Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Protocol on Transfer of Care of People Experiencing Homelessness in Dublin

(Adapted from: National Homeless Hospital Discharge Protocol)

Is this document a:

Policy [ ] Procedure [ ] Protocol [√] Guideline [ ]

Insert Service Name(s), Directorate and applicable Location(s):

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http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/PPPG_Document_Development_and_Inventory/

Contents

PART A: Outline of PPPG Steps

Title: <u>Protocol on Transfer of Care of People Experiencing Homelessness in Dublin (Version 2)</u>

(Formerly titled: Dublin Homeless Hospital Discharge Protocol)

General principles that underpin the protocol and procedures outlined below have been adapted from the National Homeless Hospital Discharge Policy and informed by an independent evaluation of the Dublin Homeless Hospital Discharge Programme in 2023 and a Feasibility Study commissioned in 2018.

Specific roles and responsibilities of management and staff in protocol implementation are also outlined below.

This protocol is designed for standard discharges for patients experiencing or at risk of homelessness, not delayed transfers of care. Standard discharges involve planned transitions where patients leave as scheduled, with housing and follow-up services arranged. Delayed transfers occur when patients, though medically fit, remain in care due to unresolved issues like housing or support availability. These two categories employ different discharge processes.

Outline of PPPG Steps:

1. PRINCIPLES

1.1 The needs and dignity of the person experiencing homelessness or at risk of homelessness will be paramount at all stages of service delivery.

1.2 All service providers will be open and transparent and will foster a partnership approach to service delivery.

1.3 The healthcare wishes and preferences of the person will be discussed with them by an appropriate professional, and explicit consent will be obtained before any care plans or discharge arrangements are made.

1.4 Every effort should be made in the first instance to prevent the person entering homeless services, particularly in instances where the client was not previously homeless.

1.5 All discharges of people experiencing homelessness or those at risk of homelessness should be planned, with discharge planning commencing at admission or triage, whichever is the first point of contact.

1.6 Contact with the local authority/Central Placement Service (CPS) should be made as early as possible (upon initial review), providing a clear, detailed account of any changes in support needs due to accommodation constraints, including the availability of mobility-friendly spaces, single rooms, and medication management.

1.7 Persons experiencing homelessness, or at risk of homelessness, should not be discharged from hospital without assessment of their accommodation and support needs being communicated to the local authority/CPS, homeless service providers and other relevant sectors such as disability services, nursing homes, and neurodiversity services, with consent from the patient, and an appropriate time period being allowed for accommodation to be sourced.

1.8 Ensure clear and timely transfer of information between settings, including communication of any changes in support needs, medication, or abilities to all relevant parties, such as GPs, social care providers, local authorities/CPS, homeless service providers and other relevant services.

1.9 Given the pressure on hospital beds, a lack of suitable accommodation should not delay hospital discharge.

1.10 Given the pressure on emergency accommodation it should be understood that all emergency accommodation in the city is full on a nightly basis. There is a waiting list for access to 24hr STA at all times. CPS have put in place a dedicated waiting list for hospital discharges to ensure priority for patients, who are eligible for social housing supports, being discharged from hospitals in Dublin. This list is managed by the local authority/CPS.

1.11 Key workers/case managers within HSE integrated care and case management teams (i.e. Healthlinks, PACT) and the voluntary sector will be responsible for informing and supporting the assessment of need and care plan to assist the person during convalescence and in their continuity of care. This process should ideally involve the patient. The key worker or case manager from these services should be engaged early in hospital admission.

1.12 In the case of a service user changing accommodation or service providers, there should be a seamless transfer of care between voluntary organizations in the community, with integrated care plans and case management assessments shared to ensure continuity and consistency in the support provided.

1.13 Hospitals, HSE social inclusion/primary care services including Homeless Action Teams/Primary Care teams/Health-Link homeless teams and the Hospital Inreach/Discharge Liaison services, local authorities/CPS, and the voluntary sector, will meet on a regular basis to support integrated care planning for complex hospital discharges and to ensure that future developments of housing, social services and health services address the need of people experiencing homelessness.

1.14 In complex hospital discharges, where the patient has an identified unmet housing need, the local authority will be involved from an early stage so that complex cases are identified early and addressed.

1.15 Community service providers (Integrated Multi-disciplinary team) should be involved in integrated care planning for discharge.

1.16 Homeless service providers in partnership with the local authority / CPS will be given the opportunity to conduct their own assessment, where they request same, to satisfy themselves that their service can meet the needs of the patient following discharge from hospital.

1.17 Care packages, where required, should be approved with primary care and hospitals in advance of discharge to ensure that homeless service providers can meet the patient's needs. Approval of care packages prior to discharge, where required, will assist local authority/CPS in securing 24hr STA, for individuals that are eligible for social housing supports in Dublin and present with high need.

1.18 "Out of Hours" (i.e. outside of Mon-Fri 9-5) discharges should be avoided, if at all possible. While it is acknowledged that EDs operate 24/7, patients experiencing homelessness or at risk of homelessness should ideally be discharged during the working hours of their accommodation provider unless specific arrangements are in place. If accommodation is unavailable during hospital working hours, out-of-hours discharges may happen. In such cases, emergency accommodation can be accessed via the Homeless Freephone service at 1800 707 707.

1.19 In the event of an unplanned self-discharge against medical advice, where possible, the patient will be informed that homeless services may not be in a position to support them to secure accommodation and/or offer supports which may be required at time of self-discharge. A discharge summary will be completed and sent to the appropriate services where possible and with consent from the patient. If appropriate services cannot be identified, the discharge summary can be sent to the Homeless Health-Link teams and SafetyNet In-Reach for patient follow-up, where possible. Given the limited capacity of these teams to follow up on all self-discharges, cases requiring follow-up should be prioritised based on urgency and need.

1.20 Prevent early self-discharge by identifying vulnerabilities, such as anxiety over losing accommodation, unmanaged mental health issues, or substance dependence, upon admission. Create a tailored plan, which may include maintaining access to hostel accommodation, providing methadone prescriptions, or coordinating with local homeless services and key workers. Involving peer advocates with lived experience of homelessness can also improve patient engagement and lead to better discharge outcomes.

1.21 In the event of no accommodation being identified and with patient consent, the hospital should contact the CPS/Freephone and provide a patient update & handover.

1.22 A review and monitoring mechanism will be adhered to by each Hospital Group / Health region to ensure that the discharge protocol is operating effectively and information is shared in relation to the health and social needs of people experiencing homelessness.

2-4. PROCEDURES

2. GENERAL

2.1 Each hospital will develop an internal pathway or the coordination of work involved in the discharge of homeless persons *by end of Q1 2025* and will liaise with the local authority, and other relevant stakeholders in the development of such pathways.

2.2 Each hospital will enhance escalation and care pathways between care directorates, including mental health, disability services, and primary care, to ensure a more integrated and responsive approach to patient care.

2.3 Each hospital will develop monitoring and review mechanisms in line with hospital discharge activity metrics.

As part of this pathway:

2.4 A hospital consultant and/or relevant hospital staff member/s will be identified as a homeless discharge coordinator or liaison team that will support local authorities/CPS/voluntary sector and other healthcare providers with care planning for complex medical issues in individuals experiencing homelessness.

2.5 The homeless discharge coordinator or liason team will oversee the completion and timely dispatch of discharge summaries. Discharge summaries will be accurate, complete, and sent before the patient arrives at the receiving facility. This will help ensure that receiving facilities/services (e.g. PEA, STA, SUSD, GP) have all necessary information in advance. Discharge summaries are to be shared with both primary care and community services (including homeless service providers).

2.6 Discharge summaries should, at a minimum, include the following information: admission date, reason for admission, medical or psychiatric team responsible for care, discharge plan, and details of the services the patient is currently engaged with. Any hospital follow-up appointments must be noted to ensure continuity of care.

2.7 Discharge summaries should be written on and shared using Discharge Summary Template.

2.8 Patient queries in relation to housing are to be channeled via local authority/CPS to support the management of the dedicated hospital discharge 24hr STA waiting list or PEA for homeless persons who are eligible for social housing, being discharged from Dublin hospitals.

2.9 Local authority/CPS will liaise with hospitals, allowing hospitals to select priority patients on the dedicated waiting list for the next available bed.

2.10 A senior staff member in the local authority/CPS will be identified to support with complex homeless discharges.

2.11 A regular Integrated Multidisciplinary Team meeting will be established to discuss complex hospital discharges, with attendance of the homeless discharge coordinator, local authority/CPS, homeless key worker(s)/case manager(s) and/or local nursing services or other health care providers from PACT/healthlinks homeless team, as appropriate. It is not always feasible for all interested parties to attend multidisciplinary team (MDT) meetings due to time constraints. In that case identify a single representative within each team who can attend on behalf of others and ensure that the patient's care needs are

represented in discussions.

Local authorities/CPS will:

2.12 Recognise health needs and the need for hospitals to maintain patient flow in prioritising accommodation.

2.13 Meet regularly with the Dublin Homeless Health Coordination Group to discuss discharge processes, identify unmet needs and planning of future homeless services to ensure that they meet needs of patients and review implementation of pathway.

2.14 Local authority/CPS will designate a dedicated contact who will act as a liaison person, working closely with hospitals to identify and support patients experiencing homelessness in securing appropriate accommodation. This includes assisting those who are unable or unwilling to communicate their connection with support services.

Hospitals will:

2.15 Designate a homeless discharge coordinator or a dedicated liaison team responsible for overseeing the discharge process of individuals experiencing homelessness. This role includes:

2.15.1 Leading the discharge planning process, beginning at the patient's first point of contact with hospital services.

2.15.2 Coordinating with local authorities/CPS, the voluntary sector, and other healthcare providers to develop and implement individualised care plans.

