the challenges they face,
- developing a formal structure for this new clinical discipline within nursing,
- helping these nurses to understand the potential within their role to deliver more inclusive health systems generally.

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The nursing role in the hospital discharge of people experiencing homelessness

Types of Roles

The project mostly considers the work of inpatient based nurses holding a specific specialist title, and in a role entirely devoted to improving hospital discharges for people experiencing homelessness. However, the project did involve nurses based in community settings who also work to improve homeless hospital discharge arrangements, and the role of nurse 'champions' - nurses without a specialist role who influence the system to enable better homeless hospital discharge pathways. All three types of nurses were involved in this project. More detail on each role follows below:.

Specialist Nurses based in hospitals

> *'You're my one person this morning. I've got plenty of time. I'm going to try to get the whole picture of how things are for you'*
>
> *'Other staff have trouble, but it depends very much on how you approach her. You need to give her respect, let her lead'*
>
> *'If they are at risk of self-discharge it's important just to be present.'*
>
> *'I've got to be like a barrister, fighting for people's rights. That last email was a work of art and it had to be!'*
>
> *'In every interaction I have I am teaching people. Quietly, subtly, but it's part of the grand plan'*
>
> *'I'm always thinking about how to improve things, what can we do next?....'*

These nurses are based primarily or entirely within inpatient settings, assessing patients admitted to the hospital who describe themselves as currently homeless.

In many ways focusing on the activity of 'homeless hospital discharge' is misleading. Whilst the ultimate aim of homeless hospital discharge nursing is to ensure that patients who are homeless when admitted to hospital are discharged safely, effectively and compassionately from hospital, the broader aims for each individual patient are to:

- effectively engage the patient in all relevant services / support,
- maximise the benefit of the attendance / admission for the patient from a health and social care perspective,
- link the patient into all necessary health and social care and support pending discharge,
- advocate for the patient to receive assessment, treatment or services when this is required,
- safeguard patients effectively,
- ensure a safe and effective discharge to accommodation (where this is possible)
- stop the revolving door.

The nurse triages, prioritises, assesses and manages a caseload of patients, a high percentage of whom will have mental health problems, addiction problems, communication difficulties, disabilities and legal complexities in addition to their physical health care problems. Patients often present with tri-morbidity (the co-concurrence of physical health, mental health and addiction problems) and other multiple complex needs, and may have non-engagement issues and/or challenging behaviour patterns. Nurses tend to have an individual ongoing caseload of between 10-15 patients, with teams seeing between 200-800 patients a year (team sizes in general reflect the number of referrals).

Where the nurse sits as part of a wider team the nurse is generally the operational lead. The nurse is also sometimes the clinical lead for the team. The clinical leadership depends on whether there is medical input, and the extent of this input.

The nurse also works to improve the effectiveness and quality of service being delivered and the discharge pathways available for this group of patients. Much of this work will be done in active partnership with a wide variety of partners. In addition, the nurse aims to influence the hospital and related systems to proactively identify and better respond to the needs of currently homeless and otherwise disenfranchised people, which often includes the provision of formal teaching.

A job plan outlining a suggested breakdown of activities for the Band 7 role (the most common banding of the role) can be found in Appendix 1.

Seventeen nurses in England and Scotland have so far been identified they hold posts similar to this. None have yet been identified in Wales and Northern Ireland. One has been identified in Dublin, Ireland.

Specialist nurses based in the community with a partial remit to improve homeless hospital discharge

> *If I become aware that a patient in hospital is to be discharged to rough sleeping, the way I tackle it is to go to the hospital to testify face to face with Consultants / Ward Sisters etc as to the risks associated with their discharge'*
>
> *'I've provided case studies for Commissioners, and developed a draft protocol to improve things [with the City Council]'*

'

This group of nurses is based in the community, and they usually have a pre-identified caseload. These nurses work to ensure that the benefits of hospital admission are maximised for any clients on their caseload that are admitted, and that the admission is also used to enable discharge to the best possible accommodation. However, this is generally only part of their overall case management remit.

These nurses are often working at senior level, and have a remit to influence the hospital and related systems to better respond to the needs of currently homeless and otherwise disenfranchised people.

Nine nurses were included on this project who fit into this category, although there are many more. Several of these nurses are in senior roles in the community.

Nurse champions for patients currently experiencing homelessness

> *'We ask everyone here if they have somewhere safe to go to when they get admitted… We make sure we are ahead of the game'*
>
> *'I want to be the homeless patients ward. I want them to have a good experience here.'*
>
> *'They feel very busy [the staff], and it all feels too difficult'… 'but they watch me [the staff], and they learn how to manage the behaviour, and everyone is happier'*

This group of nurses do not have a specialist role, but attempt to influence the hospital and related systems to better respond to the needs of currently homeless and otherwise disenfranchised people. This group of nurses can still have a considerable impact of the culture of a health care organisation.

Examples of interventions include being a homelessness link nurse in a ward or A&E, or indeed initiating a programme of such interested nurses without having a specialist team in place. A key responsibility of these nurses is developing and keeping updated leaflets about local services, and holding clothes and other sundries to give to people needing these.

Some hospitals have 'housing worker only' intervention teams. However, the housing workers are generally attached to or allocated to or naturally end up working with certain nurses who then become homeless champions for the rest of the system. These nurses often work in hospital discharge teams, but can have other roles. One hospital was routinely asking everyone whether they had a safe place to go on discharge, which is clearly excellent practice.

Six nurses were identified on this project that fitted this criterion.

Knowledge, skills, and experience for the role

This section focuses on the role of nurses based in hospitals, where the entirety of the nurses' role is devoted to ensuring safe, effective and compassionate discharges for people experiencing homelessness.

It is based primarily on the role at Band 7 (the modal banding for the nurses on the project).

Analysis of notes from shadowing visits and in-depth interviews with sixteen of the nurses enabled theses key areas of recommended knowledge, skills and experience to be identified. It is important to note that some nurses said they didn't have all these attributes when they started their roles.

KNOWLEDGE	• Social determinants of heath and how this directly effects patients • good generalist clinical knowledge spanning physical health and mental health • addictions, addictions management and the health sequelae of addictions • how to identify and manage communication barriers e.g. language, literacy, cognition, behaviour • how to identify and work with disability (including hidden disabilities) e.g. physical disabilities, dyslexia etc • knowledge around cause and effects of complex trauma and personality disorder and treatment approaches • cultural competence • mental capacity and cognition • safeguarding legislation • harm reduction approaches • suicide prevention approaches • medication and concordance techniques • knowledge of how to manage of chronic medical conditions • rights to healthcare and NHS charging • rights to housing, housing options and local authority processes • support options available for people experiencing homelessness in the local community • immigration status and its impact on welfare rights • migrant health issues • public health and screening programmes • health promotion approaches and how to 'make every contact matter' • data sharing legislation • change management approaches

SKILLS	• excellent oral, and written communication skills • high levels of motivation • confidence, leadership and role modelling skills • ability to engage clients from a variety of highly disenfranchised populations • high level clinical advocacy skills and an ability to negotiate with senior staff without generating conflict • ability to triage and prioritise in a multiple complex needs context and make independent decisions • caseload management skills • ability to undertake effective comprehensive holistic health, housing and social care assessment for a patient including the assessment of risk in high-risk patients • ability to work daily with multiple patients with highly distressing personal circumstances and stories • understanding of and ability to maintain appropriate boundaries • motivational interviewing skills • management of challenging behaviour • working with complex trauma and personality disorder • problem and conflict resolution skills • team working skills • supervision, coaching and management of other staff • clinical audit skills • ability to monitor and produce reports on team performance • ability to build and manage partnerships with hospital, statutory and voluntary sector partners • ability to design and deliver teaching on a 1:1 basis and within large groups • ability to undertake a service user feedback exercise • ability to deliver culture change and be a systems leader
EXPERIENCE	• extensive clinical experience in a relevant discipline • leadership experience • experience of monitoring and managing team performance • experience of delivering systems change • ideally experience of working in both primary and secondary care • experience of triage / prioritisation in a complex needs clinical context • experience of managing fast-moving case load management • experience of working successfully with patients with non-engagement issues • experience of working successfully with challenging behaviour • experience of working with patients with communication barriers and disabilities • experience of working with clients with mental capacity and/or safeguarding issues • experience of independently assessing clinical risk in high risk patients

	• experience of successfully clinically advocating for patients with senior staff in a wide variety of situations without generating conflict • experience of multidisciplinary working • experience of 1:1 and group teaching

Important areas for consideration for the role

1. The need for broad clinical experience

'I use all my nursing skills to identify all that needs to be done. I've been a nurse for 45 years and I use all that experience.'

The nurses on this project had an average of 23 years post qualification experience, underlining the seniority of the role. Nurses had worked in a variety of settings, although most had a combination of having worked in both acute hospital and community settings. Common prior acute settings were general medicine, liver, neurological and renal wards. Common prior community settings were district nursing, community addictions and blood born virus services.

Nurses need considerable experience in order to be able to make very rapid initial visual top-to-toe assessments of new patients. Sometimes patients will engage verbally and effectively from the start, but often engagements need to be built up gradually, with dialogue focused on the patient's agenda (and not necessarily clinical priorities). Essentially nurses need to be able to simultaneously assess and understand the bottom-line clinical priorities, and prioritise them, whilst also mentally developing a future engagement approach that will work. Repeatedly during observation of practice, senior nurses were observed to quietly take stock of the patient before them before then taking a brief opportunity to focus on a clinical priority they had just worked out.

These nurses also need to have very broad-based clinical experience because they come across a wide variety of complex presentations across the hospital. Of particular benefit is direct experience in areas such as accident and emergency, general medicine, gastroenterology, hepatology, renal and neurology, or dual qualification in mental health or learning disabilities. Time spent in community services is also recommended.

2. The need for very high-level client engagement and motivational interviewing skills

'What would you say is your main concern?'

'I'm so proud of what you have achieved. Are you proud of you?'

'How do you feel about these options? Do you understand them?'

'Have you struggled with your drinking? How has that impacted on you? '

'What you've achieved is amazing. How can we help you to keep going?'

The ability to engage patients, and entering into an equal dialogue with them cannot be underestimated in this role, and engagement approaches obviously are adapted to the individual situation. Trust in the system is a massive issue, and the nurse is an ambassador for this – brokering new trust for the future.

These nurses also have to be experts at empowering people, and motivating people in order to help people to accept and want change.

3. The ability to overcome the challenge of 'complex needs'

People with multiple and complex needs have several overlapping problems at the same time, such as mental ill health, homelessness, drug and alcohol addiction, offending and family breakdown.

These individuals tend to fall through the gaps between services because no one takes overall responsibility for helping them to break the cycle they are in. They can find themselves in a downward spiral, living chaotic lives and experiencing poverty, stigma and discrimination. Nationally there are an estimated 60,000 people living in crisis due to the complexity of their needs and the lack of effective support services. This group of people often has communication difficulties, disabilities and may present with challenging behaviour patterns based primarily on a lack of trust.

Working with people with complex problems poses a number of challenges; nurses working with them are on the frontline when patients are at their worst point. The ability to not get overwhelmed, and adopt a pragmatic problem-solving approach, whilst not becoming desensitised is a key skill that is needed.

4. The importance of skilled partnership working

'She's fantastic, she texts me all the time.'

The ability to build effective partnerships with outside agencies is also really important for this role. The role can often require a nurse to enter into complex communications with many people in multiple agencies every single day. This requires an ability to manage what can be diverse and separate agendas, and bring people together in a collaborative way.

Practice case studies

The following practice case studies have been chosen to underline key aspects of the role. All case studies were forwarded by nurses on the project.

Case study 1

A man in his 40s with chronic leg ulcers was admitted from a private homeless hostel, after an accidental heroin and benzodiazepine overdose. Secondary complications included hypovolaemic shock, an acute kidney injury, compartment syndrome, rhabdomyolysis, and foot drop. He also diagnosed with HIV whilst an inpatient. He was in hospital for 3 months, with no family or friends visiting. The gentleman was not linked into any community services prior to admission, including addiction services, having historically rejected 'the system'.

The nurse visited frequently whilst he was in hospital, befriending him, forming a trusting relationship, and helping to ensure he understood his conditions and prognosis. Cash was provided from a hardship fund for comfort items whilst he was in hospital, including providing a laundry service. A mobile phone with credit was also provided for professionals to be able to contact him. The nurse made multiple referrals to other teams including getting him registered with the local specialist GP service. The nurse discussed all referrals, and the reasons for the referrals carefully with the patient.

He was eventually discharged into ground floor, disabled access accommodation with 24-hour support after considerable liaison, and advocacy to reject more unsuitable options. The nurse then visited a number of times post discharge to ensure the man was engaging with services, and felt happy and comfortable with his care. At the time of discharge from the service he was:

- engaging with mainstream housing support services
- accepting homecare social care support to help with daily activities on account of poor mobility and engaging with community rehabilitation services (physiotherapy and occupational therapy)
- engaging with a GP and community homeless health team and receiving dressing follow-up for his leg ulcers
- engaging with the local addiction services, scripted for Methadone and linked into the community pharmacy for daily pick up and support
- in possession of Narcan (and received overdose training in hospital whilst an inpatient)
- engaged with the community BBV nurse for ongoing treatment of his HIV
- fully aware of all follow up appointments for renal team, HIV team, and orthotics
- in possession of orthotics for his foot drop.

Throughout the patient received ongoing motivational support, and harm reduction advice. The nurse also supported all initial engagement with referral services. This was a significant piece of work with a very positive outcome.

Case study 2

A man in his 60s with Type 1 diabetes, foot ulcers, alcohol dependence, and anxiety had a long-term history of street homelessness, and was a frequent attender at the hospital (sometimes daily use), with frequent anti-social and challenging behaviour. He was divorced and socially isolated. He had refused several offers of community support and accommodation, saying that he wanted to live in an environment with a higher and different level of support to what he was being offered. He was well known to the hospital prior to a homeless team being set up.

Soon after the Homeless Support Team was set up, this gentleman was admitted because of infected leg ulcers. The nurse then visited the gentleman daily during his admission, and initially supported his detoxification from alcohol – alongside the hospital alcohol nurses. She then worked to build up a trusting relationship, by setting and maintaining clear boundaries, but also being consistent and a friendly face. Subsistence support was provided for things like newspapers and drinks. Constructive and supportive feedback was given when his behaviour at times became difficult, but the nurse also helped staff to understand his behaviour and to use effective de-escalation techniques.

The nurse then supported several assessments of his mental capacity regarding his ability to manage his health conditions and negotiated with the Liaison Psychiatry team to get a good assessment of his cognition and a full assessment of his mental health. He had previously been deemed to have no mental health condition, and adequate mental capacity at the time of his discharges to be discharged to the street. Tissue viability, diabetes specialist, and dietician review were also requested and effective engagement with these teams was supported.

This man was later deemed to have a formal personality disorder by the mental health team, requiring ongoing mental health support. The nurse then negotiated directly with the CCG to sanction extraordinary funding for a nursing home placement where mental health support could be provided. The nurse then facilitated the building of an effective relationship with the placement, and ensured that the discharge was thorough in terms of follow-up within primary care, outpatient appointments, medication etc.

The nurse followed him up a month following discharge to ensure he was managing in this environment, which he was. The gentleman had no further admissions when this case study was submitted, was now using primary care appropriately, and remained abstinent from alcohol.

Case study 3

A woman in her early 60s had lived under the radar in various parts of the UK over the past eighteen years. She had been denied asylum status, and had no recourse to public funding or housing entitlement. She was however registered at a local homeless specialist GP for care of her insulin-controlled diabetes prior to admission.

She was admitted to hospital on account of weight loss and found to have advanced myeloma. She was referred to the homeless hospital discharge team nurse because of her housing status which she revealed when the potential complications of treatment were discussed.

The woman disclosed that she was living in an otherwise disused / derelict building that was infested with rats for very low rent, paid for by a family member. Her 'landlord' was intimidating her, and apparently stated that he wanted to have sex with her. The building was often left without power deliberately. This was obviously a safeguarding issue, as well as being an unacceptable discharge destination.

The nurse then took on her case, and provided daily visits and subsistence support. As the relationship built, she found that the woman was a member of a church, and had people she knew via this, and one son (somewhat estranged), living in Northampton. The nurse then built a relationship with the son, and contacted a number of local faith charities to discuss potential support.

The nurse was eventually able to facilitate a move for the woman post-discharge to live in a church hostel with three other African women. After discharge these women then helped care for her on a daily basis as her condition worsened and the nurse maintained contact with them. The nurse also approached a local supermarket, who agreed to provide free unused fresh food at the end of each day for the women to collect to provide her with good nutritional support.

The woman was finally admitted back to hospital as she approached end of life. The nurse then discussed end of life care plans with her and her son. She was transferred to a local hospice - it was her wish to die somewhere quiet, surrounded by birds and flowers, and that was achieved. The nurse then visited her at the hospice in the days leading up to her death, and supported her and her son until she died.

Case study 4

A lady in her 60s had been 'no fixed abode' for 15 years, probably sleeping on buses, and in transport hubs - she had never been picked up by outreach teams rough sleeping. She may also have been supported by church members, because she had a strong Catholic faith and attended church frequently.

A frequent attender at hospital, she often deliberately gave multiple names and dates of birth, and repeated admissions had therefore gone unnoticed. She was often brought in by ambulance after being found wandering and incontinent, or with falls, minor head injuries and cellulitis. She had consistently refused to engage with services, and had been previously found not to have a mental illness and assessed as having capacity to make her own decisions. She was often paranoid about her possessions during contact with the team - often accusing staff of stealing things, and sometime stuck her fingers in her ears if staff tried to speak to her. She routinely self-discharged.

Considerable research by the homeless team nurse revealed that the lady had lived with her mother for 15 years, but had lost this council accommodation after her death, and her distress over this appeared to be a trigger for a chronic deterioration in her mental health. Other family were identified.

The homeless team requested a further assessment by liaison psychiatry, but she was again deemed not to have a serious mental health problem, despite the evidence of her behaviour long-term. However, the homeless team felt she should not be discharged, and organised a best interests meeting, involving the woman, her family, hospital and community staff. They also befriended her as much as possible running up to this. Following this meeting a Deprivation of Liberty Order was requested, but at the assessment the external assessor recommended that the woman should be sectioned and admitted under a Section 2 (as had been originally thought by the team). The lady was admitted for a period of assessment to a mental health hospital.

