Towards system leadership:

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

Burdett Trust for Nurses

Strengthening Nursing Leadership Award 2018-2019

The role of nurses working in homeless hospital discharge

1. Background

In 2018, funding was awarded by the Burdett Trust for Nurses under the 'Strengthening Nursing Leadership' banner to support nurses working in the developing field of homeless hospital discharge. Specialist homeless hospital discharge nurse roles started to emerge around 15 years ago, however the recent Homelessness Reduction Act (2017) makes it likely that more similar nurse roles will appear in the future.

This project was established to clearly define the role and it's continuing professional development needs, but also to better understand the system leadership potential of these nurses. Hosted by the Pathway charity, the project ran over 15-months from January 2018 - March 2019. The Pathway charity undertakes needs assessment for, and supports the set-up of multi-disciplinary homeless hospital discharge teams within acute and mental health hospitals nationally.

The project was led by Samantha Dorney-Smith, Nursing Fellow, Pathway, who previously worked as a nurse lead for the Kings Health Partners Pathway Homeless Team (working across Guys and St Thomas', Kings and the South London and Maudsley). The project was supported by the Queens Nursing Institute, Royal College of Nursing and London Homeless Health Programme (Healthy London Partnership) who sent senior representatives to the project's steering group. The Queens Nursing Institute also provided ongoing expert advice outside the steering group, alongside Dr Zana Khan from the Pathway Education committee.

The project involved nurses working in both Pathway and non-Pathway teams nationally, and also nurses based solely in the community settings, although the majority were based primarily in hospital in-patient settings.

The project's objectives at the outset 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
- Consider the future and potential of the role to influence health systems

2. Key project activities and methodology

The project was designed so that the self-identified needs of the nurses could be addressed as much as possible. The chance for peer support was a key part of the approach with the intention that this be an enduring part of the project's legacy.

The main activities undertaken in delivering the project were:

- Engagement with nurses and their managers from January 2018 onward
- 32 nurses were contacted and a support network of nurses was established
- Nurses were enabled to develop knowledge and skills in quality improvement and leadership via three full-day workshops facilitated in London in June and October 2018, and January 2019. Around 20 nurses attended each workshop. Content focused on a variety of key issues including quality improvement, sharing best practice and innovation, key performance indicators, obtaining service user feedback and defining competencies. Experts by Experience were involved in the design and delivery of the workshops.
- Shadowing visits to 14 different sites to observe and understand practice were undertaken. Notes were taken throughout including key quotes from nurses, and set interviews were conducted.
- 1:1 support was also offered to nurses by the project lead on specific topics during shadowing visits and during the life of the project
- A task and finish group with Experts by Experience was used to develop a suggested service user feedback form.
- Multiple engagements with educationalists and educational standards setters were undertaken. These included discussions with the Royal College of Nursing, Queen's Nursing Institute, Nursing and Midwifery Council, University College London, University of Edinburgh, the Academy of Royal Medical Colleges and the Council of Deans of Health.
- Three steering group meetings were held in February and July 2018 and March 2019

In developing the project, it was very clear that the nurses were in great need of support from colleagues doing similar work.

Photos: *Nurses at Workshop 1 and 3*

3. The nursing role

'Other staff have trouble, but it depends very much on how you approach her. You need to give her respect, let her lead'

'I've got to be like a barrister, fighting for people's rights.'

Nurses working in homeless discharge fulfil a complex, sensitive and sometimes political role. The core nursing role is to deliver a safe, effective and compassionate discharge for all homeless patients referred, most of whom have a range of issues including mental health problems, addictions, communication difficulties, disabilities and legal complexities.

In order to deliver safe discharge, key nursing activities include:

- the effective engagement of the patient in all relevant services and support,
- maximising the health and social care benefits for the patient when they attend or are admitted to hospital,
- linking the patient into all necessary health and social care or support pending their discharge,
- advocating for the patient to receive assessment, treatment or services when required,
- ensuring patients are effectively safeguarded,
- ensuring a safe and effective discharge to accommodation (where this is possible),
- reducing or stopping the revolving door for patients being frequently readmitted to hospital

The nurse triages, assesses, prioritises, and manages a caseload of patients. Where the nurse sits as part of a wider team the nurse will usually be the operational lead and in some cases will also be the clinical lead. Nurses tend to have an individual ongoing caseload of between 10-15 patients, with hospital discharge teams seeing between 200-800 patients a year.

The nurse also works to improve the effectiveness and quality of health services being delivered to homeless people across the wider health system, as well as the discharge pathways available to them. Much of the work will be done in active partnership with a wide variety of community partners. The work also often involves the provision of formal teaching to staff across the hospital or community.

Individual case study of nursing practice

A gentleman in his 40s with chronic leg ulcers was admitted to hospital from a temporary hotel placement, 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. The man was not linked into any community services prior to admission having historically rejected 'the system'.