2.15.3 Ensuring all relevant hospital staff are informed of the discharge protocol and are adhering to it.

2.15.4 Overseeing completion and dispatch of discharge summaries that will be accurate, complete, and sent before the patient arrives at the receiving facility.

2.16 Monitor activity metrics.

2.17 Provide HSE/CPS/local authorities with data (activity metrics) on homeless hospital attendances and identified needs on a monthly basis.

2.18 Provide information on the Protocol to relevant hospital/community staff to ensure all staff involved has a clear understanding of the procedures involved.

2.19 Support staff attendance at any relevant training for homeless hospital transfer of care protocol implementation.

2.20 Ensure that information on services, and entitlements for persons experiencing homelessness, will be available in an accessible format at all the likely points of contact.

2.21 Ensure that all patients experiencing homelessness and patients at risk of homelessness are identified, recorded and referred to the dedicated homeless discharge coordinator or liaison team, for support.

2.22 An up to date list (that includes roles and contact details) of all stakeholders will be maintained, and readily available, so that staff working in all agencies will know who to contact to help to resolve any problems which arise in the process.

3 INPATIENTS

3.1 All persons experiencing homelessness or at serious risk of homelessness, to be identified by the medical team on admission to hospital, at either ED or ward level, and referred to dedicated homeless discharge coordinator/liaison team (where available) *within 24 hours of admission (*Mon to Fri excl. bank holidays).

3.2 Dedicated homeless discharge coordinator/liaison team will review patient and, with hospital multi-disciplinary team (MDT), complete an assessment of patients discharge needs within 48 hours of referral (Mon to Fri, excl. bank holidays).

3.3 A dedicated homeless discharge coordinator/liaison team will develop nursing home discharge pathways and ensure that all necessary referrals, such as Occupational Therapy, Physiotherapy, and other referrals, are set in place based on an assessment of needs.

3.4 *On initial assessment,* homeless discharge coordinator/liaison team will determine the need for a full multidisciplinary integrated assessment of the person experiencing homelessness including mobility, cognition/capacity and addiction *within 48 hours of referral* (Mon-Fri, excl. bank holidays)

3.5 Homeless discharge coordinator/liaison team, *on initial assessment*, will record the patients housing status e.g. no fixed abode (NFA), in Private Emergency Accommodation (PEA), Supported Temporary accommodation (STA), or Long-term Accommodation (LTA), and will record and identify patient's local authority and housing application status.

3.6 Homeless discharge coordinator/liaison team, *on initial assessment* will seek verbal or written consent, as set out in the HSE National Consent Policy, to facilitate an appropriate sharing of information between the hospital and relevant community services, whilst safeguarding the individual's right to privacy and confidentiality.

3.7 *On initial assessment,* the homeless discharge coordinator/liaison team will contact the local authority/CPS and provide a clear, detailed account of any changes in support needs that may impact the suitability of accommodation, such as the need for a single room or wheelchair-accessible housing*, even when patient has reported discharge destination.* Contact with local authority/CPS should always be made in order to establish whether ongoing care needs can safely be provided before discharge. The variability in emergency accommodation services means that this cannot be assumed.

3.8 The homeless discharge coordinator/liaison team, will further liaise with local authority/CPS in order to ascertain and document patient's status on the PASS system (registered/assessed etc.) as soon as possible and will support local authority/CPS regarding completing registration within 48 hours *(*Mon to Fri, excl. bank holidays) of this being ascertained.

3.9 Homeless discharge coordinator/liaison team should contact the local authority/CPS to ascertain *on initial review*, via the PASS system, whether the patient has a key worker or case manager in the community. If the patient consents, the key worker or case manager should be contacted, and their details recorded in the patient's documentation.

3.10 Homeless discharge coordinator/liaison team, will ascertain on *initial* review whether patient receives a service from another community agency i.e. community mental health team. If so, and, if the patient consents, the service should be fully informed of treatment and discharge plan. Where relevant, the patient's parent(s)/family member(s)/guardian should also be contacted on initial review and if the patient consents they should also be fully informed of treatment and discharge plans.

For patients without a discharge destination:

3.11 Homeless discharge coordinator/liaison team, will contact designated liaison person in local authority/CPS within 24 hours (Mon to Fri, excl. bank holidays) of initial assessment and advise of probable discharge date and accommodation/support needs.

3.12 Homeless discharge coordinator/liaison team, will ascertain on *initial* review whether patient receives a service from another community agency I.e. community mental health team. If this is the case, and, if the patient consents, the service should be fully informed of treatment and discharge planning.

3.13 The Homeless discharge coordinator/liaison team will consult with local authority/CPS to identify appropriate discharge destination (Mon to Fri, excl. bank holidays).

3.14 If no appropriate and available discharge accommodation is identified, the homeless discharge coordinator/liaison team will continue to work with CPS and the hospitals to source accommodation.

For patients with secure discharge destination:

3.15 Even when the discharge destination is known, the first step upon initial review is for the homeless discharge coordinator/liaison team to contact the local authority/CPS to confirm the suitability of the accommodation. This ensures that any specific needs, such as single rooms or wheelchair-accessible

housing, are met. Additionally, the local authority/CPS should be informed of the expected length of stay (ELOS) and the expected date of discharge (EDD).

3.16 With patient consent and upon consultations with local authority/CPS once the discharge destination has been confirmed, the homeless service provider should be contacted *within 24 hours* of this being known by homeless discharge coordinator/liaison team (or parent/family member/guardian where relevant), to inform of admission. The expected length of stay (ELOS) and expected date of discharge (EDD) should be communicated within 24 hours of this being known. If the identified bed is in a PEA, the contact should be with local authority/CPS and the PACT team (refer to the stakeholder register).

3.17 In complex hospital discharges, the homeless service provider and local authority/CPS will be invited to attend MDT meeting and/or will have an opportunity to flag concerns and to plan discharge.

3.18 If, following the MDT meeting, the homeless service provider is unable to accommodate the patient, the local authority/CPS & HSE will immediately explore alternative solutions to address the accommodation difficulty.

3.19 If concerns are in place regarding the homeless service provider's ability to manage the patient, the homeless service provider will notify local authority/CPS and HSE social inclusion and should make contact with the medical doctor or social worker in covering the case as soon as possible.

3.20 The local authority/CPS should be contacted *at least 24 hours prior to discharge* regarding care arrangements. Once the accommodation arrangements have been agreed and confirmed with local authority/CPS, the accommodation provider should be informed immediately to ensure proper care arrangements are in place.

3.21 For homeless patients, with patients consent, discharge summaries will be faxed/emailed *within 24 hours prior to discharge* to named key workers/case managers, registered medical facilities and homeless service providers, local authority/CPS and other services as appropriate. If the patient's discharge accommodation is STA and they are not registered with GP, discharge summaries should be sent to Safetynet In-reach (see stakeholder register). If the patient's discharge accommodation is PEA and they are not registered with GP, discharge summaries should be sent to Ana Liffey Drug Project (ALDP) nursing team (refer to stakeholder register).

In the event of an unplanned self-discharge against medical advice:

3.22 Where possible, the patient should be informed by the medical team or homeless discharge coordinator/liaison team that homeless services may not be in a position to support them to secure accommodation and/or offer supports where required.

3.23 Where possible, ward staff should provide information & contact details of local homeless services and where consent is provided the hospital should contact local authority/CPS and provide a patient update & handover.

3.24 It is recognised that this may not be possible where an unplanned discharge takes place out of core working hours and/or when staff are not aware of the patients plans to self-discharge.

3.25 Homeless discharge coordinator/liaison team, will notify the primary service provider of the unplanned self-discharge on the *next working day.* If appropriate services cannot be identified, the discharge summary can be sent to the Homeless Health-Link Teams and Safetynet In-Reach (see stakeholder register) for patient follow-up, where possible. Given the limited capacity of these teams to follow up on all self-discharges, cases requiring follow-up should be prioritised based on urgency and need.

4 EMERGENCY DEPARTMENT

4.1 ED MSW will assess accommodation needs and record discharge destination.

4.2 ED triage/MDT (nurse/doctor/MSW) will identify patients experiencing homelessness with complex health/accommodation needs and will flag these with homeless discharge coordinator/liaison team or ED MSW for discussion at homeless hospital discharge MDTs.

4.3 Where possible, the ED MDT (nurse/doctor/MSW) will identify the homeless individual's GP, being cognizant that they may have more than one GP and/or also attend services for opiate substitution, and record this in patient record.

4.4 ED triage/MDT will identify if the patient experiencing homelessness receives a service from a community mental health community team and record this in the patient record.

4.5 ED discharge summary will be faxed/emailed to patient's GP and community mental health team (as appropriate) and phone contact will be made with accommodation provider as possible/appropriate.

4.6 If the patient provides verbal consent, the hospital should attempt to contact the hostel medical/social care staff to notify them of the outcome of the ED attendance (e.g. did patient self-discharge, any follow-up outpatient appointments) and to advise of accommodation and support needs prior to discharge.

4.7 Support safe discharge of patient, where possible, by ensuring transport arrangements to hostel accommodation.

4.8 A contact person(s) in ED will be available to answer queries related to homeless discharge(s).

Patients at risk of homelessness:

4.9 *During triage or nursing assessment* when asking whether a person is experiencing homelessness, a second question regarding tenancy status should be asked. If the patient is in private rented accommodation, the question as to whether the tenancy is going well should be asked. Person can be at risk of homelessness when they lack reasonable accommodation for themselves and those who may reside with them such as couch-surfing (moving from one temporary housing arrangement to another due to a lack of housing), etc. Entering homeless emergency accommodation should be avoided wherever possible, and it should never be assumed that such accommodation is more suitable than the patient's current housing.

If a patient is identified as being at risk of homelessness:

4.10 Referral to MSW/dedicated homeless discharge coordinator or liaison team (where available) should be made *immediately* and responded to as soon as the referral is received.