The woman did not try to self-discharge from the hospital, although she did appeal her section (this was declined). The team attended meetings regarding her care. She was then subsequently housed in residential care close to a church, where she could maintain her faith, and regain links with her family.

Case study 5

A male, 40s, Polish, moved to UK to find work. He worked completely legally in the UK in catering, but only for 2 months prior to being admitted to hospital.

At this stage he was hit by a car, and suffered a serious injury to his leg, which later developed into osteomyelitis, resulting in a need to have his leg amputated. Prior to admission he was staying with a friend, but was unable to return there due to needing disability accessible accommodation. He did not want to return to Poland, having moved country for personal reasons.

Staff in hospital concluded that the man had no recourse to public funds, and was thus not entitled to housing support. Rehabilitation services also refused to engage with someone that was homeless. The consultant and matron were in agreement after a period of delay - 'We've told him he has to go to the airport'.

However, the nurse identified correctly that he should have retained worker status, and he was referred to and then supported by a legal advocacy agency in the community. He was supported to go to tribunal, and was awarded worker status with full entitlement. He was then housed, and able to access full rehabilitation in the community. This case study exemplifies the advocacy element of the role.

Job titles, job descriptions and AfC banding

Job title

Suggesting an appropriate job title for this role has proved challenging. Firstly, although Pathway calls its teams homeless hospital discharge teams, and this has become a widely used term, as previously stated the role of the nurses and the teams is wider than hospital discharge.

Secondly, although the word 'homeless' or 'homelessness' appeared in all but one of the nurse's titles considerable engagement with Experts by Experience for the project leads to wondering whether this is appropriate. It is important to note that homelessness is a state, not a trait, and recently there has been a move to talk about people experiencing homelessness (a current state), rather than homeless people (which suggests an inherent trait). It also leads sometimes to the nurse being seen as a housing worker whose sole purpose is to get the patient out of hospital.

'Inclusion health' has recently been defined by UCL as a social justice movement that aims to prevent and address the harms of extreme inequality through research, service and policy, and gives examples of people that would come under an inclusion health agenda – people that are homeless, prisoners, migrants, drug users, sex workers. As such the suggested overarching job title within this project is inclusion health nurse. Even this seems unsatisfactory though, because of essence it suggests the patient is excluded. Perhaps the title 'complex needs practitioner' chimes more in line with the nature of the role.

Having recommended a change of title it is recognised that for now at least current titles are unlikely to change.

Job descriptions and Agenda for Change Banding

The majority of nurses that contributed to the project were banded at Band 7. Two were Band 8a, three were Band 6.

Four specimen job descriptions for roles 5, 6, 7, 8a have been developed in consultation with the nurses, and are available in Appendix 2. These have been constructed using Agenda for Change guidance. These roles are titled:

- Inclusion Health Lead Nurse – Band 8a
- Inclusion Health Clinical Nurse Specialist – Band 7
- Inclusion Health Nurse – Band 6
- Inclusion Health Support Nurse – Band 5

A Band 5 junior post would only be sustainable in larger teams where nurses have senior support, and in the usual course of events if there was only one nurse this role would ideally be Band 7.

Is this a clinical nurse specialist role?

Clinical Nurse Specialists

The role description for the title 'clinical nurse specialist' are not formally defined in the UK.

However, many nurses exist with this title and research for this project suggests that clinical nurse specialist are nurses with expert knowledge and skills in a specific clinical area e.g. diabetes, urology, oncology, who primarily spend much of their time providing clinical services directly to patients, undertaking detailed clinical assessments and delivering specialist nursing interventions. Such nurses have complex decision-making skills, often possess competencies for expanded practice, and usually autonomously design, implement and evaluate evidence-based treatment pathways during episodes of care.

In addition to this clinical nurse specialists are usually responsible for defining quality care within their organisation and ensuring this is delivered. As part of this they will analyse patient results and feedback (both in terms of both satisfaction and medical outcomes) in order to develop policies and service responses that will ensure safe, evidence-based care. They will also need to keep abreast of best practice to identify new areas for potential improvements. Clinical nurse specialists also have a role in teaching best practice methods of patient care to other staff within an organisation.

'The Clinical Nurse Specialist role improves the quality and experience of care for patients, reinforces patient safety, demonstrates leadership and can increase productivity and efficiency'

(Macmillan 2013)

Nurses working in homeless hospital discharge teams seem to fit very easily and neatly into this clinical nurse specialist definition.

Advanced practice criteria

Although the role description 'clinical nurse specialist' has not been formally defined, the Department of Health position statement of Advanced level Nursing (DH 2010) essentially defined the expected level of practice for a clinical nurse specialist.

This statement provided guidelines and agreed agenda for change profiles that help define advanced level practice, separate from generalist practice. The position statement clustered the elements of advanced nursing practice around the following four themes:

- clinical/ direct patient care;
- leadership and collaborative practice;
- improving quality and developing practice;
- developing self and others

and broke down these areas. Again, on the basis of the practice described in this document, the homeless hospital discharge nurse role at Band 7 definitely seems to be a clinical nurse specialist role. Appendix 1 provides a job plan for the role set in this Advanced Practice context.

RCN Advanced practice criteria

As part of this project RCN credentialing of advanced practice was considered as potential route for nurses to validate their seniority. Applications are open to members and non-membership of the RCN, so non-membership of the RCN at the point of application was no barrier.

The RCN defines Advanced Practice as:

'a level of practice, rather than a type of practice. Advanced Nurse Practitioners are educated at Masters Level in clinical practice and have been assessed as competent in practice using their expert clinical knowledge and skills. They have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis and treatment of patients.'

Practice is split into 4 areas: Clinical, Management and Leadership, Education, and Research. To credential applicants need:

1. a relevant master's degree
2. a non-medical prescribing qualification
3. experience and expertise mapped against the four pillars of advanced nursing practice
4. a job plan that demonstrates current advanced level practice verified by a senior nurse/ employer
5. a clinical reference verifying the applicant's clinical competence
6. evidence of continued professional development related to advanced nursing practice over the previous three years
7. a qualification in Health Assessment.

Discussion with the nurses revealed that many nurses could not meet criteria 1. and 2. despite being able to meet 3-7. The RCN has already recognised that criterion one might exclude many (often older) nurses who currently are working at this level, but who are unlikely to undertake a masters degree now. As such they have created a pathway to enable these nurses to demonstrate their expertise and equivalencies for the criteria, or to acquire the additional skills and knowledge required. The transition pathway is time-limited and available until December 2020. The nurses were made aware of this.

However, criterion 2. is non-negotiable, and seems unfair, as it feels like it is directed more towards nurse practitioner type roles.

Nurse practitioner roles are rather different from clinical nurse specialist roles. While nurse practitioners also take comprehensive health histories, they tend to diagnose and treat often undifferentiated minor illnesses, or chronic conditions. They prescribe, and act as independent care providers, but tend to be generalists rather than specialists.

This is different from clinical nurse specialists who deliver and promote best practice in a specific clinical area, and focus on education, research and consulting. Prescribing might be a part of this, but might equally may not.

References:

14. Macmillan (2012) Clinical nurse specialists: an evidence review. Impact briefing https://www.macmillan.org.uk/documents/aboutus/commissioners/clinicalnursespecialistsanevidencereview2012.pdf
15. RCN (2018) Royal College of Nursing Standards for Advanced Level Nursing Practice https://www.rcn.org.uk/professional-development/publications/pub-007038

Common Challenges

A number of common challenges were identified by the nurses. Having a chance to discuss and draw out these challenges was perceived to be a key benefit of the project.

'Get them out' and being seen as a housing worker

One of the problems with being called a hospital discharge team is that this can lead other staff to interpret the role of the team as getting the patients out of the beds as quickly as possible – rather than delivering a safe, effective and compassionate discharge.

This was being experienced by all of the nurses to a greater or lesser degree, and caused a high emotional and mental burden on the nurses. It was recognised that inappropriate or unhelpful key performance indicators (e.g. a reduction in A&E attendances or length of stay) did not help hospitals understand the core objectives of homeless hospital discharge teams, and that renegotiating these objectives might help.

'I get told by the bed manager – "they are blocking my beds".'

'Last week one of the staff said 'If they came in homeless, why can't they leave homeless'. Obviously, I had to swallow and explain why…'

'I'm always having to argue people's cases'

'I just had to say – she's not going anywhere. I couldn't believe he was be serious about discharging her'

Having to challenge every day and the potential for burn out

The role can be incredibly emotionally and mentally draining as it involves challenging systems every day. Most patients seen by these services will not fit the referral criteria for at least one, or often many of the support services they need - by matter of complexity (e.g. dual diagnosis), eligibility, geography (e.g. lack of a local connection) or simply a lack of an address (e.g. many mainstream intermediate care and neuro-rehabilitation services will not take clients without an address), and this can often feel Kafkaesque – the people most in need of support services are least likely to get them.

In a time of austerity services are also gatekeeping hard, and this was a shared experience.

'It's been so difficult to make challenges and advocate for patients, the barriers as you know are huge.'

'She's had all these people come and see her, and nothing has been done. If I wasn't here, what would happen?'

'They [hospital staff] just don't consider the drug use to be a condition that they can work with'

'Threshold is a word that comes up again and again.'

'I've given up trying to understand this system.'

'You know how it is… you just come up against barrier after barrier'

Homeless patients are a test of the system, and the function that these nurses are performing is vital, because otherwise these clients would often have no one to speak up for them in a broken system. However, it is vitally important that the efforts of these nurses are recognised, and that they receive adequate support and supervision.

'I just feel that there are some things that are beyond my capability to fix.'

'It was the saddest most depressing meeting I have ever attended, it was pretty dire.'

No recourse to public funds

The challenges of working with people with no recourse to funds who also have deteriorating chronic health conditions came up repeatedly. All nurses had experienced working with very unwell clients with no housing eligibility who did not meet social care thresholds, many of whom had highly complex immigration situations. These nurses tend to get referred all patients with no recourse to public funds who are admitted to a health care organisation, and unlike other professionals and services they do not say no to these clients.

Several nurses had supported patients where legal challenges or tribunals had been held with and prior decisions on eligibility had been overturned, although not before considerable hardship had been incurred. Several nurses also described situations in which eligibility for health care was wrongly being confused by staff in their organisations with eligibility for welfare.

'Sometimes I am able to negotiate a continued stay in hospital but this seems impossible for Eastern Europeans.'

'We don't actually have that many of them, but it feels more, because every case requires so much input, and many times there's no real result.'

Lack of senior guidance and professional isolation

Many of the nurses were in organisations where they were the most senior person in their speciality in that organisation, and sometimes the only person in their speciality if they were a lone worker. Although their managers often came from related areas e.g. hospital discharge, and A&E, this did not necessarily mean that they could give relevant guidance on what to do in certain situations, particularly those involving complex eligibility issues.

As such, many of the nurses had developed their expertise and services independently, in line with their own thoughts and experiences. This challenge was often cited as a benefit of being a part of this networking project and taking part in the workshops, which have been reported by the nurses as providing a chance to benchmark and sense check approaches to practice.

'I'm glad to have this opportunity to reflect. I often wonder whether I'm doing the right thing. There's no one really to ask'

'It's a big difference to other work, needing to be the person that knows the law. It can be quite worrying'

Not feeling like a nurse

'You've made me feel like a nurse again'

Many of the nurses had feelings of 'being more like a social worker', and no longer being a nurse - largely because of a lack of hands on care, and a lack of nurse peers in the same area. With this comes a risk of the nurses not fully valuing their roles and themselves.

However, in interviews all the nurses recognised on reflection that their nursing qualification was vital to their role, and that not being practically hands-on did not translate to not needing or using clinical acumen.

Pilots, reviews, evaluations and tendering

Frequent requests for services to prove their worth, and/or constant service reviews and/or issues with tendering/retendering (within community services) were described, along with the anxiety and hard work on evidence and report writing that these situations invoke.

As inclusion health is an emerging speciality, and homeless hospital discharge services an emerging specialist service this is to be expected. However, this situation can lead to services feeling quite marginalised (along with their patients), and somewhat 'optional', and can be extremely stressful for the staff.

It is important to note however that several services had recently acquired secure status within their organisation, so there was a recognition of potential light at the end of the tunnel for some, and the nurses should be recognised (alongside others) for their commitment in achieving this.

'It was the best day when I was told we had permanent funding. What a relief. I really felt I had really done something good.'

Links with specialist community services

Having good links between the hospital and specialist community services was felt to be vital, and where services were not joined up this was often felt to be less than ideal. There was a general feeling that staff should ideally be able to cross primary and secondary care to some extent in order to benefit patient engagement and continuity of care. This was also felt to be beneficial for staff development, updating and maintenance of hands on clinical skills.

'I've love to be able to go to the practice sometimes. It would be good to be able to say to patients "I'll see you at the GP appt to check how you are doing". I'm sure that would promote engagement'

'I wish I had been able to get out more. It makes a big difference, connecting directly with the hostels and agencies'

Staff management issues

Many teams have staff from a number of organisations involved in service delivery e.g. the nurse might be hospital employed, but the GP seconded from a local specialist GP practice, and the housing worker seconded in from a local voluntary sector organisation.

Overall this is felt to be very positive and aids with community integration. However, this can be challenging for the operational lead for the team, as it will mean that they do not have full management jurisdiction over their staff members. Staff from different organisations can have differing agendas and priorities and working practices and if performance issues surface they can take up considerable time to resolve. Added to this that staff in this sector often have strong personalities which can create challenges.

Data sharing and access

Information sharing was an issue for many services from two perspectives.

Firstly, most services were involved in some sort of double or sometimes triple data entry in order to promote integration and joined up care (e.g. documenting in the hospital notes, on a community system, and in the team records), and this was obviously time consuming. This also often sat alongside a separate need to do additional data entry for reporting.

Conversely many services did not have sharing links to partnership health care services that would promote the effective development and dissemination of clear plans of care e.g. data links with the nearest specialist homeless health service provider, addictions and mental health services. Sometimes the services did have links to other clinical systems, but usually in these cases they were required to log in and log out of databases in order to achieve this. In addition, staff often had access to other systems – like the street outreach contacts system, which was adding to this burden.

'Sometime the documentation takes so long, and it drives me a crazy, but I know it's so important, this is a communication game.'

Substitute prescribing for opiate misuse

Substitute prescribing was an issue that came up with some services – both patients getting access to substitute prescribing in a sensitive and timely manner, and some hospital services not managing pain well on a background of already receiving substitute prescribing. For example, in some cases if patients were prescribed rapidly after admission to hospital, this then later mitigated against the client getting any other form of pain control.

There was a feeling that current guidance on the emergency prescribing of Methadone for example might benefit from a national review that involved homeless hospital discharge nurses to help explain the reality of the challenges faced getting some of this patient group to stay in hospital.

Lack of complex trauma and dual diagnosis services

Although thresholds for services have been previously mentioned the very specific lack of adequate service services to support patients with personality disorder and/or patients with dual diagnosis presentations was a frequent frustration in every area.

Social care thresholds

Similarly, social care thresholds are worthy of a specific mention. Common experiences included social care not deeming clients with significant cognitive deficits to have care needs, and social care gatekeeping or refusing to assess patients felt to be unlikely to be eligible for a care package, or ordinarily resident elsewhere.

Lack of step-down care and/or adequate housing placements

Every nurse operating in an area without step-down care expressed the lack of step-down facilities as a major frustration.

And finally

Overall the nurse described many challenges, but interestingly this didn't really include the inherent issues of the emotional impact of people's stories, and the challenges of working with people with engagement issues and multiple complex needs – these were somewhat taken as a given. However, all the nurses recognised this was a challenging role with limited support, and really valued the potential to network in order to problem solve, and simply share the load.

'Fantastic networking and sharing of experiences. Really motivational and inspirational to be here. Great to feel part of a wider network and feel like there are others out there who understand the struggle.'

N.B. Appendix 3 outlines numerical data from the interviews which details the percentage of interviewees that outlined discussed the issues outlined above.

Vision and potential

Shadowing and interviews revealed a group of nurses with exceptional clinical expertise, a passion for the job, experience of working with limited senior clinical support, the ability to build positive working relationships with all relevant partners and the ability to inspire the whole health care team to always provide the best care – *'bringing everyone along with them'*.

Specifically, within their existing roles these nurses have the potential to make a huge difference to individual patients' health and housing outcomes, and on a practical level they can also work with hospitals to meet their duties under the Homelessness Reduction Act. They are also extremely well placed to work to deliver more integrated care pathways for patients, as they largely treat their role like a community in-reach role, even if most of the nurses are actually employed by the hospital. Indeed, most of the nurses said they would like to be able to fully cross boundaries and work on both sides of the primary / secondary care divide.

There is also considerable potential for leading quality initiates to improve health outcomes for this specific group of patients, although they would often need increased capacity for this. Examples might be working on specific health outcome objectives (e.g. getting people into Hep C treatment), and or possibly the potential to do primary care in-reach (e.g. vaccinations, or screening whilst patient is in hospital bed).

However, there is also a much wider, system related potential impact for this role. The base skill set is around multiple complex needs and does not apply only to people experiencing homelessness. These nurses have the potential to identify where the system is not working for all of our most disenfranchised patients, throw a light on this, and work to resolve it. They should be considered for positions on strategic and senior management as they know the range of the problems that are being experienced on the front line, and have developed solutions and work-arounds. In addition, there is potential to have Inclusion Health Consultants within organisations similar to Safeguarding Leads, which would be about the real-time delivery of social justice within health care.

How to deliver quality for patients

Introduction

Quality improvement was an underlying theme of the overall project, and was a key area of interest for the nurses. As such workshop 2 focused entirely on quality improvement, and specifically on the setting of key performance indicators, the core elements of clinical assessments, and effective ways to obtain service user feedback. Workshop 3 then focused on sharing local innovations and achievements. Output from both workshops is highlighted in this section.

It is important to note that workshop 2 started with a base agreed assumption about quality in this context. Prior to workshop 2 the group agreed that the ultimate aim of this area of nursing was to ensure that patients who are admitted to hospital homeless are discharged safely, effectively and compassionately from hospital, with effective follow up in place, rather than reducing secondary care usage per se.

As such it was jointly agreed from the beginning that reduced length of stay would most likely not be a suitable metric for quality assessment. This is because many of the activities of the nurses / teams actually increase length of stay in order to achieve a better discharge outcome (although it may be that the average length of stay does decrease when the team initially starts due to the resolution of a number of long-standing complex cases).