The gentleman was in hospital for 3 months, during which time no family or friends visited. The nurse however visited frequently whilst he was in hospital, befriending him, forming a trusting relationship, and helping to ensure he understood his conditions, medications and prognosis.

The nurse provided cash from a hardship fund for comfort items whilst he was in hospital, and organised a laundry service. She also provided a mobile phone with credit 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 whilst he was an inpatient. The nurse discussed all referrals, and the reasons for the referrals carefully with the patient. The nurse also supported all initial engagements with referral services. Throughout his admission the patient also received ongoing motivational interviewing support, and harm reduction advice from the nurse.

The gentleman 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 all relevant community services, and felt happy and comfortable with his care.

At the time of discharge, he was engaging in the community with housing, social care and rehabilitation services support services, his GP and the community homeless health team. He was also engaging with the local addictions' services, scripted for Methadone and linked into the community pharmacy for daily pick up and support, and in possession of Narcan (having received overdose training in hospital whilst an inpatient). He was receiving dressing follow-up for his leg ulcers, and in possession of orthothotics for foot drop developed in hospital. Finally, he was engaged with the community blood borne viris nurse for ongoing treatment of his HIV, and fully aware of all follow up appointments for renal team, HIV team, and orthotics.

6 months later the gentleman had only had one further brief admission, and was still engaged with services.

4. Knowledge, skills and experience required

'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 involved in 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.

Expertise spanned patient engagement, physical health, mental health and addictions, safeguarding, mental capacity and cognition, harm reduction and motivational practice, concordance, and health and housing rights. All the nurses also had teaching and leadership skills.

5. Continuing professional development requirements

Analysis of the continuing professional development needs of the nurses during this project revealed the following information:

- There was no recognised post-basic Continuing Professional Development pathway
- All the nurses had clinical post graduate qualifications of some sort, and many had several. The most common post graduate qualifications held were in community nursing, advanced assessment, addictions, liver, sexual health / women's health, neuro, renal
- Nearly all the nurses had a teaching qualification and many had undertaken leadership training
- Other training relevant to the role (e.g. around health and housing law) 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 e.g. CRISIS, Shelter

Problems being experienced with accessing CPD were a lack of time, a lack of funding, and a lack of appropriate courses, mirroring prior research in this area (Davis and Lovegrove, 2015).

No specific post graduate clinical course currently exists that prepares nurses for this role - the need for an appropriate, accessible course was felt quite keenly.

6. Challenges of the role

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

Nurses reported that the role is extremely challenging. Every patient that presents is likely to require skilled advocacy and negotiation, and there is an ongoing requirement to challenge the many system barriers to care that exist every day. The hopes of patients are often directed on to these nurses, and sometimes optimal outcomes are not deliverable. As such burn out is a very real risk of the role.

The specific challenges of day to day work include:

- System leaders seeing the role as a route to 'get them out' quickly, rather than to deliver safe, effective discharges
- Continual pilots, reviews, evaluations and tendering
- Lack of time to develop links with specialist community services
- High numbers of patients with no recourse to public funds with few options available
- Lack of access to step down / appropriate housing
- Lack of community services to support clients with dual diagnosis
- High social care thresholds / perceived gatekeeping
- Lack of access to responsive substitute prescribing e.g. for Methadone
- Lack of senior guidance and professional isolation
- Lack of professional development opportunities and a lack of professional recognition of the role
- Team management issues particularly where staff come from different organisations
- Data sharing and access as effective care requires effective information sharing
- Excessive workload in the time available

Patients are also innately complex and rarely present with only one or two issues.

7. Evidence base for the nurse role

There is evidence that both multi-disciplinary and housing worker hospital discharge interventions have patient benefits and are cost effective (insert ref). There is also an emerging body of evidence for inclusion health interventions generally (insert ref). However, there is little evidence currently available about the importance and key aspects of the nursing role specifically.

As this is an emerging clinical discipline, extra support needs to be mobilised to help these nurses develop the evidence base. 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 they are the best discipline to be leading this research.

Examples of where the evidence base needs to develop includes work around priority interventions e.g. what is the impact of wider staff teaching on patient outcomes versus delivering more individual one to one interventions. 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.

Recommended practice interventions (based on observation and analysis of existing practice) and local innovations are profiled in the full report.

8. Delivering quality

In the absence of a clear evidence base, quality measurement methods have tended to develop locally. Consequently, as part of this project the nurses worked to develop a collective view on quality, and a potential quality framework and key performance indicators for homeless hospital discharge interventions was developed.

Ultimately the thinking of the group chimed with the notion of 'value-based health care' as defined by Michael Porter in 2010 (Porter, 2010). 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.