4.11 MSW/dedicated homeless discharge coordinator or liaison team (where available) should support the patient to contact THRESHOLD (Freephone: 1800 454 454) and their local authority/CPS as needed. Local authority/CPS are responsible for determining if an individual is at risk of homelessness or not. Each patient should be advised to contact the relevant local authority for assessment.

4.12 Referrals to pre-existing support services should be made by MSW/homeless discharge coordinator or liaison team, once the cause of the issue is known.

4.13 Information relating to making a housing application should be provided, along with access to HAP, and any other voluntary services which may be appropriate (see stakeholder register).

All MSWs and/or dedicated homeless discharge coordinators/liaison teams should:

4.14 Be aware of the tenancy protection and support services available throughout the four Dublin local authorities.

4.15 Ensure a list of tenancy protection and sustainment services is made available to all staff.

4.16 Ensure that information pertaining to these services are on display in ED waiting rooms.

4.17 Dedicated homeless discharge coordinators/liaison teams should have access to a nominated staff member in Placefinders with whom they can liaise.

5. ROLES AND RESPONSIBILITIES

Management are responsible for:

5.1 Ensuring all staff members are aware of this protocol and are able to advise concerned individuals on same.

5.2 Ensuring that all persons experiencing homelessness and those at risk of homelessness are provided with care in line with this protocol.

5.3 Ensuring a process of review and monitoring is taking place to ensure the discharge protocol is operating effectively and is updated as required.

5.4 Regular outcomes reporting to the National Oversight Group.

Staff members are responsible for:

5.5 Ensuring that any other concerned individual is made aware of the protocol as appropriate.

5.6 Assisting other staff members and representatives to implement protocol procedures when requested to do so.

5.7 Following all other steps regarding appropriate discharge for homeless patients and those at risk of homelessness as outlined in this protocol.

5.8 Ensuring they keep themselves informed in relation to this protocol.

6. DISCHARGE PATHWAY

The following discharge pathway represents the finalized version from the summary document of the Protocol on Transfer of Care for People Experiencing Homelessness in Dublin.

ED

1. Patient experiencing homelessness (or at risk of homelessness), source (i.e. STA, PEA, rough sleeping), their LA (i.e. DCC, FCC, SDCC, DLRCC) and housing application status is identified and recorded.
2. Patient is referred to and seen by MSW/IHT/dedicated homeless worker/homeless nursing service.
3. Upon *initial assessment, always contact the LA/CPS* and provide a clear, detailed account of any changes in support needs. LA/CPS contact is: homelesshd@dublincity.ie
4. When contacting LA/CPS, ask them to share key worker/case manager's contact details from PASS system.
5. Engage key worker/case manager and record their details.
6. Key worker/Case manager and Parent/Guardian/ Family (where possible/appropriate) involved in care planning and advocacy.
7. Direct communication with other relevant community providers (e.g. GPs, NGO's, Safetynet, PACT, Healthlinks teams, SUSD, CMHT), primary care services and clinicians to ensure concerns/history and care plan conveyed.
8. Identify the need for further MDT assessments/meetings for patients with complex presentations.

Inpatient

Designated person to ensure **discharge summaries** sent to relevant people before the patient arrives at the receiving facility. Discharge summaries are to be shared with both primary care and community services.

1. Obtain *consent* from patient for liaison with integrated MDT, including local authority, other service providers and family/guardian (where appropriate).
2. Assess discharge needs (including housing needs and eligibility for Housing First tenancies or other supported accommodation e.g. STA, LTA, PEA and failed Housing First tenancies).
3. Immediate liaison with LA/CPS to secure most suitable discharge bed for current health presentation and ongoing health needs. LA/CPS should be informed of the ELOS and EDD within 24 hours of confirmation.
4. Once the discharge destination is known, the LA/CPS will contact homeless service provider to inform them of the admission and planned discharge.
5. Dedicated homeless discharge coordinator/IHT to develop or update integrated care plan with key worker/case manager, relevant community providers and parent/guardian/family where appropriate (Integrated MDT).
6. Record details of relevant service providers in the integrated MDT who are involved in discharge planning/integrated care plan.
7. Record and store relevant homelessness data including assessment of needs and care plans in a timely and standardised way.

Discharge

1. Formally communicate discharge plans with integrated MDT prior to discharge. For complex hospital discharges this may take the form of an MDT meeting. Share integrated care plan and discharge plan with integrated MDT.
2. Send the discharge summary to both primary care and community services (including homeless service providers) before the patient arrives at the receiving facility. Use discharge template to write and share discharge summary.
3. If patient leaves against medical advice, discharge summary/integrated care plan to be sent as soon as possible to relevant community service provider for follow-up (If appropriate services cannot be identified, the discharge summary can be sent to the Homeless Health-Link Teams and Safetynet In-Reach for patient follow-up, where possible. Given the limited capacity of these teams to follow up on all self-discharges, cases requiring follow-up should be prioritised based on urgency and need). If no plan is available key worker/case manager to contact ward for follow up.
4. Out of Hours' discharges (outside Mon-Fri 9-5) should be avoided, if at all possible. While EDs discharge patients 24/7, homeless inpatients should ideally be discharged during the working hours of their accommodation provider, unless agreed arrangements are in place. However, if accommodation is unavailable during these hours, out-of-hours discharges may happen. In such instances, to access emergency accommodation outside of regular hours, contact the Homeless Freephone service at 1800 707 707.
5. Referrals to PHN Community Services for dressings should be sent before the Friday of discharge to ensure weekend coverage. Homeless accommodation does not provide 24/7 nursing, so Primary Care must meet the client's needs over weekends. If intravenous therapy is required, it can be administered in the accommodation using CIT services.
6. Key worker/case manager is responsible for coordinating ongoing care in the community and must involve Primary Care Services where applicable
7. Regular interagency meetings should be held in the community to support continuation of care and integrated care planning

Patients at risk of homelessness

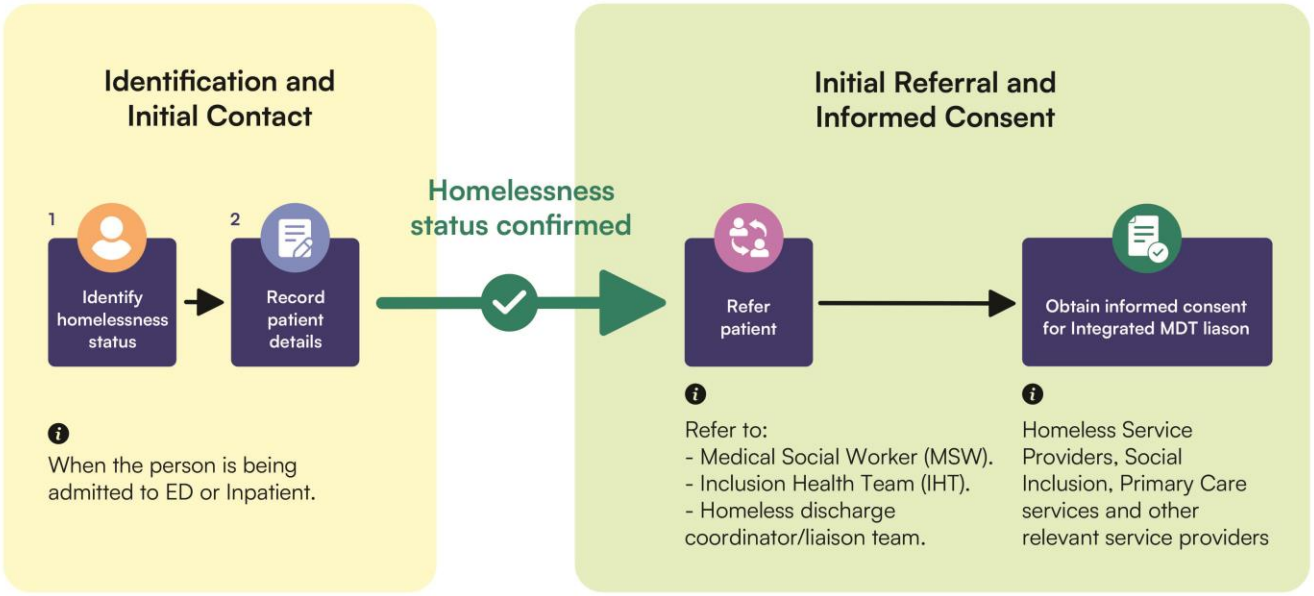
For patients at risk of homelessness,

1. **Identification:** During triage, assess the patient's tenancy status to identify those at risk of homelessness.