Equally a reduction in overall A&E attendance was also not felt to be a suitable metric for quality assessment. This is largely because levels of rough sleeping in the local area are a factor that will affect this, and these are not something that the nurse / team can control. It was felt that it may be perfectly reasonable to work towards, for example, a reduction in A&E attendance for some individuals. However, this should ideally not be included in routine monitoring, as it can be hard to measure on an ongoing basis, although it may be a useful exercise for more detailed service evaluation.

Clearly homeless populations do present with high levels of unscheduled and emergency health service usage, and historically perceived potential cost savings have been a reason why homeless hospital discharge services have been piloted or commissioned. However, the point here is the nurses believe that the main reason for funding services is based on equity and human rights. It was felt that is was not acceptable to argue that such services should only be commissioned on a cost saving basis. Being prepared only to provide necessary care to homeless people because it saves the NHS money would not be applied to equivalent areas such as palliative care and cancer care.

Ultimately the thinking of the group chimed with the notion of 'value-based health care' as defined by Michael Porter in 2010[15]. In his article he talks about not the cost of the admission per se, but the need to get better financial value out of the health care system by getting better outcomes from each admission. It was however recognised that efficiency and effectiveness is a key delivery objective.

15.Porter, M (2010) What is value in health care. The New England Journal of Medicine. 363, 26. p2477-81

Quality improvement workshop overview

Workshop 2 was led by a quality improvement expert from the University College London Partnership, and required considerable preparation. Quality improvement was specifically defined for the workshop as being 'about making healthcare safer, effective, patient centred, timely, efficient and equitable.' Experts by Experience had a lead role in designing and delivering the quality improvement work.

The agreed working objectives set before the beginning of the workshop were that the overall purpose of the work was:

1. To deliver safe, effective and compassionate discharges from hospital that improve health and housing outcomes
2. To increase the number of patients receiving safe, effective and compassionate discharges from hospital that improve health and housing outcomes

and that key performance indicators needed to be produced to support the delivery of these objectives.

It was agreed that the key performance indicators should be:

- Meaningful – i.e. they aim to be important and worthwhile
- Material – i.e. they aim to underline the business value of the team
- Strategic - i.e. they aim to support the current strategic positioning of the team, but also to support and argue for development of the service

The morning was split into three sessions with the following questions that were considered in small groups run by Experts by Experience. The sessions were focused on these questions:

1. Think about all the barriers that might stop these core objectives being achieved? Try to theme these.
2. Think about one the themes you identified in the first group. Which can you have an impact on, and how could you go about achieving this?
3. What Key Performance Indicators might be used to measure the activities identified above?

The theme areas that were identified, and worked on were:

- Practical issues in the hospital admission
- Hospital culture related issues
- Lack of links / relationships with community services
- No time take to highlight what is working well

This workshop also looked into what should be the main content of assessments, and ways to obtain service user feedback. A full write up of the session can be found in Appendix 4. After the workshop further work was undertaken to propose potential key performance indicators, suggested standards for assessment, and a service user feedback form.

Proposed Key Performances Indicators

After analysis of the workshop feedback the proposed set of key performance indicators were suggested to be:

1. To increase the number of people currently experiencing homelessness that are identified as homeless during their hospital stay **– to enable equitable access to care**

2. To increase the number of currently homeless people referred to and seen by the homeless team **– to enable equitable access to care**

3. To deliver timely, holistic assessment, treatment and discharge plans to people experiencing homelessness that improves health and housing outcomes **– to deliver best quality care and improve health outcomes**

4. To provide a homeless hospital discharge experience that patients value highly **– to deliver value-based healthcare**

5. To reduce delayed discharges / delayed transfers of care **– to improve hospital efficiency**

6. To reduce the number of people that rough sleep on leaving hospital **– to reduce reattendances and improve health**

7. To increase the number of people engaged with a GP on discharge **– to reduce reattendances and improve health**

8. To increase the number of people with accurate follow-up details recorded in hospital **– to reduce reattendances and improve health**

It is important to note that these are suggestions, and would need to be adapted and moulded to any pre-existing local contexts, but are meant to be suggestions for key performance indicators that deliver better care for patients, rather than cost reduction per se.

Further work was undertaken to suggest how these key performance indicators might be measured and monitored, and these are detailed in the table overleaf:

Key objectives	Team Activities	Measurement / monitoring method
1. To increase the number of people currently experiencing homelessness that are identified as homeless during their hospital stay **– to enable equitable access to care** 2. To increase the number of currently homeless people referred to and seen by the homeless team **– to enable equitable access to care**	Education of hospital staff Ongoing work with hospital services and systems to improve identification of homelessness at admission Tracking of background homelessness trends in the community to understand what might be expected Development of an open, responsive referral system Open dialogue with referrers	Recording the of number of referrals Recording of the time of admission and referral time and establishment of median[1] time to referral (should go down over time as hospital staff became aware of team and importance of referral) Recording of the number of rejected referrals (should go down over time as referrals would be increasingly appropriate) Review of feedback on the nurse / team from partner services in hospital - to be sought and collected at least once a year Regular review of referral system
3. To deliver timely, holistic assessment, treatment and discharge plans to people experiencing homelessness that improves health and housing outcomes **– to deliver best quality care and improve health outcomes** N.B. For suggestions for what should be included in assessment and treatment plans based on observations of practice see box	Referrals are seen within a target timeline (? 2 days) Patients receive a holistic assessment (see guidance below), treatment and discharge plan that aims to improve health and housing outcomes Nurse / team works with partner services and agencies to deliver planned activities successfully Nurse / team runs effective MDT meetings or similar to facilitate this process	Recording of time of referral and time of assessment and establishment of mean time from referral to assessment (should be within target time – nurse / teams not achieving this could be seen to be in need of review or extra capacity) Care Plan audit: practice review of random selection of patients' notes to assess whether best practice was delivered – to be undertaken once annually Service user feedback to be obtained

below.		Regular review of MDT / case conference minutes or similar to review effectiveness Complaints monitoring and review Incident monitoring and review
4. To provide a homeless hospital discharge experience that patients value highly **– to deliver value-based healthcare**	Nurse / team communicates in a way that improves the patient experience Nurse / team provides a clinical service that improves the patient outcomes and experience Nurse / team provides subsistence support that improves the patient experience (optional)	Service user feedback questionnaires to be obtained Complaints monitoring and review Incident monitoring and review
5. To reduce delayed discharges / delayed transfers of care **– to improve hospital efficiency**	Nurse / team works with hospital managers to prioritise patients who are delayed, and prioritises work to expedite discharge where this is relevant Nurse / team works with partner services and agencies to deliver planned activities successfully	Delayed Discharge audit: practice review audit of notes of patients who had a considerably delayed discharge to assess whether best practice was delivered – to be undertaken once annually Review of feedback on the nurse / team from partner services in hospital - to be sought and collected at least once a year
6. To reduce the number of people that rough sleep on leaving hospital **– to reduce reattendances and improve health**	Nurse / team works to get patients into appropriate housing on discharge wherever this is possible Nurse / team works to safeguard vulnerable adults that have no housing options	Record of number of referrals discharged to the street Discharged to Rough Sleeping audit: Practice review of notes of patients who returned to the street after their hospital admission

	and need safeguarding	Record of no of accepted referrals that self-discharge (hopefully this would always be low, but it would prompt a review of the reasons if self-discharge increased)
7. To increase the number of people engaged with a GP on discharge [2] **– to reduce reattendances and improve health** 8. To increase the number of people with accurate follow-up details recorded in hospital [2] **– to reduce reattendances and improve health**	Nurse / team checks GP registration during assessment Nurse / team undertakes activity focused on achieving GP registration Nurse / team undertakes check of follow-up details on discharge	No of people accepted as service patients who have no GP on their hospital records is recorded. No of patients assisted to register with a GP is recorded No of people accepted as service patients who have the wrong contact details on their hospital and service notes is recorded. No of people with the wrong contact details who have had action taken to rectify this is recorded Service user feedback questionnaires to be obtained

Notes:

1. Median time is used here, because it is noted that there will always be a patient that is referred after e.g. 6 months of being in intensive care, so this data point is effectively removing extreme outliers.

2. As well as ensuring a patient is registered with a GP, and that contact details are correct this will also over time ensure that future discharge notes go to the correct GP, and that future attendances and admissions are charged to the correct CCG. This may be cost saving for some hospitals – patients who have NFA and no GP recorded on their records are automatically charged to the CCG in which the hospital is in.

What should an assessment and treatment plan cover?

Routine assessment forms being used in practice were shared as part of workshop 2. In addition, assessments were observed by the project lead.

After this the recommendation below was agreed by the nurses as the core areas to be included within routine assessment and treatment plans.

Assessment and treatment plans should cover:	
ESSENTIAL • Physical health (not just the condition admitted for) • Mental health • Addictions and Smoking • Cognition / mental capacity • Language / literacy challenges • Understanding of current medications • Safeguarding concerns / safety • Current housing status and needs	• Support in the community • Rights to healthcare – GP registration / HC2 • Benefits / debts / financial concerns – including need for sick note **DESIRABLE** • Nutritional status • Dental • Eye care • Missed screening / vaccinations

Recommended practice

As this is an emerging discipline little evidence yet exists on the detail of how these nurses / teams should work. As such observation of the teams, interviews with the nurses and workshop 3 were used to identify a number of common areas of perceived best practice.

The table overleaf was created with the thought that these are the core activities that all services should be working towards in an ideal world. Obviously, it is acknowledged that it is not always possible for an individual nurse / teams to deliver all of these areas of best practice due to capacity, resource etc.

Recommended Practice Interventions

Referral into service

- Pro-active identification of cases within hospital system (may require comprehensive teaching programme in hospital and/or proactive identification processes to be put in place)
- Homeless link nurses are identified on wards to support specialist nurse / team
- Homeless link nurses / other staff know what to do out-of-hours
- Team has readily available leaflets about community services, which are also readily available to all staff
- Every contact with staff is seen as a teaching opportunity
- Team takes a system change approach that fits into a hospital strategy

Clinical Intervention

- Plenty of time available for comprehensive assessment
- Assessments and plans equally consider both health and housing outcomes
- Harm reduction work takes place routinely
- Opportunistic public health interventions take place as routine practice, even if this is just reminders e.g. about vaccinations / screening
- Team is able to fulfil subsistence needs as required
- Discharge checklist is used to check safe discharge for all patients
- Clients are followed up routinely in the community to check health and housing outcomes

Working within a multi-agency setting

- Nursing role sits within a multidisciplinary team
- Team is integrated or clearly networked with specialist community health services
- Regular case reviews or multidisciplinary meetings take place
- Hospital discharge protocol is in place with Local Authority
- Integrated clinical records with community services are in place

Peer Involvement

- Team has peer involvement e.g. through care navigators
- Service user feedback is gained routinely
-

Follow Up Care

- Step-down 'medical respite' care is available, or being worked towards
- Patients are followed up after discharge.

Learning and improving practice

- Reflective practice takes place regularly

Obtaining Service user feedback

The nurses agreed that seeking feedback from service users was central to service improvement. However, gaining effective service user feedback was identified as an area of

challenge. One session in workshop 2 concentrated on this issue. In this session it was felt that feedback forms were often not the best way to obtain service user feedback because:

- Potentially lots of key feedback would be missing such as what happened after the discharge, whether the discharge process was fully understood, how well specific elements of the discharge process (e.g. medication management) were managed.
- It was difficult to design meaningful questions that were easy for people to answer honestly if a staff member was directly administering the survey.

As such in depth interviews or focus groups with less people were felt to be a much better way of obtaining feedback, and this has been achieved on some teams (particularly during the pilot phase of services).

However, it was recognised that often service user feedback forms were the most practical and quick method of obtaining service user feedback, and as such a new proposed service user feedback form was developed which can be found in Appendix 5.

Local innovations

In this section local innovations have been highlighted. These innovations were either observed in practice or presented in workshop 3.

It is recognised these innovations may not be appropriate or deliverable for all sites, and they are often about service innovation, rather than the nursing role per se, but they may be worthy of consideration in service design. Practiioners interested in finding out more about any of the services listed are recommended to contact the author initially. Each service is listed in the table below:

Organisation	**Activities**
Hospital Teams	
Guys and St Thomas' NHS Foundation Trust (GSTT) Pathway team	• weekly review of deaths, safeguarding cases, cancer patients and older adults • peer advocate on the team, who can take patients to health appointments after discharge • housing workers seconded in from two different organisations (providing two perspectives) • charitably funded project which gives the team access to immediate expert legal advice from Lawyers around complex housing and immigration issues • has used hospital volunteers • has Occupational Therapist on team • runs frequent attender's forum • on same clinical system as Kings, SLAM and community-based Health Inclusion Team • monthly reflective practice with Kings and SLAM teams
Kings College Hospital NHS Foundation Trust Pathway team	• robust checking of A&E notes to see who has come in the last 24 hours, and informing the community service

Organisation	**Activities**
	• all clients seen by the team have the ICD 10 code for homeless added to the notes (to enable better capture of homelessness in hospital performance data) • Social Worker on the team • also benefits from peer advocate, housing workers from two organisations, and legal advice • on same clinical system as GSTT, SLAM and community-based Health Inclusion Team • monthly reflective practice with GSTT and SLAM teams
South London and Maudsley (SLAM) NHS Foundation Trust Pathway team	• team is based in a mental health hospital • regular meetings with local homeless mental health team and psychology in hostels service providing wrap-around perspective • formal economic evaluation has been undertaken • has used hospital volunteers • has Occupational Therapists on team • on same clinical system as GSTT, Kings and community-based Health Inclusion Team • monthly reflective practice with GSTT and Kings teams
University College London (UCLH) NHS Foundation Trust Pathway team	• has managed Care Navigator programme over several years – training people with lived experience to be peer advocates and housing advisors. Care Navigator on team now NHS employed (was originally funded by Pathway) • extensive nursing and medical student programme • has developed comprehensive 44-page A6 advice booklet including info on rights to health services and housing • fully integrated into hospital discharge service • has 2 step-down beds at Ollalo House (funded by hospital)
Royal London Hospital Pathway team (managed by East London NHS Foundation Trust)	• has also managed Care Navigator programme – Care Navigator on team now NHS employed (was originally funded by Pathway) • has very successful, well attended MDT meeting bi-weekly • has Occupational Therapist and Social Worker on team • has 6 step-down beds at Gloria House (funded by CCG) • part of Randomised Controlled Trial in 2016

Organisation	Activities
Pathway Homeless team in Royal Sussex County Hospital, Brighton (jointly managed by ARCH Healthcare, Brighton and Sussex Community NHS Foundation Trust)	• nurse based jointly in hospital and community-based team • nurse works in the community one day a week to keep up skills, and maintain links with one of the key hostels • service is integrated with specialist homeless GP practice • Just Life Service supporting team – 5 floating support workers • part of Randomised Controlled Trial in 2016
Bradford Pathway Homeless Team in Bradford Royal Infirmary (managed by Bevan Healthcare)	• nurse-led • service is integrated with specialist homeless GP practice • nurse also manages street outreach • 14 bedded step-down unit • mental health nurse provides input one day a week • economic evaluation done on step down service • identified as gold standard care by NIHR study • nurse lead shortlisted for 2 national awards in 2018
Homeless Assessment and Liaison Pathway team (managed by Leeds Community Healthcare)	• team does outreach to services for sex workers to build relationships (Leeds has a managed zone, which makes this possible • service has access to specialist input for Gypsies and travellers as nurse manager is a specialist • 3 step-down beds available • step down service currently has occupational therapist
Homeless Support Team, Bristol Royal Infirmary (managed by University Hospitals Bristol)	• Social Worker as part of the team • Personal support plans in A&E as part of a high impact user group. • collecting information specifically around the management of endocarditis with a view to improving care • Nurse was shortlisted for national award in 2018 •
Homeless Nurse Practitioner, based at Heartlands Hospital (managed by University Hospitals Birmingham NHS Trust)	• single nurse works over several hospitals • service is part of discharge team • very thorough and comprehensive assessment
Homeless Liaison Team, based at Glasgow Royal Infirmary (managed by NHS Greater Glasgow and Clyde)	• longest running service – running continuously for 18 years • covers several hospitals • nurse led • has delivered a comprehensive teaching and culture change programme

Organisation	Activities
Community Teams	
Homeless Health Team, Nottingham (managed by Nottingham City Care)	• homeless hospital discharge protocol written with local partners • extensive list of case studies • excellent engagement with media
Pathways Homeless Team, City Reach Services, Norwich (managed Norfolk Community Health and Care)	• fully integrated service for rough sleepers, with very well attended MDT meeting including several hospital based representatives • mental health nurse as part of the team • also working on prison pathways
Nurse Champion	
Nurse support for Homeless in Hospital Discharge Team with Bath Royal United Hospital (managed by Developing Health and Independence)	• routine asking of 'do you have some safe to go; • link nurses • expertise with rural poverty

Draft standards for Practice

One of the original objectives for this project was the creation of a competency framework for nurses working in this area. Several competency frameworks or similar were examined as research for the project e.g. Tuberculosis Nurse Competency Framework (jointly produced by Royal College of Nurses, Public Health England and the NHS), Caring for people with liver disease (RCN), Emergency Care Advanced Clinical Practitioner Credentialing project (Royal College of Emergency Medicine, Health Education England, RCN, College of Paramedics) and an unpublished Knowledge and Skills Framework for homeless health nurses (developed by the London Network of Nurses and Midwives Homelessness Group).

However, it was agreed in the steering group that developing a full competency framework would have been beyond the scope of what was possible for this project. It also agreed that it probably wouldn't get used, and that there were too few nurses nationally to justify it.

An alternative suggestion was the development of draft voluntary standards for practice for Inclusion Health nurse education and practice, to mimic the QNI voluntary standards for practice e.g. QNI / QNIS Voluntary Standards for District Nurse Education and Practice, QNI / QNIS Voluntary Standards for General Practice Nurse Education and Practice etc.

Such standards have taken a year or more to develop and ratify, and have been developed using an international steering group, but are now being used to suggested expected standards of practice for senior practitioners in these roles, and the requirements for

educational courses that might seek to educate a nurse to hold the title of e.g. District Nurse or General Practice Nurse.

Draft standards for practice for Inclusion Health nurses suggested by the author as a starting point for discussion are presented in Appendix 6.