9. Potential of the role

'In every interaction I have I am teaching people. Quietly, subtly, but it's part of the grand plan'

The role is not just about effective hospital discharge. For an individual patient it is also about front-line engagement for the whole health system (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.

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.

10. Professional recognition

The majority of nurses on this project were banded at Band 7 or 8a.

Although the title 'clinical nurse specialist' is not formally defined in the UK, this role clearly meets the definition of a clinical nurse specialist as outlined Donald et al (2014).

The role also meets the criteria for advanced level practice as described by the RCN (2018), exception that the current RCN criterion requires the nurse to be a non-medical prescriber. Many of these nurses are not actually non-medical prescribers, but this is because non-medical prescribing is mostly not appropriate in this role. This is also true of similar roles e.g. safeguarding lead nurses. This issue was raised with the RCN and NMC (who are about to consult on advanced level practice) during the project.

11. Project outputs / resources developed via the project

The following resources have been developed via the project are freely hosted for download on the Pathway website:

- An in-depth project report which details all of the work undertaken on the project and includes a literature review on hospital discharge, and a summary of current recommended practice and local service innovations
- A set of suggested key performance indicators and a suggested quality framework for practice that were developed by the group in partnership with UCLPartners, an academic health science partnership
- A service user feedback form that can be used as a template in all services
- Outline job descriptions for Agenda for Change bands 5 - 8a
- A job plan which can be used for advanced level practice accreditation
- A directory of existing freely available continuing professional development resources
- Draft standards for education and practice for inclusion health nurses (which could be used as a basis for the formal development of voluntary standards for education and practice for inclusion health nurses by the Queen's Nursing Institute)

It is hoped these resources will be useful to nurses and teams working in hospital discharge. There is also a plan to produce two journal articles to disseminate the work of the project.

12. Key insights from the project

The project proved to be an excellent vehicle to better understand what is needed to support and develop nurses in this role. Key insights have been:

- There is a tendency for hospital managers and other staff to focus on the 'get them out' aspect of the role, not the 'get them out safely' aspect, which is hard for the nurses on a day to day basis.
- The role is emotionally exhausting. Nurses have to fight all aspects of the system with limited resources every day, for every patient, or else they can achieve little. This coupled with the fact that patients themselves can sometimes be challenging, but also often have very sad backgrounds and histories, can make for an emotionally taxing role.
- These nurses are often poorly professionally supported, and are sometimes lone workers, adding to the challenge.
- The nurses undertaking these roles highly value the opportunity to network with each other as they feel that it helps them to develop their services, improve quality and support each other. This networking opportunity is not being facilitated via any NHS route.
- There are some very experienced, highly qualified, creative nurses in this role, and their system change potential is untapped. These nurses are highly skilled inclusion health practitioners that can deliver benefit for the whole health system, not just patients who are homeless.
- Whilst inclusion health is emerging as a clinical specialism, and this role as an emerging clinical nurse specialist role, there is no specialist clinical course available currently, or route to formal accreditation. Further work is needed to support the development of appropriate continuing professional development and standards for practice.
- Nurses would be well placed to develop the evidence base for homeless hospital discharge interventions further, and would ideally be supported to undertake formal research in this area

13. Impact of the project on the nurses

'*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.'*

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

The nurses who attended the events reported feeling re-energised, motivated and supported. It is hoped that the benefits gained from the project will able to be sustained in the future.

14. Planned Project Follow-up

The project highlighted how vital this group of nurses is to improving the services that homeless people receive when they are admitted to, and then later discharged from hospital. However, their ability to learn from and support each other has shown to be necessary if they are to continue to work effectively.

To build on the work delivered by the project the following is planned:

- To deliver a further workshop funded by Pathway reserves in November 2019
- To look for funds or other methods to continue the network beyond this date
- To look for funding that could support the market research and subsequent business plan development for an interdisciplinary clinically focused inclusion health course.
- Additionally, to look for funding to create an on-line continuing professional development directory bringing together existing on-line free CPD
- Pathway and the Queen's Nursing Institute to investigate potential funding avenues to work together to develop national voluntary standards for inclusion health nursing practice
- To engage the senior nurse establishment in the professional recognition of the role and the associated support issues
- To talk to the National Institute of Health Research and the Collaborative Centre for Inclusion Health about potential options for supporting nurses to do formal research

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- Jason Warriner – Public Health Lead, Royal College of Nursing
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- Alex Bax, Chief Executive Officer, Pathway
- Dr Nigel Hewett, Medical Director, Pathway
- Dr Zana Khan, Education Fellow, Pathway
- Stan Burridge, Expert by Experience Project Lead, Pathway
- Susan Wood, Matron, Guys and St Thomas'
- Florence Cumberbatch, Discharge Sister, University College London Hospital

And to the nurses who were directly involved in this project:

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