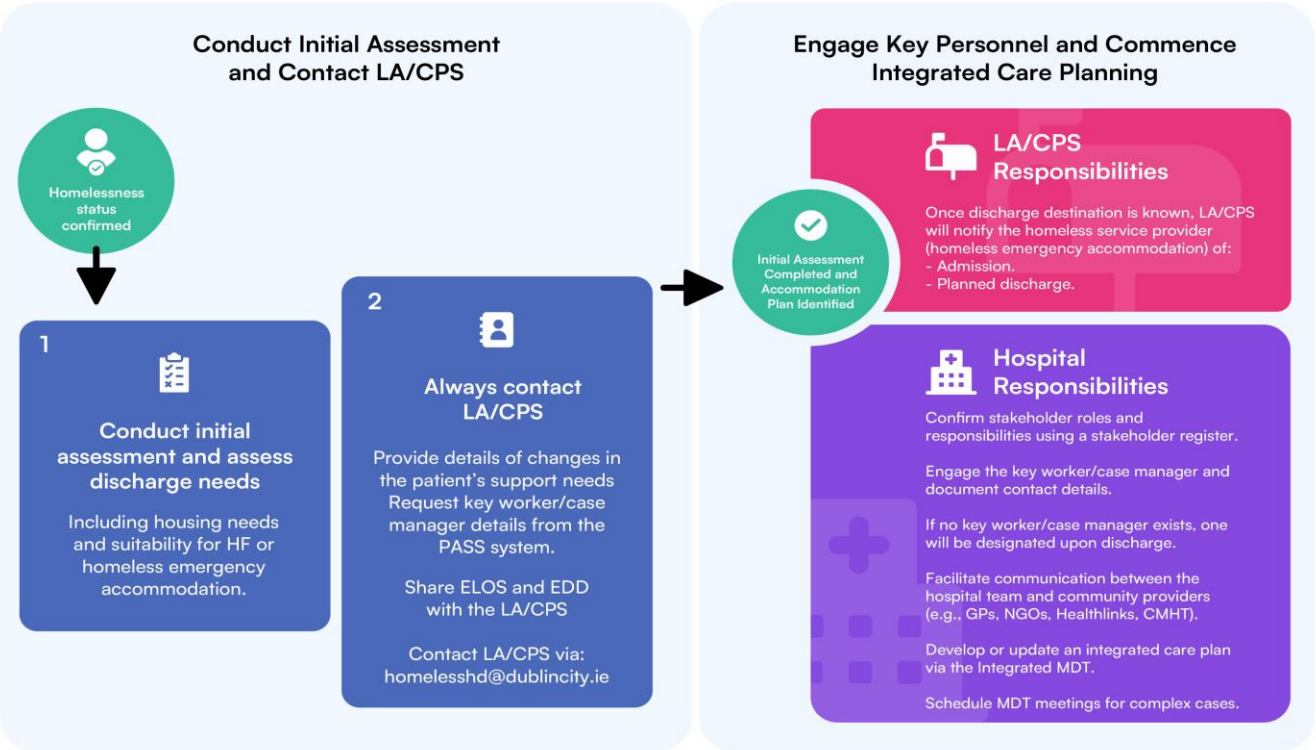
2. **Immediate Referral and Support Access**: When a patient is at risk of homelessness, an immediate referral should be made to the MSW or homeless discharge coordinator. These teams should provide information on housing applications, HAP, and relevant voluntary services, while seeking assistance from CPS/LA for particularly vulnerable patients. LA/CPS are responsible for determining if an individual is at risk of homelessness.

3. **Prevention, Tenancy Protection and Service Awareness**: MSWs and homeless discharge coordinators should ensure awareness of tenancy protection services by actively promoting these resources among staff, displaying relevant information prominently in ED waiting rooms, and fostering direct communication with a designated LA/CPS staff member for support. Additionally, they play a crucial role in prevention services by identifying at-risk individuals early, coordinating referrals to tenancy sustainment programs, and collaborating with housing and social support agencies to prevent homelessness where possible. See stakeholder register for other prevention services.

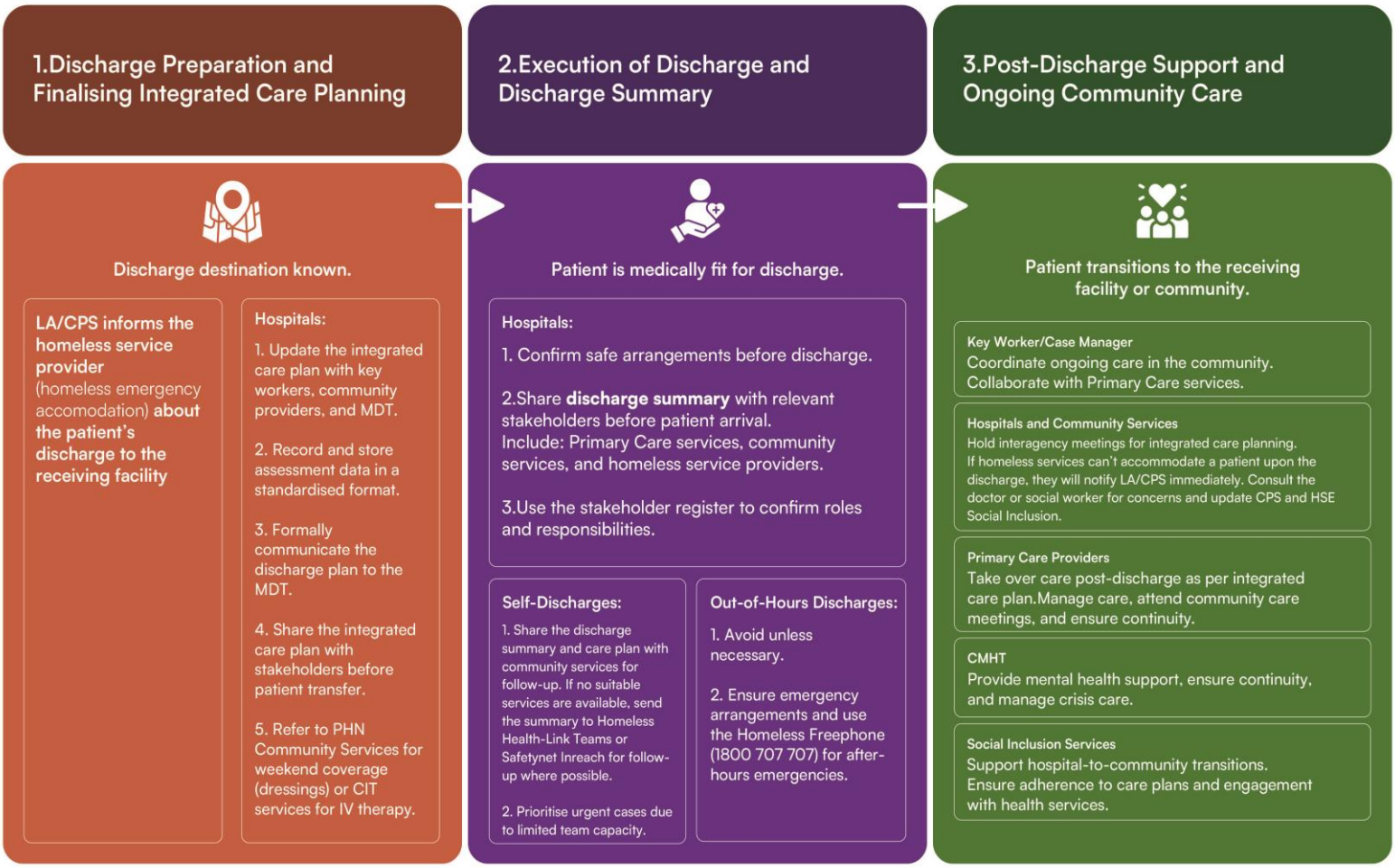
Identification, Initial Referral, and Consent