Continuing Professional Development (CPD)

Background

A report commissioned by the Department of Health National Inclusion Health Board in 2015 'Inclusion health: Education and Training for Health Care Professionals', previously outlined the potential continuing professional development needs of nurses and other professionals working in inclusion health. This document identified that the key areas for CPD were:

- Inequalities in health
- Mental health training – relevance to homelessness sector
- Addictions training – relevance to homelessness sector
- Clinical advocacy
- Advanced assessment skills
- Cultural competence including women's issues
- Health beliefs
- Safeguarding – domestic violence, abuse etc
- Trafficking
- Issues effecting migration
- Barriers to access / access to health care
- Legislation e.g. mental health, mental capacity, safeguarding, housing, equalities etc
- Public health
- Condition specific training - *i.e. tissue viability, nutritional status, blood borne viruses, hepatitis C, liver disease and Chronic Obstructive Pulmonary Disease, migrant health*

In this comprehensive report it was noted that no course was available at that time, and that health care practitioners struggled with a lack of time and funding to undertake courses anyway.

Current CPD position of project participants

Interviews with the nurses during this project revealed the following additional information about this cohort:

- There was no recognised post-basic CPD pathway
- No-one had an inclusion health qualification as such
- All nurses did have post-graduate qualification of some sort, and many had several - the most common post-graduate clinical qualifications held were in community (i.e. a community nursing course), advanced assessment, addictions, liver, sexual health / women's health, neuro, renal and leadership.
- Nearly all the nurses had a teaching qualification.
- Training relevant to the role was often obtained through conferences, events, and study days provide by Pathway, the Queens Nursing Institute, the London Network of

Nurses and Midwives Homelessness group, and various other voluntary sector providers such as CRISIS and Shelter.

- The nurses agreed that lots of 'non-clinical' CPD was needed and had to be undertaken – housing rights, immigration law, welfare rights etc

Mirroring the prior report common problems being experienced with CPD were a lack of time, a lack of funding, and a lack of appropriate courses. The need for an appropriate, accessible course seemed to be felt quite keenly, and in one case this had contributed to a decision to leave the role after 3 years.

'There's not a course is there, and I feel I'm not developing, not learning. That's one of the reasons why I think I've decided to leave.'

CPD requirements that the nurses said they had within interviews largely mirrored the list from the 2015 report but key additions for this group were:

- Housing rights and options
- Welfare rights and benefits
- Specific focus on the assessment of cognition
- Leadership training

What is currently available?

No one post-graduate nursing course currently exists that prepares nurses for this role. There are currently two masters module courses – one at UCL and one at Edinburgh that focus on inclusion health, and can be undertaken as stand-alone modules – however these do not have clinical content, and focus primarily on the social determinants of health, the structural causes of homelessness, the impact of homelessness on health, and discussion around system-based solutions.

However, some CPD courses relevant to the role are available. Many are generic, and available if funding and time are made available (like advanced clinical assessments courses and modules). Some clear gaps in CPD were noted however. These gaps included a lack of any content on:

- Prioritisation of care in this context
- How to be a clinical advocate
- Treatment concordance
- Clinical condition management in the multiple complex-needs context
- Motivational interviewing in the multiple complex-needs context
- Rights to health care access
- Assessing and managing frailty in young people

Some useful content was available though, and often this was actually available free and on-line - but it was noted that it was often hard to find, sometimes not precisely what is needed, and often not recently updated.

In order to support the nurses - in the context of the lack of time, and lack of funding described – a review was undertaken of what was available in terms of free or cheap, relevant, on-line, ideally certificated Continuing Professional Development that was available from reputable training providers for example the Royal College of General Practitioners, Royal College of Physicians Open University, National Homelessness Advice Service, E Learning for Health.

Freely available on line CPD was identified in the following areas:

- Statutory and mandatory training
- Leadership / Service improvement
- Management of care / case management
- Inclusion Health
- Public health
- Mental capacity and cognition
- Addictions Management
- Mental health awareness
- Severe and Enduring Mental Illness
- Complex psychological trauma
- Learning Disability
- The Care Act
- Healthcare access
- NHS Charging
- Housing rights
- Immigration / migrant health care
- End of Life Care
- Some clinical topics (although not in a multiple complex needs context)

The detailed results of the review and links to training can be found in Appendix 7**.**

During the review it was noted that there are also areas in which there was plenty of content, but not much which is freely available e.g.

- Working successfully with personality issues / complex trauma (although some exists)
- Welfare benefits training
- Clinical content around the liver
- Clinical content around migrant healthcare
- Cognition – e.g. how to undertake a MOCA

And areas where content that is available with no fees, but needs updating include:

- Overseas Visitor Cost Recovery content – needs updating to include Oct 2017 guidance
- Mental Capacity – needs content to include mental capacity assessments in a chronic addiction's context

What now?

Firstly, it was noted that whilst the CPD research was a useful exercise, it would be even more useful to have an on-line directory of CPD options to dip in to when this is needed. Potential options for the delivery of this need to be explored.

Secondly, more importantly, a clear message came from the nurses that these was a potential need for a clinical course at post-graduate / masters level that covers this content, that would potentially be relevant to anyone working in a complex needs setting.

Neither masters module available provide clinical content focused on such aspects of the prioritisation of clinical interventions in this context, motivational practice, promoting concordance, the assessment of cognition, the management of frailty, working effectively with clients with complex trauma / personality issues, being an effective clinical advocate, or common clinical conditions (e.g. liver disease). In a show of hands nearly every nurse at workshop 3 said they would be interested in a clinical course for inclusion health if this became available. However, it is important to note that a past offer of an inclusion health Masters programme for nurses received sufficient uptake, according to Dr Crystal Oldman from the QNI. This was again felt to be due to lack of funding and time, so it would be important to consider how such a course could be effectively delivered to promote access.

However, from a wider perspective it might be considered that the clinical expertise that is required to work effectively in this area, has a much wider reach within deprived areas generally. Potentially there could be an argument to develop a specialist practitioner programme for the nurses of the future. This might pull together some elements of existing specialist practitioner programme areas e.g. practice nursing, district nursing, health visiting, and school nursing, but add new areas. For example, a programme might have the core areas: inclusive practice, mental health, addictions, chronic disease management, public health screening, migrant health.

Thirdly, the direct interface between these nurses and mainstream practitioners has thrown a clear light on the need for curriculum content for pre-registration courses to involve pragmatic content around actually addressing inequalities in health, not just explaining the social determinants of health. These nurses see a high level of inadequate knowledge and skills related to rights and access to healthcare, NHS charging, cultural competence and inclusive practice generally.

Engagement with providers of pre-registration health practitioner education is planned via the Council of Deans of Health and Medical Schools Council, however further work to support the development of basic core curriculum e.g. ‘the ten things everyone should know’ would be required, and needs steering and funding.

Project Evaluation and Next Steps.

Feedback was obtained after every workshop, and it was clear that the nurses very much valued taking part in the project, and that it had a clinical value. Some quotes from the nurses are provided below (all feedback is outlined in Appendix 8).

- Fantastic – it has given me more thoughts and ideas for my role re assessment, improvements to the service, and KPIs
- I valued seeing other assessment forms. I feel the session has sharpened my clinical focus.
- Thought provoking. Great meeting and sharing. Experts by Experience insights very valuable.
- Quality improvement session was good as evidencing what inclusion health nurses do is crucial. Also good relevant session on patient feedback.
- It's been really great to come along to these sessions – shame there are not more… I have learned a great deal from being around other nurses working in homelessness. You have also helped to remind me that I am a nurse. Prior to these workshops I had started to lose my identity a little. Thank you.
- It has been invaluable to me as someone who is relatively new to homelessness nursing. The links with other services, resources, and knowledge of other services will greatly assure me to take our service forward to improve the lives and health outcomes of the individuals we are working with. Many thanks again.
- The whole program has been so informative and meeting others from all parts of the country looking after vulnerable clients is an inspiration. So much food for thought.
- In the three days I have learnt so much about my own role. I have also gained more to add to my service and have been able to promote more the important work we do.
- This has been the best beginning towards establishing our role as a homeless / inclusion nurse specialist.
- Thank you so much. It's funny I had to come to London to meet someone 40 miles away doing amazing work. I go back to Scotland with inspiration and have been humbled by listening to others working in the field. THANKS AGAIN. I'm not 'just a nurse'.
- Found both workshops I attended inspirational, educational, supportive, and more I feel that it is important to keep challenging managers and CCG funders as we are advocates of the people we work with – any of us could be homeless at any time, and need some help and some kind, understanding words. Thank you.
- Have only attended on the last day – however – fantastic to be with like-minded people who are often as marginalised as the people they work with. Great networking, sharing of brilliant practice, and what works across the country, and meeting people with lived experience. Thanks so much for putting this together. Stan needs an MBE by the way.

Next Steps

At the final steering group, it was also agreed that the project had been extremely valuable, delivering important outputs, with direct benefits for the nurses involved. Lots of potential follow-up areas have been identified, and it was agreed that consideration should be put to bidding for money to follow up on individual strands of the project. However, at the same time it was recognised that there is a need to focus on the priorities, and not get overwhelmed with all the potential work that could result.

The key areas for follow-up that were identified at the steering group were:

1. Profile raising for the role

It was felt that the profile of this nursing role should be raised via blogs, journal articles, and meetings with key nurse leaders and influencers. Other suggestions included making a short film about inclusion health nursing, or presenting at more mainstream nursing events such as the Royal College of Nursing Congress.

2. Future support for nurses

There was general acknowledgement that these nurses are isolated, and need connecting professionally. This nursing role is associated with very high emotional impact on those in the role, and risk of burn out, but these nurses are needed to hold the system to account, and have massive potential to drive culture change within the NHS. As such funding and supporting a clinical network would seem to be of potential value to the NHS. However, there was recognition in the steering group that many other groups of nurses find that they have to support and network themselves, and that such activity is not generally funded by the system.

It was agreed that Pathway and potentially the QNI could try to continue supporting the group, but the meetings with key system leaders should aim to reveal funds that could be used to further support the nurses. There was also discussion regarding the potential development of an online platform that could support nurses, and offer a place for discussion / exchange of content / sharing good news etc.

It was agreed that an overall objective for continued work would be to change the culture toward homeless health nursing across the NHS, and support the recognition of the importance of this role.

3. Development of voluntary practice standards

Further work would be required to progress the draft voluntary practice standards that have been presented in this report. A project to achieve this could probably be a QNI / Pathway, and would need a national steering group. Ideally the standards would also consider homeless nurses working in both primary and secondary care.

4. Development of the evidence base / nurse researchers

There was a recognition that whilst there was a considerable amount of innovation by the nurses, and enough similarities in practice to suggest what constitutes best practice, the evidence base needs to be developed. For example, there is a need to develop more evidence into what should be the priority interventions in resource poor situations e.g. how much time should be spent teaching staff and or link nurse programmes, and what the impact of wider staff teaching on patient outcomes vs delivering an individual one to one intervention is. There is also a need to test out specific ways of working that are not currently utilised by all nurses / services. This could include the routine follow up of patients, in order to understand whether this improves outcomes, and key questions to answer about whether primary care interventions should be provided to patients while they are inpatients (e.g. vaccinations and screening), and the extent to which these services should be integrated.

The steering group agreed with the principle that nurses need support to develop and lead the research agenda in the field, as nurses are the professionals in highest numbers on the ground and responsible for most direct patient care. However, it was recognised that these nurses are not generally attached to any existing research infrastructure, or receiving encouragement in this area. As such, there was a suggestion that this issue should be profiled with the UCL Collaborative Centre for Inclusion Health and/or National Institute for Health Research for further discussion, possibly by Pathway and the QNI in partnership.

There was also some discussion about a possible specific bid to the National Institute for Health Research looking at nurse-led ways of changing hospital attitudes to excluded groups with Expert by Experience partnership and involvement.

5. Development of continuing professional development

On the basis of the findings of this project, there was general agreement by the steering group that the development of a masters-level short clinical course would be a good idea to pursue.

In order to support this, it was suggested that a small amount of resource / funding would be needed to carry out a further training needs assessment, and put together a business plan for a deliverable course that nurses could actually attend, that could be presented to an interested university. This would possibly be a complex-needs type clinical module that could support inclusion health nurses in a variety of settings, or maybe an interdisciplinary clinical course but targeted specifically at the homelessness arena.

Options for the creation of an online platform directing users to current continuing professional development options were discussed. There was a concern that this is a complicated exercise to get right, and that any platform would need to be kept regularly updated, and would therefore need ownership. However, there was still acknowledgement

that this would be useful, and has been done in other clinical areas. Further discussion is needed. Pathway recently won a small Health Education England grant to produce introductory modules to inclusion health on the E-Learning for Health portal. It might be possible to follow this up with a request for more investment.

In term of the initial quality assurance of the current on-line learning content that is available, it was suggested at the steering group that nurses on the project could all volunteer to undertake and evaluate a module each.

One of the strategic areas that needs more thinking is working out how to begin to develop a recognised career pathway for these nurses (perhaps linked to the Public Health Outcomes Framework and health inequalities strategy).

6. Development of core curriculum for pre-registration health professionals

There was a clear recognition that hospital culture comes from the attitudes and actions of the employed staff, and that there seems to be a national need for more inclusion health education in the core curriculum of pre-registration courses in order to challenge some of the attitudes and misinformation that seem to pervade. Most of the nurses spent a considerable amount of time challenging the stigmatisation of their patients, or teaching staff basic information e.g. about health rights.

Although the social determinants of health are covered comprehensively in most pre-registration health courses, ways to challenge this, and actually **deliver** 'proportionate universalism', and improve the health of the poorest, fastest (as described by Dr Michael Marmott), do not seem to be well covered.

It was agreed that there is a to develop clear ideas about what core content should be, discuss this with key people e.g. Deans of Health via the Council of Deans of Health, and maybe also get some publicity for this.

Appendices

Appendix 1: Specimen Job Plan

Band 7 Clinical Nurse Specialist Role

Clinical/ direct patient care – average 60% (approx. 22.5 hours a week)

- Independently undertaking effective comprehensive holistic health, housing and social care assessments for patient including independent assessments of risk. Health assessment to cover physical health care problems, mental health problems, addictions problems, communication difficulties, disabilities, mental capacity issues, safeguarding, and potentially any missed primary care screening or interventions that are not being met due to any eligibility and legal complexities.
- Developing effective treatment and discharge plans based on the above assessments and advanced clinical knowledge which manage risk, multiple complex needs, non-engagement issues and/or challenging behaviour patterns, and ensuring these are delivered.
- Clinically advocating for best health outcomes whilst patient is at the hospital
- Liaising with partnership agencies to deliver discharge plans as required
- Advocacy with partnership organisations as necessary
- Maintenance of excellent care records, and sharing of information as necessary (ensuring maximum integration and best patient care, but adhering clearing to data sharing legislation and guidance)
- 6-8 new patient assessments per week, 10-15 patient reviews per week

Leadership and collaborative practice – average 15% (approx. 5.5 hours a week)

- Representing the service in a variety of different contexts
- Being and role model for inclusion health practice within the host health organisation
- Advising others in the organisation on inclusion health practice / other areas (e,g, health and housing rights) as necessary
- Facilitating and chairing multidisciplinary meetings and case conferences as necessary
- Developing pathways with partners which improves discharges for people experiencing homelessness
- Developing and delivering teaching to achieve culture change within the hospital
- Triage, prioritisation and oversight of caseload on a day to day basis
- Operational management of service on a day to day basis

Improving quality and developing practice – 12.5% (approx. 4.5 hours week)

- Monitoring and provision of reports on service performance
- Undertaking of audits
- Proactively identifying adverse trends and responding to these
- Identifying areas for service improvements

- leading service improvements and developments
- Obtaining service user feedback and acting on this

Developing self and others – average 12.5% (approx. 4.5 hours a week)

- Management of staff including staff from partnership organisations working via a service level agreement
- Clinical supervision of staff
- Attending relevant and appropriate continuing professional development
- Attending clinical networking as appropriate
- Ensuring staff are trained and developed appropriately
- Managing own stress levels and potential for burn out and that of others in highly stressful role

Example daily routines:

CLINICAL DAY

TIME	ACTIVITY
9.00 - 09.30	Assess new referrals, review caseload, allocate work for the day
09.30 - 11.30	Direct patient assessments and client reviews (sometimes with students / staff shadowing / other team members as required)
11.30 – 12.30	Liaison with partnership agencies and record writing
12.30 – 13.00	LUNCH
13.00 – 14.00	Partnership meetings / teaching etc
14.00 – 16.00	Direct patient assessments and client reviews (sometimes with students / staff shadowing / other team members as required) Case conferences / MDT meetings
16.00 – 16.45	Liaison with partnership agencies and record writing
16.45 – 17.00	Final review of caseload

LEADERSHIP / MANAGEMENT DAY

TIME	ACTIVITY
9.00 - 09.30	Assess new referrals, review caseload, allocate work for the day
09.30 - 11.30	Direct patient assessments and client reviews (sometimes with students / staff shadowing / other team members as required)
11.30 – 12.30	Liaison with partnership agencies and record writing
12.30 – 13.00	LUNCH
13.00 – 16.45	Project / partnership meetings Reporting Audits Management and supervision of staff
16.45 – 17.00	Final review of caseload

Information based on observations and interviews of nurses in practice.

Appendix 2: Job Descriptions 8a, 7,6,5

Job Description: Inclusion Health Lead Nurse – Band 8a

This template gives guidance and recommendations for essential points that could be included in a job description for a Band 8a Nurse.

Job purpose

Homeless hospital discharge teams

The homeless hospital discharge service provides enhanced inpatient care, and ensures safe, appropriate and sustainable hospital discharges that meet the need of patients currently experiencing homelessness.

In detail the service aims to:

- effectively engage the patient in all relevant services / support,
- maximise the benefit of the attendance / admission for the patient from a health and social care perspective,
- link the patient into all necessary health and social care and support pending discharge,
- advocate for the patient to receive assessment, treatment or services when this is required
- safeguard patients effectively
- ensure a safe and effective discharge to accommodation (where this is possible)
- stop the revolving door

The service works with a variety of hospital, statutory and voluntary partners to achieve these objectives.

The service also aims to bring a wider influence to hospital, housing and social care system to proactively identify and better respond to the needs of currently homeless and otherwise disenfranchised people.

Nurse role

The Band 8a nurse is the operational manager and lead for the service, and inputs expert clinical knowledge and skills. The nurse is also a senior role model for inclusion health practice in the wider organisation, and is able to provide expert consultancy and clinical advice across the wider organisation.

The Band 8a nurse is responsible for homeless hospital discharge strategy within the organisation, and has service design responsibility which may include undertaking needs assessments for and writing business cases for development of the service. The nurse may also be responsible for other inclusion health services. The nurse manages all partnership relationships for the service.

As a key part of a multi-disciplinary intervention, the Band 8a nurse advises on and may also assist with and/or independently manage patients that are identified within

organisation as experiencing homeless - in order to improve and maintain their health, by identifying and managing (or influencing the system to manage) unmet health, housing and social care needs. Unmet needs include e.g. physical health care problems, mental health problems, addictions problems, communication difficulties, disabilities, mental capacity issues, safeguarding, missed primary care screening or interventions that are not being met due to any eligibility and legal complexities. Patients often present with tri-morbidity (the co-concurrence of physical health, mental health and addictions problems) and other multiple complex needs, and may have non-engagement issues and/or challenging behaviour patterns.

On a day to day basis the nurse is responsible for the clinical governance of the service, and is responsible for pro-actively initiating and delivering quality improvement initiatives as required. The nurse if also responsible for ensuring adverse trends are identified, reported and managed.

The nurse is a key player in delivering system change within the organisation including identifying the need for and taking a lead on teaching and development programmes to deliver culture change.

Key responsibilities

Clinical responsibilities

- To contribute expert clinical knowledge and skills to the service
- To provide expert consultancy and clinical advice to the wider organisation
- To advise other staff members on the management and effective discharge of patients and to oversee their work
- To lead on the triage and clinical prioritisation of patients on the caseload, ensuring changing demands are managed
- To expertly undertake effective comprehensive holistic health, housing and social care assessments for patient including independent assessments of risk as required and coach other staff in this as required
- To ensure all patients admitted the service have the benefits of their admission maximised as much as possible
- To identify the need for and undertake e.g. mental capacity assessments, safeguarding referrals, challenges to NHS charging decisions within the caseload
- To challenge decisions made in respect to undertake e.g. mental capacity assessments, safeguarding referrals, challenges to NHS charging decisions as necessary without generating conflict
- To record work all work undertaken with patients in an accurate and timely manner in all relevant clinical databases, enabling effective integrated care, and the collection of monitoring and evaluation data and ensure all staff do the same
- To clinically advocate and negotiate on behalf of clients with senior staff without generating conflict
- To convene case conferences / case reviews and Chair / lead as necessary

- To effectively engage patients from a variety of disenfranchised backgrounds and support other staff to achieve this
- To utilise strategies to manage challenging behaviour in patients as necessary and support other staff with this
- To develop a 'making every contact count' culture on the team with respect to health promotion, harm reduction and suicide prevention
- To lead on the motivation and empowerment of patients to help them make make changes around their health
- To proactively identify adverse trends in the population e.g. increases in deaths in the population, increases in self-discharge, poor clinical practice within the hospital in respect of the client group and put in strategies to mitigate against these
- To identify clinical skill deficits within the team, and manage these deficits as required
- To clinically supervise staff on the team and develop a team culture of reflective practice

Management responsibilities:

- To be responsible for homeless hospital discharge strategy in the organisation
- To act as a role model and expert consultant for inclusion health practice within the organisation
- To be a spokesperson for the organisation at borough level on homelessness / inclusion health issues
- To be the operational lead for the service
- To line manage other staff within the service as necessary (including staff from other organisations if required), and to manage and monitor delegated management relationships within the service
- To motivate and coach staff as necessary
- To identify and meet staff training and support needs
- To manage the service caseload on behalf of the service as required and/or delegate appropriately
- To proactively identify opportunities to improve the service for patients
- To proactively identify adverse trends, and lead service improvements and developments as required
- To deliver needs assessments for developments to the service as required
- To write business cases for developments to the service as required
- To deliver pilot interventions related to the development of the service as required
- To manage partnership relationships as required e.g. via Service Level Agreements
- To ensure quality clinical records and data capture are maintained on the service
- To monitor and report on the performance of the service as required, and suggest interventions to mitigate against adverse trends
- To ensure that service user feedback is obtained on the service and that appropriate responses are delivered
- To identify the need for and direct the delivery or undertake clinical audits as required

- To lead on the delivery of specific service targets e.g. GP registration for patients, ensuring correct contact details are registered for patients, ensuring service user feedback is obtained, and review these regularly, making changes to targets as necessary
- To undertake service evaluations and research as required
- To lead on needs assessment for and the delivery of relevant teaching programmes within the organisation as required
- To manage student teaching for nurses, medical students and other students as required
- To produce team resources e.g. leaflets, posters etc as required and monitor their effectiveness

Partnership responsibilities:

- To convene and/or attend multi-agency meetings concerning patients and Chair / lead and provide expert clinical input and advise as required
- To be visible to, and proactively engage with, all relevant partnership agencies
- To work collaboratively with hospital, statutory and voluntary sector partners to develop effective discharge pathways as necessary
- To Chair partnership meetings as necessary, and ensure meetings achieve their service improvement objectives
- To manage partnership relationships as required including e.g. setting up and monitoring Service Level Agreements
- To ensure the service has a ‘good name’ with partner organisations

Professional responsibilities:

- To comply with all local NHS Trust policies
- To ensure mandatory training is up to date
- To ensuring nursing registration is up to date, and revalidation requirements are met
- To proactively identify and address own learning needs in relation to specialist role

Person Specification

Experience

Essential:

- extensive clinical experience within inclusion health
- experience of being a senior role model
- experience of project management
- experience of undertaking needs assessments
- experience of service development
- experience of writing a business case
- experience of being a spokesperson at e.g. senior level meetings
- experience of managing others to deliver a quality service

- experience of managing a multidisciplinary team
- experience of delivering delegated management
- experience of setting up partnership relationships
- experience of motivating and coaching other staff
- experience of successfully managing poor performance
- extensive experience of managing a fast-moving clinical case load
- extensive experience of triage / prioritisation in a clinical context
- extensive experience of working successfully with patients with non-engagement issues
- extensive experience of working with patients with communication barriers and disabilities
- extensive experience of working with clients with mental capacity and/or safeguarding issues
- extensive experience of working daily with multiple patients with highly distressing personal circumstances and stories
- extensive experience of maintaining boundaries
- extensive experience of independently assessing clinical risk
- extensive experience of delivering harm reduction interventions
- experience of suicide prevention practice
- extensive experience of successfully clinically advocating for patients with senior staff in a wide variety of situations without generating conflict
- experience of monitoring team performance against key performance indicators and maximising team performance
- extensive experience of identifying the need for and delivering clinical audits
- experience of undertaking needs assessments for, designing and deliver teaching programmes
- extensive experience of running student nurse programmes
- experience of teaching large groups in a variety of contexts
- experience of undertaking service user feedback exercises

Desirable:

- extensive clinical experience in a variety of relevant areas including inclusion health
- extensive experience of service development and service evaluation including having independently delivered pilot interventions in the past
- experience of writing journal articles or similar
- experience of producing academic posters
- experience of talking to the media about a service
- experience of setting up a new service
- experience of successfully managing poor performance in a multi-disciplinary and partnership context
- extensive experience of teaching large groups in a variety of contexts
- experience of successfully having delivered a system and/or culture change

Knowledge

Essential:

- Masters level education or equivalent
- Leadership training
- Management training
- Post basic qualifications in a relevant clinical discipline
- NMC approved mentorship course
- very good generalist clinical knowledge spanning physical health and mental health
- expert clinical knowledge in inclusion health
- expert knowledge of the social determinants of heath and how this directly effects patients
- knowledge of the different types of interventions that exist in homeless hospital discharge, and able to discuss the relative merits of these
- expert knowledge of how to work successfully with patients with communication barriers e.g. language, literacy, cognition, behaviour
- expert knowledge of how to work successfully with patients with disabilities e.g. physical disabilities, learning disabilities etc
- cultural competence
- expert knowledge around how to assess mental capacity and cognition
- expert knowledge of safeguarding legislation
- expert knowledge around addictions and sequelae of addictions
- expert knowledge around harm reduction
- knowledge around suicide prevention
- knowledge around public health interventions
- specialist knowledge regarding the effective management of patients with personality disorder / complex trauma
- expert knowledge around rights to healthcare and NHS charging
- expert knowledge regarding rights to housing, housing options and local authority processes
- expert knowledge regarding the support options available for people experiencing homelessness
- knowledge regarding the support options available for people experiencing homelessness in the local community
- knowledge on immigration status and its impact on welfare rights
- expert knowledge around data sharing legislation
- expert knowledge and understanding of the clinical governance responsibilities of the role
- expert knowledge about the management of change
- expert knowledge around quality improvement in an NHS context

Desirable:

- Master level qualification in inclusion health
- advanced assessment qualification
- research methods training

- expert knowledge of the different types of interventions that exist in homeless hospital discharge, and able to discuss the relative merits of these
- expert knowledge regarding the support options available for people experiencing homelessness in the local community
- previous journal publications in this area or similar

Skills and abilities

Essential:

- excellent oral and written communication skills
- excellent general organisational skills
- demonstrated ability to motivate, lead and be role model for a team
- demonstrated ability to set up and work effectively within partnership relationships
- demonstrated ability to take independent decisions
- demonstrated ability to be the spokesperson in an organisation
- ability to undertake needs assessments
- ability to write a business case
- ability to deliver a service development or pilot
- demonstrated ability to manage conflict effectively
- demonstrated ability to engage of clients from highly disenfranchised populations
- demonstrated ability to work daily with multiple patients with highly distressing personal circumstances and stories
- demonstrated ability to process large amounts of complex information very quickly
- demonstrated collaborative problem-solving ability
- demonstrated ability to triage and prioritisation in multiple complex needs context
- demonstrated ability to manage a caseload on behalf of a wider team
- demonstrated ability to independently undertake an effective comprehensive holistic health, housing and social care assessment for a patient including the assessment of risk
- demonstrated ability to clinical advocate and negotiate on behalf of a client with senior staff without generating conflict
- demonstrated ability to use motivational interviewing techniques with clients
- demonstrated ability to work successfully with patients with personality disorder and complex trauma
- demonstrated ability to deliver harm reduction interventions
- demonstrated ability to maintain boundaries with patients
- demonstrated ability to teach large groups of people effectively
- demonstrated ability to identify the need for and deliver clinical audits
- demonstrated ability to independently produce reports on team performance
- demonstrated ability to undertake a service user feedback exercise
- demonstrated ability to use a wide variety of resources Microsoft programmes to develop team resources as necessary – e.g. leaflets, posters, Powerpoint presentations

- demonstrated ability to proactively identify areas for quality improvement
- self-motivated
- ability to identify and address own learning needs, and to reflect on own practice

Desirable

- expert motivational interviewing skills
- ability to deliver culture change in an organisation

Values

- Belief in the structural causes of homelessness
- Commitment to improving the health of homeless and other multiply excluded patients
- Commitment to addressing social exclusion
- Commitment to promoting independence and patient choice
- Understanding of and commitment to equal opportunities in service delivery
- Commitment to evidence-based practice
- Committed to continuing professional development

Job Description: Inclusion Health Clinical Nurse Specialist – Band 7

This template gives guidance and recommendations for essential points that could be included in a job description for a Band 7 Nurse.

Job purpose

Homeless hospital discharge teams

The homeless hospital discharge service provides enhanced inpatient care, and ensures safe, appropriate and sustainable hospital discharges that meet the needs of patients currently experiencing homelessness.

In detail the service aims to:

- effectively engage the patient in all relevant services / support,
- maximise the benefit of the attendance / admission for the patient from a health and social care perspective,
- link the patient into all necessary health and social care and support pending discharge,
- advocate for the patient to receive assessment, treatment or services when this is required
- safeguard patients effectively
- ensure a safe and effective discharge to accommodation (where this is possible)
- stop the revolving door

The service works with a variety of hospital, statutory and voluntary partners to achieve these objectives.

The service also aims to bring a wider influence to hospital, housing and social care system to proactively identify and better respond to the needs of currently homeless and otherwise disenfranchised people.

Nurse role

The Band 7 nurse is an operational manager and lead for the service, and also contributes senior clinical knowledge and expertise. The nurse is also a role model for inclusion health practice in the organisation.

As a key part of a multi-disciplinary intervention, the nurse assists patients identified within the organisation as experiencing homelessness to improve and maintain their health, by identifying and managing (or influencing the system to manage) unmet health, housing and social care needs. Unmet needs include e.g. physical health care problems, mental health problems, addictions problems, communication difficulties, disabilities, mental capacity issues, safeguarding, missed primary care screening or interventions that are not being met due to any eligibility and legal complexities. Patients often present with tri-morbidity (the co-concurrence of physical

health, mental health and addictions problems) and other multiple complex needs, and may have non-engagement issues and/or challenging behaviour patterns.

On a day to day basis the nurse is responsible for the clinical governance of the service, and identifies areas for quality improvement and ensures adverse trends are identified, reported and managed.

The nurse is a key player in delivering system change within the organisation including taking a lead on teaching around inclusion health within the organisation.

Key responsibilities

Clinical responsibilities

- To contribute expert clinical skills and knowledge to the service
- To be a role model for other staff on the service, delivering inclusive practice at all times
- To triage and clinically prioritise patients on the service effectively
- To oversee the care of all patients managed by the service and review all patients on the service with respect to unmet need and the development of effective discharge plans
- To ensure all patients have the benefits of their admission maximised
- To advise other staff members on the management and effective discharge of patients as necessary
- To effectively engage patients from a variety of disenfranchised backgrounds
- To utilise strategies to manage challenging behaviour in patients as necessary
- To independently undertake effective comprehensive holistic health, housing and social care assessments for patient including independent assessments of risk
- To take time to listen to patients who may have highly distressing personal circumstances and stories to understand their needs
- To utilise strategies to improve communication with patients e.g. accessing Language Line, taking time to explain leaflets and letters etc
- To utilise strategies to work to minimise the impact of disability on patients e.g. identifying the need for a walking aid, or new wheelchair etc
- To provide subsistence support to patients as required in line with service policy
- To manage service funds to support subsistence support as required
- To develop effective discharge plans for patients and work to achieve effective discharges for all patients on the service
- To make appropriate referrals for patients as necessary
- To record work all work undertaken with patients in an accurate and timely manner in all relevant clinical databases, enabling effective integrated care, and the collection of monitoring and evaluation data and ensure other staff do the same

- To identify the need for and undertake e.g. mental capacity assessments, safeguarding referrals, challenges to NHS charging decisions within the caseload as necessary
- To clinically advocate and negotiate on behalf of clients with senior staff without generating conflict
- To convene case conferences / case reviews as necessary
- To motivate and empower patients to make changes around their health
- To deliver effective health promotion, harm reduction and suicide prevention interventions in line with 'making every contact count'
- To proactively identify adverse trends in the population e.g. increases in deaths in the population, increases in self-discharge, poor clinical practice within the hospital in respect of the client group
- To identify clinical skill deficits within the team, and report on / manage these deficits as required
- To clinically supervise staff on the team in line with reflective practice principles

Management responsibilities:

- To act an operational lead for the service
- To act as a role model for inclusion health practice within the organisation
- To manage the service caseload on behalf of the service
- To line manage other staff within the service as necessary (including staff from other organisations if required)
- To lead on the development and provision of relevant teaching programmes within the organisation
- To manage student teaching as required
- To produce team resources e.g. leaflets, posters etc as required
- To undertake clinical audits as required
- To lead on the delivery of specific service targets e.g. GP registration for patients, ensuring correct contact details are registered for patients
- To lead on the monitoring and reporting of the performance of the service as required e.g. by maintaining Excel data sheets in addition to clinical notes
- To lead on the collection of service user feedback for the service
- To ensure quality clinical records and data capture are maintained on the service
- To monitor and report on the performance of the service as required
- To proactively identify adverse trends, and lead service improvements and developments as required

Partnership responsibilities:

- To be a senior representative for the service in a variety of contexts
- To work collaboratively with hospital, statutory and voluntary sector partners at all times in order to improve patient pathways
- To independently develop relationships with partnership organisations as required

- To support / manage partnership staff within the team as necessary
- To attend and/or attend multi-agency meetings as required and lead as necessary

Professional responsibilities:

- To comply with all local NHS Trust policies
- To ensure mandatory training is up to date
- To ensuring nursing registration is up to date, and revalidation requirements are met
- To proactively identify and address own learning needs in relation to specialist role

Person Specification

Experience

Essential:

- extensive clinical experience in a relevant discipline
- experience of being a role model for staff
- experience of successfully line managing staff
- experience of successfully managing poor performance
- experience of motivating staff
- experience of monitoring team performance against key performance indicators
- experience of successfully managing a fast-moving clinical case load that involves triage and prisonisation
- experience of working successfully with patients with non-engagement issues
- experience of working successfully with challenging behaviour
- extensive experience of managing patients with communication barriers and disabilities
- extensive experience of managing patients with mental capacity and/or safeguarding issues
- extensive experience of working daily with multiple patients with highly distressing personal circumstances and stories
- experience of maintaining boundaries
- experience of delivering harm reduction interventions
- experience of suicide prevention practice
- experience of successfully clinically advocating for patients with senior staff in a wide variety of situations without generating conflict
- experience of multidisciplinary working
- experience of delivering clinical audits
- experience of delivering successful partnership working
- experience of designing and deliver teaching programmes
- experience of running student nurse programmes

Desirable:

- extensive clinical experience in inclusion health
- experience of regularly using motivational interviewing techniques
- experience of managing and directing the work of a multidisciplinary team
- experience of managing staff from other organisations
- experience of independently producing reports on team activity and performance
- experience of setting up, and maintaining relationships with a wide variety of relevant community partners
- experience of undertaking service user feedback exercise
- experience of delivering service development initiatives independently

Knowledge

Essential:

- Nursing qualification
- At least degree level education or equivalent
- Management training
- Post basic qualification in a relevant clinical discipline
- NMC approved mentorship course
- good generalist clinical knowledge spanning physical health and mental health
- good clinical knowledge in inclusion health
- good knowledge of the social determinants of heath and how this directly effects patients
- good knowledge of how to work successfully with patients with communication barriers e.g. language, literacy, cognition, behaviour
- good knowledge of how to work successfully with patients with disabilities e.g. physical disabilities, learning disabilities etc
- cultural competence training
- good knowledge of how to assess mental capacity and cognition effectively
- good knowledge of how to apply safeguarding legislation effectively
- good knowledge around addictions and sequelae of addictions
- good knowledge around harm reduction
- good knowledge around suicide prevention
- knowledge around public health interventions
- good knowledge around rights to healthcare and NHS charging
- knowledge around quality improvement in an NHS context
- good knowledge regarding the support options available for people experiencing homelessness
- good knowledge around data sharing legislation
- knowledge and understanding of the clinical governance responsibilities of a service operational lead

Desirable:

- specialist knowledge regarding the effective management of patients with personality disorder / complex trauma
- Leadership training
- expert knowledge around rights to healthcare and NHS charging
- knowledge regarding rights to housing, housing options and local authority processes
- knowledge regarding the support options available for people experiencing homelessness in the local community
- knowledge on immigration status and its impact on welfare rights
- knowledge about the management of change

Skills and abilities

Essential:

- warm, friendly manner
- excellent oral and written communication skills
- excellent general organisational skills
- team worker
- confident to problem solve and make independent decisions
- ability to lead the service and be role model for staff
- ability to take clinical governance responsibility for the service
- ability to manage the service caseload, triaging and prioritising effectively
- ability to manage personal stress levels effectively
- ability to manage conflict effectively
- ability to work in a rapidly changing environment, highly adaptable
- ability to maintain a positive attitude in difficult circumstances
- ability to independently undertake an effective comprehensive holistic health, housing and social care assessment for a patient including the independent assessment of clinical risk
- ability to work daily with multiple patients with highly distressing personal circumstances and stories
- ability to maintain boundaries with patients
- ability to interpret and manage highly complex information
- ability to set up and develop relationships with hospital, statutory and voluntary sector partners
- ability to clinical advocate and negotiate on behalf of a client with senior staff without generating conflict
- ability to effectively use motivational interviewing techniques with clients
- demonstrated ability to design teaching programmes and large teach groups of people effectively
- ability to identify the need for and independently undertake clinical audits
- ability to produce reports on team performance
- ability to undertake service user feedback exercises
- ability to use a wide variety of resources Microsoft programmes to develop team resources as necessary – e.g. leaflets, posters, Powerpoint presentations

- ability to proactively identify areas for quality improvement
- self-motivated
- ability to identify and address own learning needs, and to reflect on own practice

Desirable

- expert motivational interviewing skills
- demonstrated ability to work successfully with patients with personality disorder and complex trauma
- ability to culture change / systems leadership
- ability to deliver service development initiatives independently

Values

- Belief in the structural causes of homelessness
- Commitment to improving the health of homeless and other multiply excluded patients
- Commitment to addressing social exclusion
- Commitment to promoting independence and patient choice
- Understanding of and commitment to equal opportunities in service delivery
- Commitment to evidence-based practice
- Committed to continuing professional development

Job Description: Inclusion Health Nurse – Band 6

This template gives guidance and recommendations for essential points that could be included in a job description for a Band 6 Nurse.