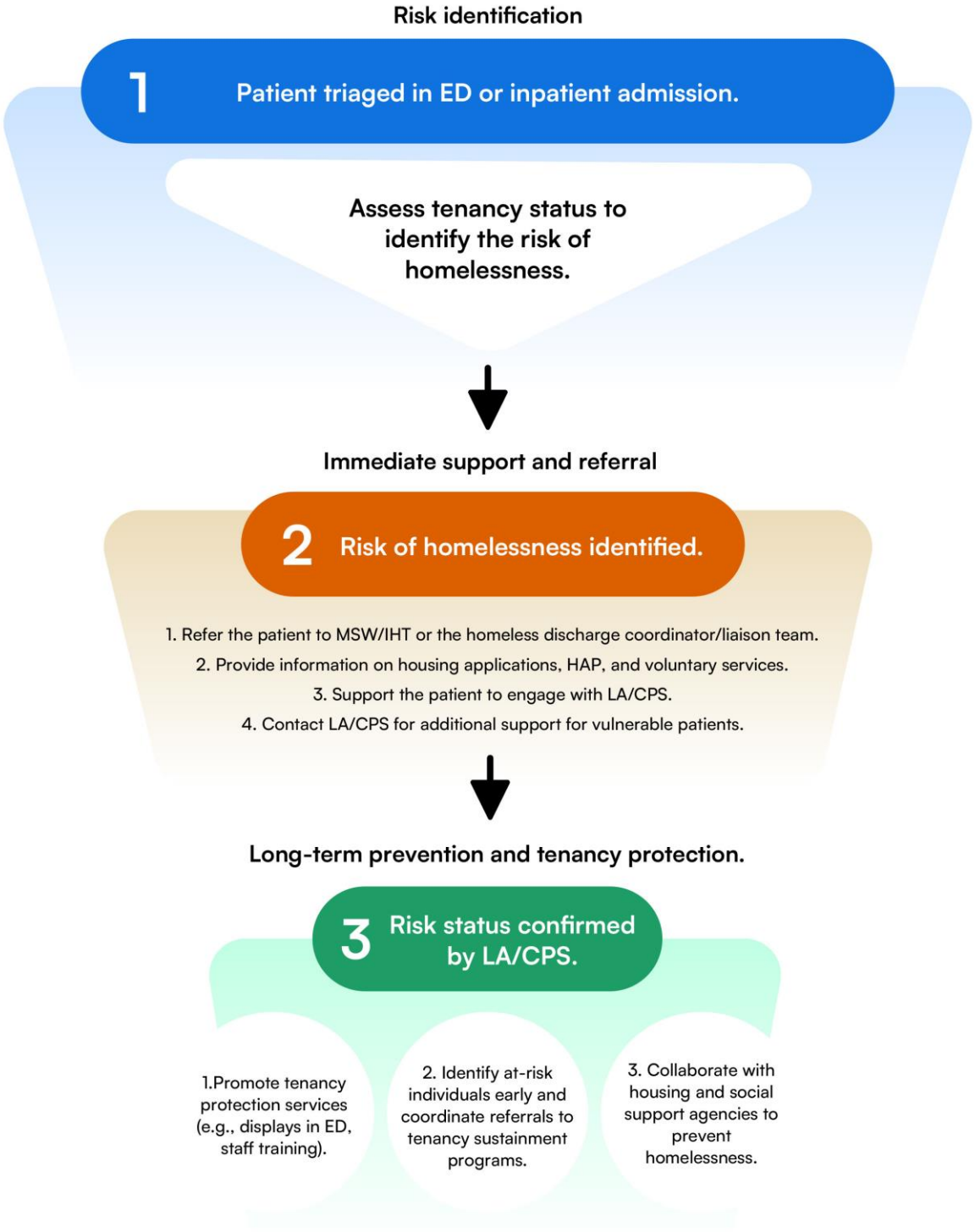
Assessment and Care Planning



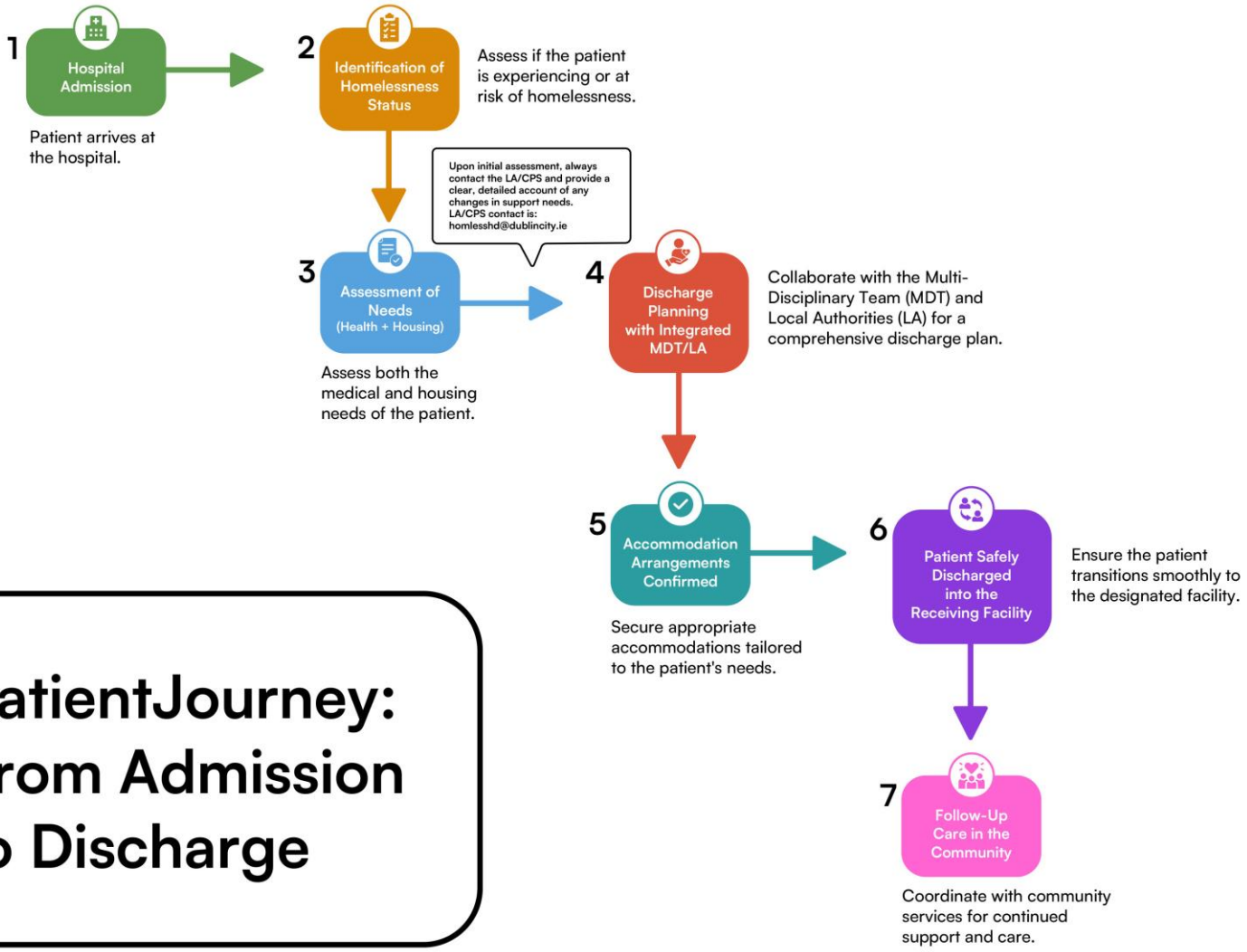
Discharge Preparation, Execution, and Follow-Up



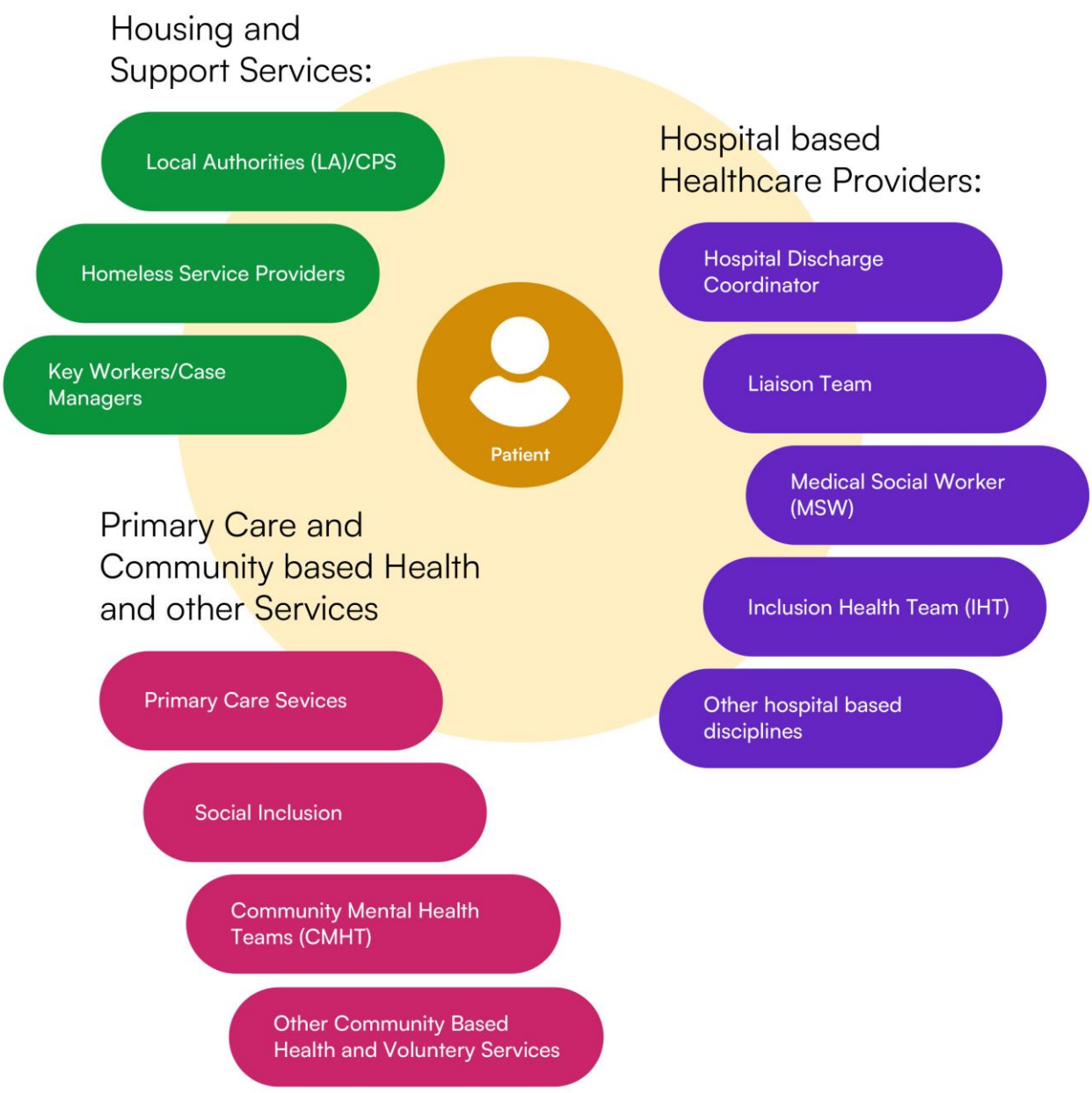
Early Identification & Risk Management for Those at Risk of Homelessness