Job purpose

Homeless hospital discharge teams

The homeless hospital discharge service provides enhanced inpatient care, and ensures safe, appropriate and sustainable hospital discharges that meet the needs of patients currently experiencing homelessness.

In detail the service aims to:

- effectively engage the patient in all relevant services / support,
- maximise the benefit of the attendance / admission for the patient from a health and social care perspective,
- link the patient into all necessary health and social care and support pending discharge,
- advocate for the patient to receive assessment, treatment or services when this is required
- safeguard patients effectively
- ensure a safe and effective discharge to accommodation (where this is possible)
- stop the revolving door

The service works with a variety of hospital, statutory and voluntary partners to achieve these objectives.

The service also aims to bring a wider influence to hospital, housing and social care system to proactively identify and better respond to the needs of currently homeless and otherwise disenfranchised people.

Band 6 Nurse role

The Band 6 nurse triages referrals to the service, and independently manages a caseload of patients, prioritising work effectively.

As a key part of a multi-disciplinary intervention, the Band 6 nurse assists patients identified within the organisation as experiencing homelessness to improve and maintain their health, by identifying and managing (or influencing the system to manage) unmet health, housing and social care needs. Unmet needs include e.g. physical health care problems, mental health problems, addictions problems, communication difficulties, disabilities, mental capacity issues, safeguarding, missed primary care screening or interventions that are not being met due to any eligibility and legal complexities. Patients often present with tri-morbidity (the co-concurrence of physical health, mental health and addictions problems) and other multiple

complex needs, and may have non-engagement issues and/or challenging behaviour patterns.

The Band 6 nurse teaches other staff within the organisation about inclusion health, and supports and manages nursing students and junior staff as necessary.

The Band 6 nurse proactively reports adverse trends to the service lead, and undertakes audits of practice as required.

Key responsibilities

Clinical responsibilities

- To triage service referrals effectively
- To independently manage a caseload of patients, prioritising work effectively
- To effectively engage patients from a variety disenfranchised backgrounds
- To independently undertake effective comprehensive holistic health, housing
- and social care assessments for patients including independent assessments of risk
- To take time to listen to patients who may have highly distressing personal circumstances and stories to understand their needs
- To utilise strategies to improve communication with patients e.g. accessing Language Line, taking time to explain leaflets and letters etc
- To utilise strategies to work to minimise the impact of disability on patients e.g. identifying the need for a walking aid, or new wheelchair etc
- To provide subsistence support to patients as required in line with service policy
- To manage funds to support subsistence support as required
- To develop effective discharge plans for patients and work to achieve these
- To make appropriate referrals for patients as necessary
- To proactively identify the need for e.g. mental capacity assessments, safeguarding referrals, challenges to NHS charging decisions within the caseload and take action as required
- To record all work undertaken with patients in an accurate and timely manner in all relevant clinical databases, enabling effective integrated care, and the collection of monitoring and evaluation data
- To clinically advocate and negotiate on behalf of clients with senior staff without generating conflict
- To attend case conferences / case reviews and/or convene them as necessary
- To motivate and empower patients to make changes around their health
- To deliver health promotion interventions to patients as necessary
- To deliver harm reduction and suicide prevention interventions as necessary
- To clinically supervise junior staff as delegated

Management responsibilities:

- To manage junior staff within the service as necessary (including staff from other organisations as required)

- To mentor student nurses as required
- To deliver teaching sessions on teaching programmes within the organisation as required, including developing teaching resources
- To produce team resources as directed e.g. leaflets, posters etc as required
- To independently undertake clinical audits as required
- To contribute to the delivery of specific service targets e.g. GP registration for patients, ensuring correct contact details are registered for patients
- To contribute to the monitoring and reporting of the performance of the service as required e.g. by maintaining Excel data sheets in addition to clinical notes
- To collect service user feedback as required
- To identify adverse events and trends, and threats to service quality and report these to the service lead

Partnership responsibilities:

- To independently develop relationships with partnership organisations as required
- To support / manage partnership staff within the team as necessary
- To work collaboratively with hospital, statutory and voluntary sector partners at all times in order to improve patient pathways
- To attend and/or attend multi-agency meetings as required and contribute positively

Professional responsibilities:

- To comply with all local NHS Trust policies
- To ensure mandatory training is up to date
- To ensuring nursing registration is up to date, and revalidation requirements are met
- To proactively identify and address own learning needs in relation to specialist role

Person Specification

Experience

Essential:

- significant clinical experience in a relevant discipline
- experience of working with clients with non-engagement issues
- experience of working with challenging behaviour
- experience of independently managing a caseload
- experience of triaging patients
- experience of working daily with multiple patients with highly distressing personal circumstances and stories
- experience of maintaining boundaries

- experience of working with patients with communication barriers and disabilities
- experience of working with clients with mental capacity and/or safeguarding issues
- experience of independently assessing clinical risk
- experience of multidisciplinary working
- experience of mentoring students
- experience of delivering teaching sessions to nurses

Desirable:

- experience of working with people experiencing homelessness
- experience of working in a mental health or addictions setting
- experience of working in the community
- experience of managing a fast-moving clinical case load
- experience of delivering harm reduction interventions
- experience of suicide prevention practice
- experience of successfully clinically advocating for patients with senior staff without generating conflict
- experience of managing junior staff
- experience of delivering teaching sessions to allied professionals
- experience of developing teaching materials
- experience of independently undertaking audits
- experience of partnership working

Knowledge

Essential:

- Nursing qualification
- Degree level education or equivalent
- NMC approved mentorship course
- post basic training in a relevant area
- good general clinical knowledge spanning physical health and mental health
- good knowledge of the social determinants of heath and how this directly effects patients
- good knowledge of how to work successfully with patients with communication barriers e.g. language, literacy, cognition, behaviour
- good knowledge of how to work successfully with patients with disabilities e.g. physical disabilities, learning disabilities etc
- knowledge around addictions and sequelae of addictions
- good knowledge around rights to healthcare and NHS charging
- understanding of how to assess mental capacity and cognition
- good knowledge of safeguarding legislation
- good knowledge around data sharing legislation
- knowledge of harm reduction practices

- knowledge of suicide prevention practice
- knowledge regarding the support options available for people experiencing homelessness
- knowledge and understanding of the concept of clinical governance

Desirable:

- post basic qualification in a relevant area e.g. addictions
- cultural competency training
- knowledge around public health interventions
- knowledge around quality improvement in an NHS context

Skills and abilities

Essential:

- warm, friendly manner
- very good oral and written communication skills
- very good general organisational skills
- team worker
- ability to triage service referrals effectively
- ability to manage a caseload of patients, prioritising effectively
- ability to manage junior staff and mentor students effectively
- ability to work in a rapidly changing environment, highly adaptable
- ability to maintain a positive attitude in difficult circumstances
- ability to manage personal stress levels effectively
- ability to manage conflict effectively
- ability to independently problem-solve
- ability to engage of clients from highly disenfranchised populations
- ability to independently undertake an effective comprehensive holistic health, housing and social care assessment for a patient including the independent assessment of clinical risk
- ability to work daily with multiple patients with highly distressing personal circumstances and stories
- ability to maintain boundaries with patients
- ability to interpret and manage highly complex information
- ability to develop relationships with hospital, statutory and voluntary sector partners
- ability to clinical advocate and negotiate on behalf of a client with senior staff without generating conflict
- ability to teach large groups of people as required
- ability to use a wide variety of Microsoft programmes to help develop team resources as necessary – e.g. leaflets, posters, Powerpoint presentations
- ability to undertake a clinical audit
- ability to contribute to reports on team performance

- ability to identify and address own learning needs, and to reflect on own practice

Desirable

- ability to work successfully with patients with personality disorder and complex trauma
- motivational interviewing skills

Values

- Belief in the structural causes of homelessness
- Commitment to improving the health of homeless and other multiply excluded patients
- Commitment to addressing social exclusion
- Commitment to promoting independence and patient choice
- Understanding of and commitment to equal opportunities in service delivery
- Commitment to evidence-based practice
- Committed to continuing professional development

Job Description: Inclusion Health Support Nurse – Band 5

This template gives guidance and recommendations for essential points that could be included in a job description for a Band 5 Nurse in a Pathway team.

Job purpose

Homeless hospital discharge teams

The homeless hospital discharge service provides enhanced inpatient care, and ensures safe, appropriate and sustainable hospital discharges that meet the needs of patients currently experiencing homelessness.

In detail the service aims to:

- effectively engage the patient in all relevant services / support,
- maximise the benefit of the attendance / admission for the patient from a health and social care perspective,
- link the patient into all necessary health and social care and support pending discharge,
- advocate for the patient to receive assessment, treatment or services when this is required
- safeguard patients effectively
- ensure a safe and effective discharge to accommodation (where this is possible)
- stop the revolving door

The service works with a variety of hospital, statutory and voluntary partners to achieve these objectives.

The service also aims to bring a wider influence to hospital, housing and social care system to proactively identify and better respond to the needs of currently homeless and otherwise disenfranchised people.

Band 5 Nurse role

As a key part of a multi-disciplinary intervention, the Band 5 nurse assists patients identified within the organisation as experiencing homelessness to improve and maintain their health, by identifying and managing (or influencing the system to manage) unmet health, housing and social care needs.

Unmet needs include e.g. physical health care problems, mental health problems, addictions problems, communication difficulties, disabilities, mental capacity issues, safeguarding, missed primary care screening or interventions that are not being met due to any eligibility and legal complexities. Patients often present with tri-morbidity (the co-concurrence of physical health, mental health and addictions problems) and other multiple complex needs, and may have non-engagement issues and/or challenging behaviour patterns.

The Band 5 nurse independently manages patients on the team caseload, with support from senior staff members as necessary.

Key responsibilities

Clinical responsibilities

- To effectively engage patients from a variety disenfranchised backgrounds
- To independently undertake effective comprehensive holistic health, housing and social care assessments for patients including independent assessments of risk
- To take time to listen to patients who may have highly distressing personal circumstances and stories in order to understand their needs
- To utilise strategies to improve communication with patients e.g. accessing Language Line, taking time to explain leaflets and letters etc
- To utilise strategies to work to minimise the impact of disability on patients e.g. identifying the need for a walking aid, or new wheelchair etc
- To provide subsistence support to patients as required in line with service policy
- To develop effective discharge plans for patients and work to achieve these
- To make appropriate referrals for patients as necessary
- To proactively identify the need for e.g. mental capacity assessments, safeguarding referrals, challenges to NHS charging decisions in the caseload and report these to the service lead
- To record all work undertaken with patients in an accurate and timely manner in all relevant clinical databases, enabling effective integrated care, and the collection of monitoring and evaluation data
- To clinically advocate and negotiate on behalf of clients with senior staff without generating conflict
- To attend case conferences / case reviews and contribute as necessary
- To motivate and empower patients to make changes around their health
- To deliver health promotion interventions to patients as necessary

Management responsibilities:

- To support other staff within the service as necessary (including staff from other organisations as required)
- To teach student nurses as required
- To contribute to teaching sessions delivered by the service to other staff within the organisation as required
- To contribute to the production of team resources e.g. leaflets, posters etc as required
- To contribute to clinical audits as required
- To contribute to the delivery of specific service targets e.g. GP registration for patients, ensuring correct contact details are registered for patients
- To contribute to the monitoring and reporting of the performance of the service as required e.g. by maintaining Excel data sheets in addition to clinical notes
- To proactively identify adverse events, and report these to the service lead

Partnership responsibilities:

- To work collaboratively with hospital, statutory and voluntary sector partners at all times
- To support partnership staff within the team as necessary
- To attend and/or attend multi-agency meetings as required

Professional responsibilities:

- To comply with all local NHS Trust policies
- To ensure mandatory training is up to date
- To ensuring nursing registration is up to date, and revalidation requirements are met
- To proactively identify and address own learning needs in relation to specialist role

Person Specification

Experience

Essential:

- post basic clinical experience in a relevant discipline
- experience of working daily with multiple patients with highly distressing personal circumstances and stories
- experience of maintaining boundaries
- experience of working with patients with communication barriers and disabilities
- experience of working with clients with mental capacity and/or safeguarding issues
- experience of independently assessing clinical risk
- experience of multidisciplinary working

Desirable:

- experience of working with people experiencing homelessness
- experience of working in a mental health or addictions setting
- experience of working on a fast-moving clinical case load
- experience of triage / prioritisation in a clinical context
- experience of working successfully with patients with non-engagement issues
- experience of working with challenging behaviour
- experience of advocating for patients with senior staff without generating conflict

Knowledge

Essential:

- Nursing qualification
- Degree level education or equivalent
- clinical knowledge spanning physical health and mental health
- knowledge of the social determinants of heath and how this directly effects patients
- knowledge of how to work successfully with patients with communication barriers e.g. language, literacy, cognition, behaviour
- knowledge of how to work successfully with patients with disabilities e.g. physical disabilities, learning disabilities etc
- understanding of how to assess mental capacity and cognition
- understanding of safeguarding legislation
- understanding of the key principle of data sharing legislation
- knowledge and understanding of the concept of clinical governance

Desirable:

- cultural competency training
- knowledge around addictions and sequelae of addictions
- knowledge around harm reduction
- knowledge around suicide prevention
- knowledge around public health interventions
- knowledge around rights to healthcare and NHS charging
- knowledge regarding the support options available for people experiencing homelessness
- knowledge around quality improvement in an NHS context
- detailed knowledge around data sharing legislation

Skills and abilities

Essential:

- warm, friendly manner
- good oral and written communication skills
- good general organisational skills
- team worker
- ability to work in a rapidly changing environment, highly adaptable
- ability to maintain a positive attitude in difficult circumstances
- ability to manage personal stress levels effectively
- ability to manage conflict effectively
- ability to independently problem-solve
- ability to engage of clients from highly disenfranchised populations

- ability to independently undertake an effective comprehensive holistic health, housing and social care assessment for a patient including the independent assessment of clinical risk
- ability to work daily with multiple patients with highly distressing personal circumstances and stories
- ability to maintain boundaries with patients
- ability to interpret and manage highly complex information
- ability to work effectively in partnership with hospital, statutory and voluntary sector partners
- ability to clinical advocate and negotiate on behalf of a client with senior staff without generating conflict
- ability to support teaching delivered by the service if required
- ability to contribute to a clinical audit
- ability to contribute to reports on team performance
- ability to identify and address own learning needs, and to reflect on own practice

Desirable

- ability to use a wide variety of Microsoft programmes to develop team resources as necessary – e.g. leaflets, posters, Powerpoint presentations
- ability to work constructively with patients with personality disorder and complex trauma issues
- motivational interviewing skills

Values

- Belief in the structural causes of homelessness
- Commitment to improving the health of homeless and other multiply excluded patients
- Commitment to addressing social exclusion
- Commitment to promoting independence and patient choice
- Understanding of and commitment to equal opportunities in service delivery
- Commitment to evidence-based practice
- Committed to continuing professional development

Appendix 3 – Data from interviews with nurses

The following numerical data is taken from interviews with 14 of the nurses (who were interviewed in detail, and asked a pre-set list of questions)

Average number of years qualified: 22.6

Most common qualification:

Highest level was completed Diploma	14%
Highest level was completed Degree	86%
Highest level was completed Masters	29%
Dual qualified	28%
Specialist practice qualification	21%
Masters or dual qualified or specialist practice qualification	50%

- Several practitioners without a Masters had studied and passed courses at Masters level.
- Similarly, all those with a Degree had studied and passed courses at Degree level.

% of practitioners that had previously worked in the community: 79%

Current banding:

Band 8a	14%
Band 7	64%
Band 6	21%

Average number of directly managed staff: 1.64 (this was low because often staff members were actually line managed by managers in other services – a challenge for the nurses at times)

Average number of years in job: 4.14 (one nurse had been in the role for 14 years though)

Current average split of time:

Management of staff or service	10%
Clinical work	63%
Data work / report writing	7%
Teaching	8%
Networking with wider sector e.g. MDTs, homelessness forums, service development meetings	8%
Own Continuing Professional Development	4%

Top 10 continuing professional development training / courses undertaken for the role:

Teaching course	79%
Addictions course / training	50%
Leadership course / training	43%
BBV course / training	43%
Sexual health course / training	43%
Advanced assessment course	36%
Women's health course / training	29%
Harm reduction course / training	29%
Liver course / training	21%
Palliative care course / training	21%

- Nearly everyone described some kind of informal training received in housing law.

Top challenges (by % of those that mentioned individual challenges):

Collective barriers to safe discharge in general	100%
Bed pressures / pressure to discharge	71%
Lack of services for people with dual diagnosis	64%
Challenges around providing for EEA nationals	64%
Challenges with lack of staff or management of existing staff	57%
Issues with social care	50%
Issues with data sharing or IT systems	50%
Lack of step-down care	50%
Need better links to community services	43%
Issues are tendering or uncertain future of services (at some point)	43%
Professional isolation	43%
Inadequate resources	36%
Inadequate substitute prescribing when people are admitted	36%

Appendix 4: Notes from quality improvement workshop

GROUP WORK 1: Think about all the barriers that might stop these core objectives being achieved? Try to theme these.

Theme 1: PRACTICAL ISSUES IN THE HOSPITAL ADMISSION

- Homelessness not being picked up on admission
- A&E staff not referring clients
- Patient details wrong on system – address, significant other, GP
- IT systems not being joined up / transferring information
- Medication needs not being assessed
- Ability to get to OPA not being assessed
- Lack of information sharing with key workers / hostels etc
- Mental health not being managed in hospital
- Inadequate addictions support in hospital
- Nowhere for clients to go
- Lack of step-down beds

Theme 2: HOSPITAL CULTURE RELATED ISSUES

- Wards not understanding the impact and consequences of homelessness
- Staff avoiding asking pertinent questions for a variety of reasons
- Low staffing levels on the wards mitigating against personalised care
- Medically fit for discharge (MFFD) being seen as 'street fit'
- Bed crisis / lack of beds overriding
- Addictions treatment – not being seen as a medical problem or the ward priority
- Staff not understanding patient behaviours
- Self-discharges not being seen as a problem
- Hospitals not feeling social problems are their problem
- Lack of recognition of seniority of nurses in decision making

Theme 3: LACK OF LINKS / RELATIONSHIP WITH COMMUNITY SERVICES

- Gatekeeping not challenged
- Protocols / relationships not in place
- Lack of integration between primary / secondary care
- Staff unaware of existing services
- Services changing
- Lack of adequate, appropriate, or acceptable services in the community
- No weekend access to services
- Barriers to GP registration
- Statutory barriers e.g. NRPF, local connection

- Lack of attending homelessness forums / street meetings etc

Theme 4: NO TIME TAKEN TO HIGHLIGHT WHAT IS NOT WORKING WELL

- Service gaps not being highlighted
- Complaints not being made
- Staff burn out being ignored

GROUP WORK 2: Think about one the themes you identified in the first group. Which can you have an impact on, and how could you go about achieving this?

Theme 1: PRACTICAL ISSUES IN THE HOSPITAL ADMISSION

- Work with A&E staff to ensure homelessness questions being asked in A&E
- Always check all details on record including keyworker / significant other details
- Ensure GP is correct on GP records (and check whether using?)
- Ask about medication compliance in assessment
- Take time to explain, check literacy, consider blister packs, consider storage
- Explain TTAs on ward
- Consider links with in-patient or community pharmacists to do follow-up work
- Referral ASAP to appropriate person / team
- Referral to mental health teams / addictions teams on discharge
- Discharge summary for people who self-discharge
- Log when things go wrong

Theme 2: HOSPITAL CULTURE RELATED ISSUES

- Be part of induction days
- Target sympathetic individuals
- Training programme – new staff, ward clerks, security staff, junior doctors, porters – work out who is key to target. Maybe surgeons e.g. trauma and orthopaedics
- Feedback on negative attitudes to staff (provide pictures of discharge destination to shock staff)
- Do more safeguarding alerts
- Reward good wards with kite mark / recognition
- Put up data around the hospital on improvement

Theme 3: LACK OF LINKS / RELATIONSHIP WITH COMMUNITY SERVICES

- Make time to go out to homeless forums, MDTs etc
- Build relationships with housing
- Ensure honorary contracts are in place
- Do exchanges with other projects
- Encourage nursing students

- Have direct conversations with commissioners
- Make relationships with homeless GPs and other GPs
- Visit projects

Theme 4: NO TIME TAKEN TO HIGHLIGHT WHAT IS NOT WORKING WELL

- Collate data (even simple numbers) on regular trends – e.g. gatekeeping from a particular department, or self-discharges due to inadequate Methadone treatment
- Make time to collate that data, and get it to the right people
- Speak to IT to see if they can help with ongoing monitoring in some areas – e.g. self-discharge
- Follow up and interview clients who have self-discharged
- Report regular issues (e.g. patients leaving with wrong details on system) as incidents on main reporting system
- Have this as a standing item on team meeting agenda
- Nominate someone to lead on this
- Refer untoward deaths to serious case reviews
- Do exit interviews
- Ensure adequate supervision

GROUP WORK 3: What Key Performance Indicators might be used to measure the activities identified above?

Theme 1: PRACTICAL ISSUES IN THE HOSPITAL ADMISSION

- Reduction in number of self-discharges
- No of people who have had their medication checked and understand them
- No of patients registered with a GP
- No of patients with an active GP registration (correct on system)
- No of people street homeless on admission who have somewhere to go on discharge

Theme 2: HOSPITAL CULTURE RELATED ISSUES

- Increase in number of staff trained
- Feedback questionnaires on training from staff
- Number of referrals to team
- Number of attendees from hospital teams to MDTs
- Number of trained link nurses

Theme 3: LACK OF LINKS / RELATIONSHIP WITH COMMUNITY SERVICES

- % of people supported to a housing appt
- % of people registered with GPs
- No of services involved in care plan

- No of visits / links with outside services
- No of referrals to the team from different locations e.g. community
- No of escalations

Theme 4: NO TIME TAKEN TO HIGHLIGHT WHAT IS NOT WORKING WELL

- Patients who have self-discharged (with or without a discharge summary)
- No of frequent attenders with a care plan
- No of people where correct details were put on to the main hospital system
- No of people with GP confirmed
- Number of people housed on discharge

CLIENT FEEDBACK SESSION

AIM: Client feedback is notoriously difficult to obtain. This session was focused on ways to improve this.

When and how to get feedback

- Regularly
- From a variety of allied services
- From clients in groups in the community if possible
- Via patient interviews if possible
- Get EbEs to lead on getting feedback in groups or via interviews (paid), or if not ? volunteers, league of friends
- Electronic apps for feedback?
- If questionnaire 3-4 questions only, simple
- Forms need to be in different languages / styles

Questions to use

- How can we improve our service?
- How can we make things better for you when you come to hospital?
- Has the homeless team helped you in any way?
- Did people treat you well in this hospital?
- What was the best / worst part of your care?
- Did you feel you were listened to?
- Did you feel included in your care?
- What difference did we make to your experience?
- What could we have done better?
- 0-10 numerical scales not useful, smiles better

What to do with the feedback

- Log number of feedback forms and report this
- Use number of feedback forms and response as KPI?
- Quarterly report to stakeholders on feedback forms and responses
- Follow up with feedback
- You said, we did - bulletins / posters?
- Use to promote team
- Share within other Pathway teams
- Link with Pals to improve process
- Involve wider hospital in responses
- Via feedback adapt KPIs to what matters to patients

DOCUMENTATION SESSION

Thinking about improvements that could be made to the hospital discharge process as discussed above - could our assessment documentation also be improved to support this?

Are there any routine questions that could be added to assessments that would help?

GROUP 1

- Ask about medication – do they understand it, are they taking it
- Ask about recent admissions at all hospitals
- Ask about whether they are getting health checks in the community
- Ask about reading / writing
- Ask about sleep site
- Ask about any safeguarding issues – 'do you feel safe at home / at the hostel / where you sleep at the moment?'
- Ask about debts as well as benefits
- Ask about dentist
- Prompt for frailty assessment?

GROUP 2

- Front sheet with key information
- Ask the question 'What is important to you that would help with this stay in hospital?
- Ask about personal likes / dislikes in order to build relationship:
- e.g. drinks / food and eating habits / smoking habits / TV
- Ask about who is likely to visit and when and what would make this easier

- Ask about social situation and whether things are safe at home

GROUP 3

- When was your last sick note?
- Get them to start the story… maybe just a conversation to lead to concerns, flags and facts

GROUP 4

- Medication – do you understand what to take / how often
- Check digital skills? Social media presence?
- Check whether registered to vote?
- Check whether knows about HC2 card?
- Benefits – detailed questions to establish issues such as sanctioning
- Debt / rent arrears / bank accounts – financial assessment
- Dentist / optician / podiatry
- When they last got a sick note

Appendix 5: Service User Feedback form

pathway
Healthcare for homeless people

HOSPITAL HOMELESS SERVICE FEEDBACK FORM

You are receiving this feedback form because you have seen a specialist homeless hospital discharge worker whilst you have been at the hospital.

We want to hear about your experiences of being seen in hospital, so that we can improve services for the patients that come after you. Your views are really vital part of to helping us to understand how to provide better services in the future.

We do not need your name or contact details.

Your visit details:

Which hospital did you visit?.....

Which month was this in?.....

How many days were you in hospital?.....

If you only visited A&E tick this box ☐

The first three questions are about your overall hospital experience

1. To what extent have you felt safe and cared for during your A&E visit or hospital stay?

'I have not felt safe or cared for at all'

'I have felt totally safe and cared for'

0 1 2 3 4 5 6 7 8 9 10

2. To what extent do you feel you have been treated with kindness during your A&E visit or hospital stay?

'I do not feel I have been treated kindly at all'

'I have been treated very kindly at all times'

0 1 2 3 4 5 6 7 8 9 10

3. Has anyone checked on how it will be possible to contact you after you have been discharged? (e.g. to ensure you get any follow-up letters or appointments)

   YES NO NOT SURE

   PLEASE NOTE – if not, please can you let a healthcare worker know your details **now**

The next questions focus on the work of the homelessness worker / service that you have seen

To what extent do you think that the specialist homelessness worker(s) you have seen has helped you during your visit?

'The homelessness worker has not helped me at al'

'The homelessness worker has been extremely helpful'

0 1 2 3 4 5 6 7 8 9 10

4. What do you think the homelessness worker(s) could do to make your stay hospital better in the future?

5. What do you think the homelessness worker (s) could do to make your discharge from hospital better in the future?

THANK YOU FOR YOUR TIME

If you would like to give more feedback, or you would like to become a Pathway 'Expert by Experience' where you might regularly be asked for your opinions on how health care should be delivered to people experiencing homelessness please get in contact at: www.pathway.org.uk

Appendix 6: Draft Inclusion health nurse standards for education and practice – March 2019

Domain 1 – Clinical Care

1.1 Demonstrate a broad range of evidence informed inclusion health clinical expertise that supports high quality, person centred care for individuals across the age range in the practice population young people where appropriate.

1.2 Evaluate therapeutic and other care management strategies, aiming to ensure maximal effectiveness and patient concordance at all times.

1.3 Work autonomously and use advanced assessment skills to assess individuals with complex health care needs and associated multi-morbidity, using a range of evidence-based assessment tools to enable accurate decision making, identifying variation in individuals with a diagnosis, and ensuring correct referral and management pathways are followed. Assess when additional expertise is necessary and make timely, objective and appropriate referrals, whilst maintaining overall responsibility for management and co-ordination of care.

1.4 Diagnose conditions and prescribe if this is relevant to the role, and within the nurse's scope of competence.

1.5 Understand the connection between physical health, mental health, and addiction issues and actively identify patients with mental health issues and addictions. Deliver first lines assessments in mental health and addictions, and deliver mental health promotion, mental health crisis advice and addictions harm reduction advice as necessary. Refer patients to support services with consent.

1.6 Understand the impact of adverse childhood events and complex trauma on individuals, and use psychologically informed approaches to care. Understand the potential causes of challenging behaviour, and actively utilise strategies that help to reduce conflict and manage such behaviour.

1.7 Where appropriate, undertake the case management of people with complex needs, with the support of the multidisciplinary team, to improve care, self-management, facilitate timely discharges and reduce avoidable hospital admissions to enable care to be delivered closer to, or at home.

1.8 Apply the principles of risk stratification and case management to enable identification of those at most risk of poor health outcomes.

1.9 Safeguard individuals at all times. Undertake mental capacity assessments as necessary and contribute to best interest decision making as part of a multidisciplinary team.

1.10 Engage in effective multidisciplinary and multiagency team working whilst recognising professional accountability, to ensure optimal patient care that supports transitions across health care and other agency boundaries that are smooth and meaningful to patients.

1.11 Demonstrate partnership approaches when undertaking consultations, fostering a culture of patient-centred practice, promoting the concept of self-care and patient led care where possible and providing appropriate health promotion, education and support.

1.12 Demonstrate advanced patient engagement and communication skills and be able to foster therapeutic relationships with patients, enabling patients to know they have been listened to with

respect and compassion. Anticipate, assess and overcome common communication and therapeutic relationship boundaries with individuals e.g. literacy, language, embarrassment.

1.13 Take a rights-based approach and actively facilitate maximal access to health and social care.

1.14 Use creative problem solving, influencing and negotiation to enable shared decision making when developing care and management plans and anticipatory care. Ensure that significant others (including pets) are taken into account as and when required.

1.15 Facilitate individual contact with family, carers and support workers as necessary.

1.16 Take a public health approach, aiming to prevent disease and promote health. Facilitate behaviour change interventions for patients using motivational interviewing techniques and brief interventions where appropriate.

1.17 Understand the social determinants of health, and actively facilitate access to housing, welfare, volunteering and employment whether possible.

1.18 Engage and use digital technologies to support patient self-care if this is appropriate.

1.19 Develop at least one area of specialist nursing practice interest, in accordance with the needs of the population.

1.20 Understand the high risks related to this area of practice. Assess, evaluate and articulate risks to both patients and staff using a range of tools, professional judgment and experience. Develop and implement risk management strategies that take account of people's views and responsibilities, whilst promoting patient and staff safety and preventing avoidable harm.

Domain 2 – Leadership and management

2.1 Demonstrate the values of high quality, compassionate nursing and support the ongoing development of these values in others, whilst demonstrating resilience and autonomy in the context of increasing demand, managing change to meet the evolving shape of services through flexibility, innovation and strategic leadership.

2.2 Demonstrate professional and clinical leadership within the multi-disciplinary team (if the nurse is not a lone worker) and induct, clinically supervise, support and appraise junior team members as required. Use advanced communication skills to enable confident management of complex interpersonal issues and conflict management. Support the development of management and leadership skills in other staff.

2.3 Manage the multidisciplinary nursing team within regulatory, professional, legal, ethical and policy frameworks. Promote and model effective team work ensuring staff feel valued and have opportunities for development and to enhance resilience but also create and implement strategies when performance needs to be addressed.

2.4 Analyse the clinical caseload for the team and service, ensuring a safe and effective distribution of workload using triage, prioritisation, delegation, empowerment, education skills and effective resource management. Where appropriate, contribute to workforce planning at service, and locality level.

2.5 Manage and co-ordinate programmes of care, for individuals with multimorbidity, ensuring their patient journey is as seamless as possible between physical health, mental health and addictions, hospital and primary services and to statutory and voluntary sector agencies.

2.6 Demonstrate knowledge of social, political and economic policies and drivers that play a part in the inclusion health agenda, and analyse how these may impact on the design and delivery of services to meet the needs of the population.

2.7 Understand national and local public health strategies, and how these are aligned to support the health of the population. Collaborate effectively with other disciplines and agencies to identify how the team can lead and assist in the implementation of these strategies.

2.8 Working with the wider health and social care team, third sector partners and others, actively engage in the planning and delivery of multiagency initiatives which better facilitate recovery in individuals, and build on community assets within the population to enhance health and wellbeing.

2.9 Ensure every member of the team is able to recognise vulnerability in adults and young people and understand their responsibilities and those of other organisations in terms of safeguarding legislation, policies and procedures.

2.10 Confidently articulate the unique contribution and value of the team to both the business objectives of the commissioning body, and to improved health outcomes for patients, whilst maintaining a strategic system wide perspective.

2.11 Apply a range of change management strategies to respond flexibly and innovatively to changing contexts of care and the need for amended service provision.

2.12 Analyse the population to ensure all patients with long term conditions are identified, to ensure evidence-based pathways of care are followed and there is effective case management of patients with complex needs across the new models of primary care.

2.13 Ensure governance systems are in place that ensure patient follow up, referrals, correspondence and safety alerts are actioned.

Domain 3 – Facilitation of learning

3.1 Complete an NMC approved mentorship award/programme (if not previously achieved), supporting and facilitating the development of placements for nurses and other health care professionals within inclusion health.

3.2 Create positive teaching and learning environments and mentorship and preceptorship schemes that enhance the development of nursing students, nursing staff and other professions learning about inclusion health. Evaluate the impact of educational interventions for students, staff and patients.

3.3 Develop systems to assess the continuing professional development needs oneself and the multidisciplinary team and negotiate strategies with service management to meet these needs.

3.4 Take responsibility for the practice assessment of student nurses and ensure excellent liaison with approved education institutions.

3.5 Role model non-judgemental and value-based care in practice creating a culture of openness and recognition of the duty of candour, promoting these values in other members of the team.

3.6 Support registered nurses in the team in the revalidation process, acting as a confirmer as necessary.

3.7 Utilise all opportunities to challenge stigma faced by individuals. Teach other staff within health and partnership organisations about health rights, access to health care, and inclusion health, and deliver group teaching as the role allows.

Domain 4 – Evidence, Research and Development

4.1 Source and discern between different forms of evidence, engaging with the development of evidence-based guidelines for the service. Support staff to ensure all care is evidence informed and based on best practice.

4.2 Contribute to the development, collation, monitoring and evaluation of data relating to service provision and development, quality assurance and improvement. Analyse this information for benchmarking of inclusion health services, where appropriate.

4.3 Identify adverse and other trends that may impact service delivery and, where appropriate, produce data-informed business/operational plans to support service development and innovation.

4.4 Participate in the development of appropriate systems that ensure that considered, honest and reflective patient feedback is obtained, and enable such feedback to be obtained. Develop processes for the systematic improvement of service in response to patient feedback.