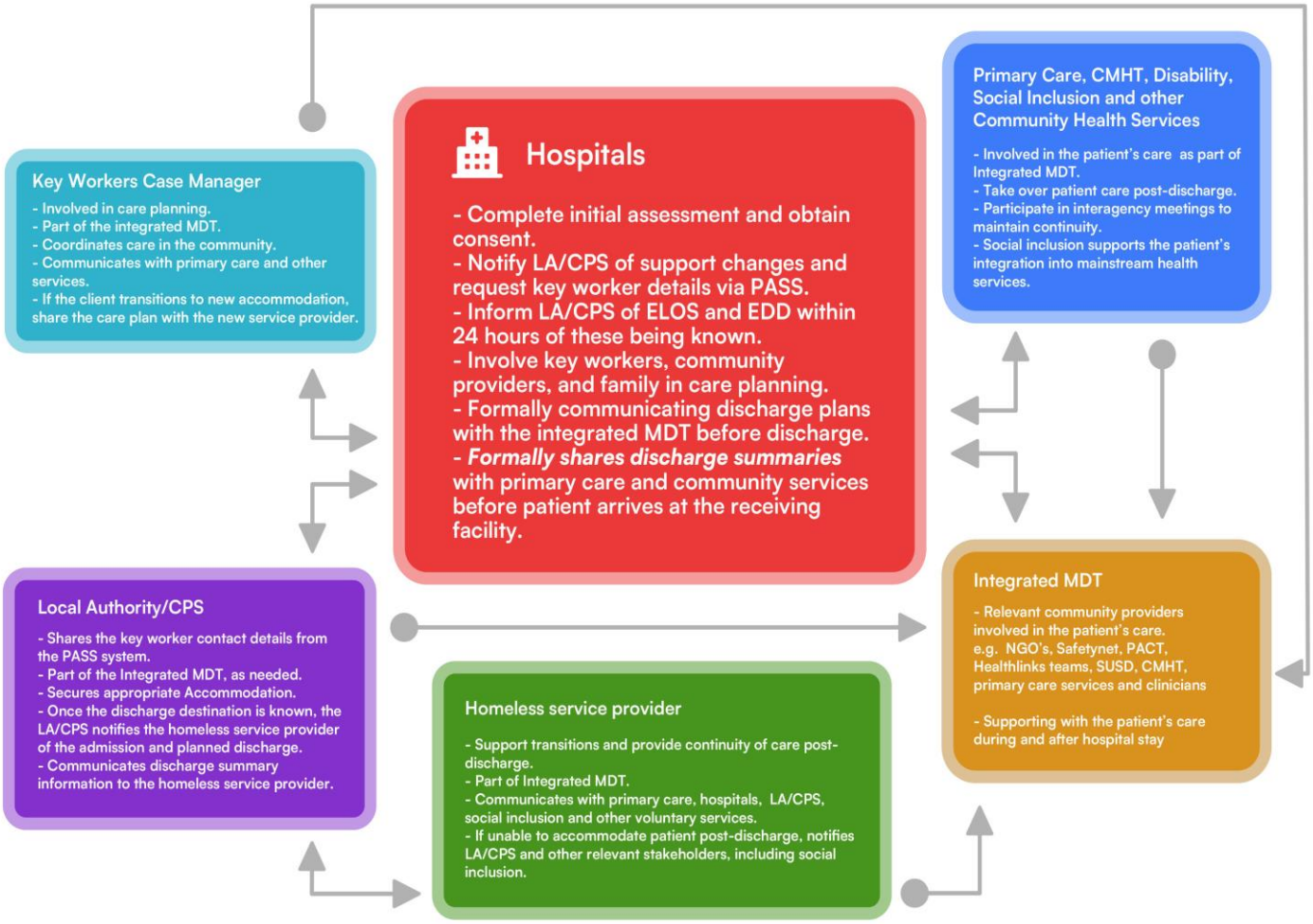
PatientJourney: From Admission to Discharge



Integrated Multi-Disciplinary Team (MDT) Structure



Communication and Information Flow



PART B: PPPG DEVELOPMENT CYCLE

1.0 INITATION

1.1 Purpose

The purpose of the protocol is to improve the health and social outcomes for people experiencing homelessness or at risk of homelessness by ensuring planned, coordinated and timely discharges from acute hospitals and appropriate onward referral.

1.2 Scope

1.2.1 This protocol covers all recommendations and actions to be taken in respect to supporting any persons experiencing homelessness who are accessing acute services in the Dublin region – this includes general acute hospitals, maternity, children and psychiatric hospitals in CHO areas 6, 7 and 9.

1.2.2 Target Users: The procedures that are defined within the protocol involve and provide guidelines for all staff members and representatives of the Health Services, Local Authorities and the Voluntary Sector who are supporting people experiencing homelessness and those at risk of homelessness being discharged from hospital.

1.3 Objectives(s)

The protocol will:

- Provide guidance so as to ensure that clear procedures are in place, involving the Health Services, Local Authorities and the Voluntary Sector, so that all discharges of persons experiencing homelessness and those at risk of homelessness, from acute and mental health care, are planned and the necessary accommodation and supports are in place prior to discharge.
- Clearly outline the roles and responsibilities of all those involved in the care and discharge of patients experiencing homeless.
- Highlight the critical importance of preventing a person becoming homeless in the first place and the support services that can be activated to help with this process.

1.4 Outcome(s)

- Increased number of planned discharges that recognize and incorporate the complex health and social needs of persons experiencing homelessness

- Increased number of integrated and comprehensive assessments completed that identify health, social and other support needs for people who are homeless or at risk of homelessness
- Increased number of people who are homeless or at risk of homelessness who have secured appropriate accommodation prior to discharge, including housing first tenancies
- Increased number of people who are homeless or at risk of homelessness linked into health and other supports prior to discharge to support identified care needs
- Increased number of integrated care plans completed with community providers to ensure continuity of care
- Increased access to health and social services in the community post-discharge
- Reduction in health care costs indicated in fewer hospital readmissions and reduced lengths of stay in hospital
- Reduced number of homeless people and those at risk of homelessness leaving emergency rooms and hospital before being treated.

1.5 Stakeholder Register

Multiple stakeholder groups have been consulted throughout the protocol development process (see 2.0 – PPPG Development) and will continue to be involved in the ongoing review and development of the document (see 6.0 – monitoring, audit and evaluation plan). A list of key service providers and stakeholders across both the health and housing sectors is included in Appendix I – Stakeholder Register.

1.6 PPPG Development Group

1.6.1 See Appendix II for Membership of the PPPG Development Group. A conflict of interest declaration form has been signed by members of the PPPG Development Group.

1.7 PPPG Governance Group

1.7.1 See Appendix III for Membership of the Approval Governance Group.

1.8 Supporting Evidence

The Protocol on Transfer of Care of People Experiencing Homelessness in Dublin is an updated protocol adapted from the Dublin Homeless Hospital Discharge Protocol (V1) and National Hospital Discharge Policy for Homeless Persons (2016).

1.8.1 Relevant legislation/PPPG's:

- National Hospital Discharge Policy for Homeless Persons (2016)
- Rebuilding Ireland: Action Plan for Housing and Homelessness (2016-2021)
- The Homeless Preventative Strategy (2002)

- Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre: Section 33(3)(e) of the Mental Health Act 2001
- HSE's Integrated Care Guidance: A practical guide to discharge and transfer from hospital (2014)
- National Housing First Implementation Plan (2021)
- Housing for All Action Plan (2021)
- HSE National Strategic Plan for the Healthcare of People Experiencing Homelessness in Ireland (2024)

1.9 Glossary of Terms

Term	Definition
CPS	Central Placement Service (CPS) is provided by the Dublin Region Homeless Executive (DRHE) – point of access for persons homeless or at risk of homelessness to receive assessment of their situation, information about options available and referral to emergency or other accommodation if eligible.
Complex hospital discharges	For the purpose of the Dublin homeless hospital discharge protocol the agreed definition of a complex case is defined as a service user who; 1. Has multiple health needs which may include one or more of the following; • ongoing severe and persistent health, mental health and/or addiction support needs, or, • postnatal care needs AND • is a frequent and ongoing recipient of services from multiple government programs/hospital/community organizations, or, • has a specific need(s) for which there is no current effective service system response, or, • requires a tailored support package along with a holistic, client centered and coordinated systems approach to service delivery, or, • who (or whose family member) requires support in order to coordinate and manage different service inputs to meet their care requirements. OR: 2. • Does not meet the criteria for habitual residence • Is not known to the PASS system or registered as homeless • Is registered to another local authority but requires transfer of local authority for medical reasons.
Concerned individuals	Includes anyone who is directly affected by the actions of the organisation, but excludes anyone who works for the organisation either in a paid or voluntary capacity, such as staff members or volunteers.
Discharge Summary	Document that outlines patient's primary care healthcare practitioner on the inpatient stay, including patient details, admission and discharge details, clinical course during the inpatient stay, changes to medication and a full list of discharged medications, treatment plan and discharging details. The data set should be fit for purpose and not be so detailed as to delay the sending of the discharge summary on the day of discharge.
Healthlinks/Homeless case management teams	Known as HSE Homeless Action Teams in other regions, the HSE Healthlinks for Homeless (South City) and Homeless Case Management Team/Healthlinks (North City). See Stakeholder register for outline of service function.
HAP	Housing Assistance Payment (HAP) is a form of social housing support provided by all local authorities. HAP means that local authorities can provide housing assistance for households who qualify for social housing support, including many long-term Rent Supplement recipients.
Homeless service provider	Refers to an individual or organization that offers housing or shelter services to individuals in need, particularly those experiencing homelessness or housing instability.
Hospital Discharge Coordinator/Homeless Liaison Team	This is a dedicated staff member or team (i.e. inclusion health team in St James/Mater) that is responsibility for coordinating the care and discharge of people experiencing homelessness or people at risk of homelessness who are staying in hospital.
Housing First	Housing First provides a comprehensive and holistic approach to addressing homelessness for people experiencing long-term homelessness and/or sleeping rough and complex health needs, including mental health, physical

	health, substance misuse, social, behavioural, and other challenges. See the stakeholder register for further programme information.
Integrated Multidisciplinary Team (IMT)	A group of community and hospital based service providers, including hospital staff, other healthcare professionals, social care providers, voluntary sector and local authorities, working collaboratively to support integrated care planning. The IMT plays a key role in addressing complex needs in hospital discharges, ensuring coordinated care and communication across housing, social services, and health services for individuals experiencing homelessness.
Key worker/case manager	Professional responsible for coordinating and overseeing the care and support of individuals, particularly those with complex needs such as homelessness, health issues, or social exclusion. Key workers/case managers ensure that the individual receives appropriate health, housing, and social services, acting as a bridge between different service providers.
Multidisciplinary Team (MDT)	Within this context, MDT refers to a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, etc.) working within hospital setting, each providing specific services to the patient. The activities of the team are brought together using a care plan.
PASS	The Pathway Accommodation and Support System (PASS) is an online shared system utilised by every homeless service provider and all local authorities in Ireland. The system provides 'real-time' information in terms of homeless presentation and bed occupancy across the Dublin region.
Person experiencing homelessness	Section 2 of the Housing Act 1988 states that you are considered homeless if: • There is no accommodation available that, in the opinion of the local authority, you and any other person who normally lives with you or who might reasonably be expected to live with you, can reasonably occupy or remain in occupation of, or • You are living in a hospital, county home, night shelter or other such institution, and you are living there because you have no suitable accommodation or • You are, in the opinion of the local authority, unable to provide accommodation from your own resources In general, one may be considered homeless if they are: • Sleeping rough • Staying in an emergency hostel or refuge • Staying in bed and breakfast or hotel accommodation on a temporary basis • Staying temporarily with friends or family because you have nowhere else to go • Squatting (occupying a building illegally)
Safetynet	Safetynet Primary Care is a medical charity that delivers quality care to those marginalized in society without access to healthcare, including people experiencing homelessness, people using drugs and migrants. Safetynet also facilitate a network of health services working with homeless people care to ensure a coordinated approach and promote best practice. See Stakeholder register for outline of service function.
Service Provider	Organisation, business or individual which offers a health social, housing or other service to consumers.
Staff member and/or representative	Should be construed broadly, and includes, for the purposes of this protocol, staff members, volunteers, interns and locums.
Types of Accommodation	PEA - Private Emergency Accommodation: this may include hotels, B&Bs and other residential facilities that are used on an emergency basis TEA - Temporary Emergency Accommodation: emergency accommodation with no (or minimal) support STA - Supported Temporary Accommodation: accommodation, including hostels, with onsite professional support LTA – Long Term Supported Accommodation HF – Housing First tenancies with wrap-around supports NFA – No Fixed Abode