4.5 Collaborate with other services and agencies in the development of the evidence base for inclusion health.

4.6 Apply the principles of project management to enable local projects to be planned, implemented and evaluated.

Appendix 7: Training / Continuing Professional Development Options available

UCL / Faculty of Homeless and Inclusion Health - Inclusion Health Masters Module

General rate £850, NHS rate £750, Voluntary sector £550 - 7-week course, next start 24th April 2019

https://www.ucl.ac.uk/iehc/study/postgraduate_taught/msc-population-health/modules/optional-modules/homeless-and-inclusion-health

University of Edinburgh – Homeless and Inclusion Health

General rate £1,189, bursaries available - 10-week course, currently in progress, date not set for next year

https://www.ed.ac.uk/health/subject-areas/nursing-studies/postgraduate-taught/cpd/homeless-inclusion-health

ONLINE CPD OPTIONS

CRITERIA USED FOR SELECTION: Credible provider, relevant, free or cheap, certificated or recordable wherever possible

TOPIC	RESOURCES
Statutory and mandatory training	E Learning for Health – **Statutory and mandatory training** Covers: Conflict resolution, data security, equality, diversity and human rights, fire safety, infection prevention and control, health safety and welfare, moving and handling, preventing radicalisation, resuscitation, safeguarding adults and children https://portal.e-lfh.org.uk/myElearning/Catalogue/Index?HierarchyId=0_37759&programmeId=37759
Leadership / Service improvement	Open University – **Introducing healthcare improvement** – Level 3 – Free - 3 hours https://www.open.edu/openlearn/health-sports-psychology/health/introducing-healthcare-improvement/content-section-0?active-tab=description-tab Open University – **Understanding service improvement in healthcare** – Level 3 - Free - 10 hours https://www.open.edu/openlearn/health-sports-psychology/understanding-service-improvement-healthcare/content-section-0?active-tab=description-tab Open University - **Lead and manage change in health and social care** – Level 3 - Free - 7 hours https://www.open.edu/openlearn/health-sports-psychology/lead-and-manage-change-health-and-social-care/content-section-0?active-tab=description-tab Open University – **Managing to meet service users' needs** – Level 3 – Free - 3 hours https://www.open.edu/openlearn/health-sports-psychology/health/managing-meet-service-users-needs/content-section-0?active-tab=description-tab E Learning for Health - **Learning from deaths** – Free (updated Nov 2018) https://www.e-lfh.org.uk/programmes/learning-from-deaths/

Management of care / case management	E Learning for Health - **Making Every Contact Count** – Free (updated between 2016 and 2017) multiple modules https://www.e-lfh.org.uk/programmes/making-every-contact-count/ E Learning for Health - **Managing Frequent Attenders** – Free (updated Dec 2018) https://www.e-lfh.org.uk/programmes/managing-frequent-attenders/
Inclusion Health	Royal College of Physicians - **Introduction to the Social Determinants of Health** - £30 https://www.rcplondon.ac.uk/education-practice/courses/introduction-social-determinants-health E Learning for Health – **Disability Matter** – Free (updated Feb 2017) https://www.e-lfh.org.uk/programmes/disability-matters/ Includes **Hidden Disabilities Matter** which may be of particular relevance E Learning for Health - **Cultural competence** – Free (updated Oct 2016) https://www.e-lfh.org.uk/programmes/cultural-competence/ E Learning for Health – **NHS Healthcare for the armed forces** – Free (updated Apr 2016) https://www.e-lfh.org.uk/programmes/nhs-healthcare-for-the-armed-forces/
Public health	Open University – **Introducing Public Health** – Level 2 - Free - 6 hours https://www.open.edu/openlearn/health-sports-psychology/public-health/introducing-public-health/content-section-0?active-tab=description-tab E Learning for Health - **Health Economics and Prioritisation in Public Health** – Free (updated Nov 2017) 2 modules https://www.e-lfh.org.uk/programmes/health-economics-and-prioritisation-in-public-health/ E Learning for Health - **Alcohol and tobacco brief interventions** – Free – 1 hour (updated Mar 2018) https://www.e-lfh.org.uk/programmes/alcohol-and-tobacco-brief-interventions/ E Learning for Health - **Sexual health and reproductive health** – Free (updated Feb 2015) https://www.e-lfh.org.uk/programmes/sexual-and-reproductive-healthcare/ E Learning for Health - **Sexual orientation monitoring information standard** - Free (updated Feb 2018) https://www.e-lfh.org.uk/programmes/sexual-orientation-monitoring-information-standard/ E Learning for Health – **Sexual health and HIV** – Free (updated May 2013) https://www.e-lfh.org.uk/programmes/sexual-health-and-HIV/ RCGP learning - **Sexual health in primary care** – Free - 2 hours and 10 minutes (updated Feb 2018) http://elearning.rcgp.org.uk/course/info.php?popup=0&id=179 RCGP learning – **Tuberculosis in primary care** – Free - 1 hour (updated July 2016) http://elearning.rcgp.org.uk/course/view.php?id=107 RCGP learning – **Early diagnosis of cancer** – Free - 1 hour (updated Oct 2018) http://elearning.rcgp.org.uk/course/view.php?id=109 RCGP learning – **Breast cancer screening – the essentials** – Free - 30 mins (updated Jan 2018)

	http://elearning.rcgp.org.uk/course/view.php?id=138 RCGP learning – **Bowel cancer screening – the essentials** – Free - 30 mins (updated Nov 2016) http://elearning.rcgp.org.uk/course/view.php?id=135 RCGP learning - **Hepatitis B and C** – Free - 2.5 hours (updated Nov 2018) http://elearning.rcgp.org.uk/course/view.php?id=279
Mental capacity and cognition	E Learning for Health - **Mental capacity and consent** – Free (updated Dec 2012) No link – search on ELfH to find E Learning for Health - **Deprivation of Liberty Safeguards** – Free (updated Feb 2016) No link – search on ELfH to find Pathway - **Mental Health and Homelessness Guidance** – Free - No certificate https://www.pathway.org.uk/services/mental-health-guidance-advice/ **Montreal Cognitive Assessment (MOCA)** – FREE - No certificate (certificate can be paid for) https://www.mocatest.org/training-certification/ https://www.youtube.com/watch?v=wO7n19KMveU
Addictions Management	E Learning for Health - **Alcohol Identification and Brief Advice** (Hospital Settings Pathway) – Free (updated Feb 2017) https://www.e-lfh.org.uk/programmes/alcohol/ RCGP learning - **Alcohol: Identification and Brief Advice** - Free: 2 hours (updated Feb 2018) http://elearning.rcgp.org.uk/course/view.php?id=100 RCGP learning - **Alcohol: Management in Primary Care** – Free: 3.5 hours (updated Mar 2017) http://elearning.rcgp.org.uk/course/view.php?id=119 RCGP learning - **Drugs: Management of Drug Misuse (Level 1)** - Free: 3 hours (updated Jan 2016) http://elearning.rcgp.org.uk/course/view.php?id=130 Novel Psychoactive Treatment UK Network – **Novel Psychoactive Drugs** – 5 modules – Free, no certificate http://neptune-clinical-guidance.co.uk/e-learning/
Mental health awareness **Severe and Enduring Mental Illness**	E Learning for Health - **Mental health awareness programme** – Free (updated Feb 2016) 4 modules https://www.e-lfh.org.uk/programmes/mental-health-awareness-programme/ E Learning for health – **Mental health awareness for GPs** – Free (updated Nov 2016) 3 modules - Depression in Adults, Medication in Mental Health, Managing Enduring Psychosis in Primary Care https://www.e-lfh.org.uk/programmes/mental-health-awareness-for-gps/ E Learning for Health - **Mental Health crisis support training** – Free (updated Sept 2017) No link – search on ELfH to find E Learning for Health - **Suicide prevention** – Free (updated Oct 2018) https://www.e-lfh.org.uk/programmes/suicide-prevention/

	E Learning for Health – Introduction to Mindfulness – Free https://www.e-lfh.org.uk/programmes/introduction-to-mindfulness/
Complex psychological trauma	E Learning for Health - **Mental health awareness for emergency medicine** – Free (updated Feb 2016) https://www.e-lfh.org.uk/programmes/mental-health-awareness-programme/ Alberta family wellness initiative - **Brain story** – alongside **PIE toolkit** - free https://www.nooneleftout.co.uk/page/toolkits/
Learning Disability	E Learning for Health – **Supporting adults with LD at risk of behaviours that challenge** – Free (updated Sept 2018) No link – search on ELfH to find E Learning for Health – **Supporting adults with LD and a mental health condition** – Free (updated Sept 2018) No link – search on ELfH to find E Learning for Health – **Supporting adults with a Learning Disability and Autism** – Free (updated Sept 2018) No link – search on ELfH to find
The Care Act	Skills for Care - **Care Act training videos** – Free - No certificate https://www.skillsforcare.org.uk/Learning-development/ongoing-learning-and-development/care-act/Learning-materials/Care-Act-videos.aspx Voices of Stoke - **Care Act Toolkit** – Free - No certificate http://www.voicesofstoke.org.uk/care-act-toolkit/
Healthcare access **NHS Charging**	E Learning for Health - **Overseas Visitors NHS Cost Recovery – Learning Path for Clinicians** – Free (updated Aug 2015 – needs to be taken alongside guidance below) https://www.e-lfh.org.uk/programmes/overseas-visitors-cost-recovery/ gov.uk - **Guidance on extension to NHS charging** – Dec 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767905/guidance-on-implementing-the-overseas-visitor-charging-regulations.pdf Pathway - **Homelessness and access to general practice** – Free – No certificate https://www.pathway.org.uk/training-and-events/gp/
Housing rights	National Homelessness Advisory Service – **Introduction to Homelessness and Local Authority Duties** – Free, webinar based, need to book on, certificate available (updated 2018) https://www.nhas.org.uk/ National Homelessness Advisory Service – **Public Authorities Duty to Refer** – Free, webinar based, need to book on, certificate available (updated 2018) https://www.nhas.org.uk/ National Homelessness Advisory Service - **Vulnerability in Housing Law** – Free, webinar based, need to book on, certificate available (updated 2019) https://www.nhas.org.uk/ NHAS can provide free in-house training on a variety of issues for new teams.

Immigration / migrant health care related	E Learning for Health - **Identifying and supporting Victims of Modern Slavery** – Free (updated Sept 2013) https://www.e-lfh.org.uk/programmes/modern-slavery/ Virtual college / Home Office - **Female Genital Mutilation: Recognising and Preventing FGM** – Free https://www.fgmelearning.co.uk/ NHS England – **Modern Slavery Awareness video** - Free https://www.england.nhs.uk/ourwork/safeguarding/our-work/modern-slavery/
End of Life Care	E Learning for Health – End of Life Care for All - Free https://www.e-lfh.org.uk/programmes/end-of-life-care/ Homeless palliative care tool kit www.homelesspalliativecare.com
Clinical topics	E Learning for Health – **Asthma (adults)** – Free (updated Apr 2016) https://www.e-lfh.org.uk/programmes/asthma/ Diabetes UK – **Diabetes in Healthcare** - Free https://www.diabetes.org.uk/professionals/training--competencies/diabetes-in-healthcare RCGP learning – **Core skills in musculoskeletal care** – Free – 5 hours (updated Feb 2018) http://elearning.rcgp.org.uk/course/view.php?id=206

Appendix 8: Participant Feedback

WORKSHOP 1

- Wonderful day – Meeting and exchanging some great ideas. Great re defining of understanding of clinical.
- Good to network, focus on roles and how much we do.
- Well delivered. Enjoyed group work and getting to meet everyone. Valuable sharing of knowledge and experience, and to learn from each other.
- Great for network, and not feeling alone.
- It was good to share experiences with other nurses that understood, and also had experience of the same type of job. Also I will take away some things that I want to explore in my own service.
- It was fun! I felt valued as a clinician. We care and it shows! We do great work. The venue and directions and food were fab!
- It's been really helpful to meet other registered nurses doing a similar job – it reminds me that I am a nurse!
- Enjoyed meeting colleagues. Interesting / thought provoking look into what we do. Friendly facilitators and good vibe. Enjoyed the tasks. Food and drinks were great.
- Loved loved loved the day!!! Really hit home why I do the job I do – so useful and inspirational seeing others that do the role – and reassuring that they face the same challenges.
- Encouraged by an inspiring group of my peers.
- Positive affirmation which sometimes feels missing.
- Like minded professionals. Enjoyed supportive feedback. Positive group.
- Great set of people. Informal which makes things easier. Topic interesting, and responses outstanding. Dragon's Den – needs to be included in each workshop. Great activity!
- Very good and informative. Made me think about my job, role. One of the things I will take away is that clinical does not mean hands on.
- Hearing from other nurses about their roles and communication from a patient point of view – Stan's piece
- I enjoyed the day immensely, and it gave me a much deeper insight into how homeless nurses work, the challenges they face, and how vital the role is. (Student)
- Excellent day – even for a non-nurse! Very moving case studies and sharing of experience. (Journalist)

WORKSHOP 2

- I found the day very supportive and welcoming. I am excited to meet such a fab group of people working in such an interesting and essential field. Thank you!
- Thank you. Meeting up with like minded nurses all working with similar challenges but in different situations with different team dynamics. Always remember the focus is on the person we have the privilege to work with.

- Very enjoyable, well put together day. All the information was relevant. Interesting speaker from RCN Advanced Level Nursing Practice credentialing – what if you are not a prescriber? Very good – hope it continues.
- 'Don't feel on my own here'
- Just to say thank you so much for a most inspiring day, thoroughly enjoyed it, can't wait for the next one, thank you.
- Fantastic – it has given me more thoughts and ideas for my role re assessment, improvements to the service, and KPIs
- Further celebration of good work done. Well deserved 'pats' on the back. RCN talk was dry.
- I valued seeing other assessment forms. I feel the session has sharpened my clinical focus.
- Another amazing day!! Thank you. Really enjoyed the networking and learning opportunities from the other teams. Looking forward to the next one. Sam you're a star.
- Good mix of workshops, presentations and EbE involvement. Good to learn and find out what others are doing. 'Keep smiling'
- Affirmation gratefully received.
- Thought provoking. Great meeting and sharing. EbEs insights very valuable. Very enjoyable and useful day. Thank you.
- Fantastic day, so helpful to share knowledge and make connections. This has given me so many ideas going forward. Many thanks, Jenny.
- Felt meeting nurses with same role beneficial. Thanks.
- Very good day – really enjoyed it. Got more than last time – got more ideas on how to move forward.
- Quality improvement session was good as evidencing what inclusion health nurses do is crucial. Also good relevant session on patient feedback.

WORKSHOP 3

- All these Pathway conferences have felt like a major 'pat on the back' for the great work we all do. A real celebration of our hard work. Thanks!
- Fantastic networking and sharing of experiences. Really motivational and inspirational to be here. Great to feel part of a wider network and feel like there are others out there who understand the struggle. Thank you.
- I may be moving on but suspect I won't be very far away unless of course I run off to Vietnam. 3 brilliant days – useful, informative, reassuring, affirming
- A useful and open forum to learn from each other. Further access to this sort of program would be amazing. It is obvious how strongly you all care.
- It's been really great to come along to these sessions – shame there are not more… I have learned a great deal from being around other nurses working in homelessness. You have also helped to remind me that I am a nurse. Prior to these workshops I had started to lose my identity a little. Thank you.
- It has been invaluable to me as someone who is relatively new to homelessness nursing. The links with other services, resources, and knowledge of other services will greatly assure me to take our service forward to improve the lives and health outcomes of the individuals we are working with. Many thanks again.

- I think the 2 days I have attended have been so informative. I have learned so much. Look forward to the next one.
- An amazing day. The whole program has been so informative and meeting others from all parts of the country looking after vulnerable clients is an inspiration. So much food for thought.
- As a non-nurse the day has been fascinating. Inspiring to hear about how so many nurses are caring for excluded groups all around the country, sometimes despite tremendous institutional obstacles (and indifference).
- Very good day. Interesting to hear from the other teams how they work. Good venue. Well organised. Took some thoughts and ideas away.
- In the three days I have learnt so much about my own role. I have also gained more to add to my service and have been able to promote more the important work we do. Esp session 2. Great food. Decent venues.
- This has been the best beginning towards establishing our role as a homeless / inclusion nurse specialist.
- It's a real honour to meet and listen to all the other Pathway professionals. I think we all share the same frustrations – and of course rewards, when things go well. It's amazing being in the company of experts by experience. Very humbling indeed.
- Thank you so much. It's funny I had to come to London to meet someone 40 miles away doing amazing work. I go back to Scotland with inspiration and have been humbled by listening to others working in the field. THANKS AGAIN. I'm not 'just a nurse'.
- What an inspirational bunch of people. Has been an honour to be part of today. Thank you. Excited for the future.
- Presenters were amazing. Sam and Jan coordinated all other meetings very well. Really enjoyed meeting all the other nurses. I have learned so much and I feel it has kickstarted a slightly jaded and burnt out nurse to become passionate about my job.
- Found both workshops I attended inspirational, educational, supportive, and more I feel that it is important to keep challenging managers and CCG funders as we are advocates of the people we work with – any of us could be homeless at any time, and need some help and some kind, understanding words. Thank you.
- Thanks for making a non-nurse (and OT) welcome. It is inspiring to see how many of you are so passionate about working with people who are homeless because I am too but so often trying to link with services wo aren't feels isolating. I realise believe your area of nursing is specialist, and I hope this is recognised ASAP. As an OT I am dual trained in physical and mental health and have to use all these skills but can still feel marginalised from other OTs. I believe in the work we all do.
- From a student nurse point of view I have found this workshop 3 session very interesting and helpful. It has also given me a clearer view on how different teams in different regions help homeless people. The session was smoothly run and everyone in the room was very nice and tried to engage me in conversation. Thank you for allowing to come along to your day.
- Wonderful group. Passionate and caring people. Will miss these days out!
- Today's session was set out really well, all presentations were very individual and flowed well. The organisation of all the sessions has been amazing, and I feel honoured to have been involved in all the workshops. The practice in Bradford will definitely be improved due to the amazing work that has been shared at these workshops.

- Have only attended on the last day – however – fantastic to be with like minded people who are often as marginalised as the people they work with. Great networking, sharing of brilliant practice, and what works across the country, and meeting people with lived experience. Thanks so much for putting this together. Stan needs an MBE by the way.