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2.0 DEVELOPMENT OF PPPG

2.1 Development overview

Addressing homeless hospital discharge and strengthening integrated care pathways is a key priority area of the HSE National Social Inclusion Office in line with Rebuilding Ireland actions 1.13 and 1.15. The HSE National Social Inclusion Office has coordinated a number of activities since 2016 (outlined below) that has lead to the development of a standard Dublin hospital discharge protocol for people experiencing homelessness and a pilot-programme of work across St James and the Mater to support safe and appropriate homeless discharges and enhance delivery of integrated care across the care continuum.

The National Discharge Policy for Homeless Persons – 2016

The need for a set of standardized procedures to guide acute hospital discharge planning for persons experiencing homelessness or at risk of homelessness was initially explored through the process of developing the National Homeless Hospital Discharge Protocol. The Dublin Homeless Hospital Discharge Protocol has been adapted from the National Hospital Discharge Protocol for Homeless Persons which was developed in line with the HSE Primary Care Operational Plan 2016 and was approved in 2016 by the National Director of Primary Care in line with the HSE Integrated Care Guidance Policy 2014 and the Implementation Plan on the State's Response to Homelessness 2014. Recommendations from the development and implementation of this document will underpin and guide the ongoing collaborative development and implementation of the Dublin homeless hospital discharge protocol with relevant stakeholders across the Dublin region.

Development Group (Draft Protocol) – July 2017

A need was identified to develop, agree and implement a local area protocol in Dublin that is in line with the national guidance framework via the Homeless Regional Statutory Management Group and in consultation with Hospital Groups/ Mental Health Services/Homeless Action Teams and other relevant stakeholders as appropriate. Subsequently a development group represented by acute hospitals and primary care services was established (2016) and draft a Dublin Homeless Hospital Discharge Protocol was produced in 2017.

Feedback Process – August 2017

The initial draft and guiding framework was distributed for comment to senior members of key stakeholder groups in July 2017 including the Acute Hospital Division, Local Authorities, Chief Officers, Primary Care Division and Mental Health services within the Dublin region (CHO 6, 7, 9). Feedback on

both documents was sought from service and stakeholder representatives and an extensive review and analysis of all feedback was undertaken with the following key recommendations:

- Input is required from Maternity and Children's hospitals to determine necessary adaptation for applicability to these settings
- Additional input required from mental health services to capture broad spectrum of services
- Interagency discussion and collaboration required to enhance data collection/reporting aligned to hospital discharge protocol including a minimum data set on homelessness in hospitals
- Further consultation with representatives as appropriate to clarify and agree on specific models of care and procedures
- Establish oversight committee with senior representatives of stakeholder groups to finalise draft and agree on implementation process.

Dublin Homeless Hospital Discharge Oversight Committee – December 2017

The Oversight Committee was established in response to requests for a standardized interagency protocol and increased involvement from mental health, children's hospitals and maternity hospitals. The key function of the oversight committee is to lead the review, implementation and evaluation of a standard homeless hospital discharge protocol in Dublin. Members represent HSE acute services, HSE mental health services, HSE social inclusion and primary care services, the Local Authority, Homeless Network and Safetynet.

Feasibility Study – 2018

Commissioned by the HSE and overseen by the Dublin Homeless Hospital Discharge Oversight Committee, the purpose of the feasibility report was to provide the Dublin homeless hospital discharge oversight committee, policy makers and planners with an overview of current homeless discharge processes and procedures, existing gaps and challenges to safe and appropriate discharges as well as the feasibility of a standardised protocol across all pilot sites (including psychiatric, maternity and children's hospitals). It provided recommendations on an approach to enhance homeless hospital discharges based on a local needs analysis and review of international best practice and best practice examples in Ireland. The report is available to view upon request via the HSE National Social Inclusion Office.

Service Reform Fund – 2018

The Department of Health, HSE, Department of Housing, Planning, and Local Government and Local Authorities (comprising the SRF oversight group) is overseeing an interagency Homeless Hospital

Discharge Pilot Project that aims to enhance integrated care pathways, safe and efficient discharges and improved links into housing first tenancies. The Homeless Hospital Discharge Pilot project at St James and the Mater hospitals will be initially supported through the homelessness programme of the Service Reform Fund (SRF) which is a joint initiative that has been established to support the implementation of reforms in Disability, Mental Health and Homelessness in Ireland. An 'Inclusion Health team' has been funded through the SRF homelessness programme to take responsibility for the needs of homeless people in hospital as well as coordinate discharge planning in close collaboration with a network of external agencies. This pilot project will be evaluated over 2 years and the oversight committee will review initial outcomes from the pilot project to inform ongoing development of the protocol. The Mater and St James hospital will also pilot implementation of the draft Dublin homeless hospital discharge protocol in 2019.

Based on evidence and recommendations from the above related activities, the oversight committee/PPPG development group lead the development of a standardised Dublin homeless hospital discharge protocol that would be independently reviewed and can be adapted in other hospitals and regions.

Independent evaluation of the Dublin Homeless Hospital Discharge Programme

An independent evaluation commissioned by the HSE Acutes in Autumn 2023 reviewed the operation of the Homeless Hospital Discharge Protocol to guide its ongoing development, primarily for HSE planning purposes. The evaluation combined qualitative and quantitative methods. Key findings reflected the varied expertise of staff involved, with input from hospital teams, homeless agencies and HSE partners. Ethical approval for the study was granted by Saint James Hospital's ethical committee.

An independent evaluation, intended solely for HSE internal planning purposes, has recommended establishing a dedicated subgroup within the oversight group to update the homeless hospital discharge protocol in 2023/2024. Key areas include reviewing the protocol's gaps, addressing services for patients experiencing homelessness in emergency departments, and creating care pathways for vulnerable groups (e.g., the young frail, those with mental health or rehabilitation needs). The update should improve communication timelines, prioritise at-risk individuals, and enhance the protocol's accessibility and dissemination. Oversight mechanisms should be strengthened, and the protocol should be edited for clarity, branded for visibility, and made available on HSE/hospital websites (One2One Solutions, 2023).

Feedback process for development of version 2.

As recommended in the independent evaluation of the Homeless Hospital Discharge Protocol, NSIO, in collaboration with HSE Acute Services, has developed a two-page draft summary of the updated protocol. This summary was created to provide a concise, user-friendly format for staff involved in homeless discharges.

The two-page document was circulated for consultation in June 2024, with the full protocol available upon request, to the Dublin Regional Homeless Executive (DRHE), the Dublin Homeless Network (a network of NGOs serving the homeless population in Dublin), hospitals, HSE Social Inclusion staff, and other HSE care directorates, including mental health and disability. Additionally, a request to update the stakeholder register was included as part of the consultation process to ensure that clinical and other staff know how and to whom they should refer their clients. Feedback was analysed, key themes were identified, and necessary changes to the protocol implemented**.**

2.2 Summary of the evidence and recommendations

2.2.1 Policy recommendations

The Protocol on Transfer of Care of People Experiencing Homelessness in Dublin will build on existing policies and legislation to ensure a standardised and consistent approach to supporting discharges of people experiencing homelessness from major Dublin hospitals that experience higher throughput of people experiencing homelessness and those at risk of homelessness with complex health and social needs.

The Protocol on Transfer of Care of People Experiencing Homelessness in Dublin has been adapted from the National Hospital Discharge Policy for Homeless Persons following an extensive review and feasibility study commissioned by the National Social Inclusion Office in 2018. The protocol has been developed in response to the Government's plan Rebuilding Ireland: Action Plan for Housing and Homelessness 2016-2021 (Department of Housing, Planning, Community and Local Government, 2016) to tackle the national increase in homelessness and achieve its objectives to end long-term homelessness and rough sleeping by the end of 2016. Prevention is a key component of the Rebuilding Ireland plan which the HSE will support with regards to specific health aspects. The protocol adapted for Dublin, aims to further advance Rebuilding Ireland actions by ensuring planned, coordinated and timely discharges from acute hospitals in Dublin and onward referral to relevant housing, homeless, health and social services and supports.

The protocol has been developed in line with the HSE's Integrated Care Guidance: A practical guide to

discharge and transfer from hospital (HSE, 2014) and is compliant with the HSE's National Framework for developing Policies, Protocols, Procedures and Guidelines (PPPGs). NCEC Standards for Clinical Practice Guidance (Department of Health, 2015) were developed to provide standards for healthcare staff when developing evidence based clinical guidance for healthcare services. The HSE has taken these standards and aligned them to each stage in the PPPG development cycle so that all future PPPGs being developed must meet these standards and are applicable to both clinical and non-clinical PPPGs. The steps/processes to develop and or advise the PPPG, as outlined in the HSE's National Framework for developing PPPGs, must be adhered to by all staff to ensure compliance with the framework.

The Homeless Preventative Strategy (Department of Health and Children, 2002) directed that no one should be released or discharged from state care, without the appropriate measures in place to ensure that they have a suitable place to live, with the necessary supports if required. Each Health Board at the time was required to put in place discharge protocols for persons leaving acute and mental health care who were experiencing homelessness or at the risk of becoming homeless. The imperative was that no person should be discharged from a hospital setting into homelessness. Whilst significant progress was made in this regard, it is true to say that there were some issues in the standardisation and consistency of approach and in the effectiveness of how the discharge protocols were operated and managed. Protocols were developed in 2003, by a HSE National Working Group on homelessness, in consultation with the National Hospital Office and the Mental Health Services, whereby admission and discharge policies were developed and implemented.

In 2014 a new National Integrated Care Guidance (HSE, 2014) was developed by the National Integrated Care Advisory Group under the auspices of the Quality and Patient Safety Division, to support healthcare providers to improve their discharge and transfer processes from the acute hospital setting back into the community, thereby supporting the delivery of high quality safe care. This Integrated Care Guidance (HSE, 2014) replaced the existing HSE Integrated Discharge Planning Code of Practice (2008). In addition, the Mental Health Commission developed a Code of Practice in 2009, which provides good practice guidelines on Admission, Transfer and Discharge to and from an Approved Centre, with specific reference to persons experiencing homelessness or at risk of homelessness.

2.2.2. Evidence

The changing profile and increasing numbers of people entering homelessness in Ireland, combined with complex health needs and challenges associated with overlapping social, physical health, mental health

and drug & alcohol problems, has led to this cohort of the population experiencing significant barriers in accessing appropriate healthcare services and using these optimally. Very often service-users are not receiving the care they require, and people are exiting homelessness at much slower rates resulting in more chronic and complex health problems.

International and Irish literature also demonstrates that people experiencing homelessness use both inpatient and accident and emergency services significantly more than housed people which translates into higher average health costs for people experiencing homelessness compared to housed people. Internationally, homeless population have been reported to attend Emergency Department (ED) three to five times more frequently than housed individuals (Kushel et al. 2001; Padgett et al. 1995). A recent Irish publication demonstrates that homeless people in Dublin have much higher rates of inpatient admissions with longer lengths of stay and increased readmission rates compared with the housed population (Ní Cheallaigh et al. 2017). These researchers also found that homeless individuals account for 0.4% of the catchment population of St James's Hospital, but represent over 6% of ED attendances and 7% of inpatient admissions.

It is widely acknowledged that there is an urgent need for strengthened liaison between primary care, secondary care services, ED and other sectors to ensure appropriate, timely, targeted and best-practice service provision that aims to prevent and address complex health conditions and support service-users to maintain stable housing. A wide body of research emphasises that housing is a key element to maintaining optimal health and it is critical that the health and housing sectors work together to address the health and housing needs of this population.

As part of the homeless hospital discharge feasibility study commissioned in 2018, a review of international literature and best-practise examples in relation to homeless hospital discharge coordination was undertaken. Recommendations to improve the homeless patient journey to and from hospital were extracted from the literature and are summarised below.

- **Individual person responsible for Homeless admission and discharge process**

Studies advocate and demonstrate the need for having a dedicated specialist managing homeless discharges at ward level who is responsible for proactively coordinating the homeless patients' journey from admission to discharge.

- **Protocols: Admission and Discharge Protocol in the Hospital**

While protocols vary from city to city and country to country, the consistent factor across all research is the importance of a formal written protocol which all parties are aware of and bought into. A consistent factor across all international pathways is the 'early identification' of people who are either experiencing homeless or at risk of homelessness (on admission) as a key factor in good discharge management. Early identification of person of NFA should be an integral part of training for all hospital staff.

- **Collaboration and Communication**

A consistent theme throughout literature is that interagency collaboration and communication is critical in successful implementation of a homeless hospital discharge protocol.

- **Training and Education**

The case for supporting and training of staff and the benefits associated with specialist training in identifying and dealing with the admission and discharge of a homeless patient arose in multiple case studies and reports. Internationally, there is insufficient knowledge and training across acute hospitals on matters relating to the care of homeless people. A consistent theme across the research is that homeless people feel that their treatment and the attitude of hospital staff changed once the person was identified as homeless, giving rise to the reluctance in many cases to admit to being homeless.

In almost all cases where a hospital implemented a Discharge Protocol for People Experiencing Homelessness, a key element included the development of a hospital-wide training programme which had the support and buy-in across the whole hospital, from senior management to front-line staff. Outcomes of in-house training programmes developed to support homeless hospital admissions only showed improvement in staff awareness and reduction in stigma 2-3years after commencement of the programme/s.

- **Long-term sustainable housing solutions**

A wide body of research emphasises that housing is a key element to maintaining optimal health and it is critical that the health and housing sectors work together to address the health and housing needs of this population. Examples of successful housing solutions offering support for those with complex medical needs include the Housing First approach and medical respite centres/step-up step-down facilities. Both of these models have demonstrated reductions in A&E attendance and hospital admissions.

Housing First is a widely recognised programme that has demonstrated excellent results internationally in long-term housing stability and health-related outcomes. It provides the person experiencing homelessness with housing and wrap-around health supports. Medical respite and intermediate step-up/down facilities offer short term rehabilitation, health-led care and support and convalescent beds to homeless patients coming to the end of a hospital admission or those preparing for admission. Step-up/Step-down projects have resulted in the ability to develop 'community based' care-plans which in many instances is better suited to the patient's needs. These facilities tend to operate more successfully when there is a high level of integrated planning with the Local Authority and GP practices.

- **Assignment of a key worker/case management model**

Upon identification of a person of no-fixed-abode, the early assignment of a 'Key Worker' was a contributing factor in the development of better outcomes for patients. There was no consistent factor as to who 'owned' this role. In some cases, it was a social worker with a specific remit for homeless people, other times it was an external NGO representative (e.g. Salvation Army person in the case of York Hospital), in the case of Bradford, the BRICSS team were assigned to patients of NFA needing continuing medical care. This is a role that may best be served in the Irish market by having a Key Worker assigned from one of the NGO's. Early intervention and the establishment of good rapport with the assigned key worker/case manager was also consistent factor in better engagement and outcomes for the patient.

- **Multi-disciplinary teams in the community**

Best practice indicates that a Multidisciplinary Team (MDT) in the community working with the hospital team can improve community after-care and reduce readmission rates. In such cases, the 'Key Worker,' along with clinical and nursing staff (the hospital discharge team), identified the medical, after-care, housing (accommodation) and social needs of the patient and from this, an MDT was put together to meet the patient's needs

- **Care planning**

A detailed care plan developed in hospital was shared first and foremost with the assigned Key Worker, who had overall responsibility for the on-going after-care of the patient through to the patient being deemed to be ready for discharge. An integrated care plan, owned and managed by the Key Worker, shared and available to the whole MDT was consistent throughout the review. One of the big differentiators with international best practice was that the post discharge teams were generally not hampered by geographical boundaries (unless the patient left the borough (e.g. left one city and went to

another).

- **Electronic Health Records System**

  The benefits of having a single common technology platform for people with complex medical and social needs is evident across literature as it enables shared monitoring of patient after-care, better inter-agency collaboration and monitoring of accurate data in relation hospital discharges. A more detailed review of technological solutions and opportunities to develop this in an Irish context is needed.

The feasibility study also involved:

- An evaluation of current homeless-specific hospital discharge processes across Dublin-based hospitals, including Psychiatric, Maternity and Paediatric hospitals
- A determination on the feasibility of one standardised protocol.
- Analysis and synthesis of data collected from surveys and semi-structured interviews with key stakeholder groups
- International and national review of existing technological solutions that have potential to enhance care coordination of homeless persons discharged from hospital
- Report on potential long-term sustainable technological solutions for the Dublin region.

Key recommendations from this study are included in Appendix V – Feasbility Study: Key Recommendations.

2.3 Resources necessary to implement the PPPG recommendations

The HSE is committed to further advancing Rebuilding Ireland health-related actions to address and prevent homelessness by improving health and social outcomes for people experiencing homelessness or those at risk of homelessness. In addition, the National Strategic Plan to Improve the Health of People Experiencing Homelessness in Ireland (2024-2027) sets out a number of principles, priorities, and actions aimed at supporting a collaborative response to the homelessness crisis, including the delivery of planned, long-term action and integrated quality healthcare initiatives that meet the needs of the changing profile of people experiencing homelessness. Within this, there is a commitment to enhance health supports in Dublin including Housing First (in line with the National Housing First Implementation Plan, 2021), Homeless Case Management services, Hospital discharge programme and mental health services which are necessary to implement protocol recommendations and enhance protocol effectiveness. The HSE continues to fund and enhance homeless accommodation supports, inreach

primary care, mobile outreach and other primary care and mental health services.

Building on the successful employment of an inclusion health nurse at SJH, supported by HSE social inclusion and the Inclusion Health pilot program at St James Hospital, support for expansion of Inclusion Health Teams and a broader network approach is supported for hospitals adopting the protocol. Funding has been secured through the Service Reform Fund to expand these teams in St James and the Mater hospitals. Within a prioritized pilot-site area, the teams is providing leadership in pilot implementation of an integrated Homeless Hospital Discharge programme and has supported pilot implementation of the Dublin homeless hospital discharge protocol.

Resource alignment may be necessary to support activities articulated in implementation plans. An oversight committee, involving membership from acute hospitals, mental health, primary care/social inclusion, and the Dublin homeless network, DRHE, CPS and Safetynet was established in December 2017 to oversee implementation, review and evaluation of the protocol and review resource requirements.

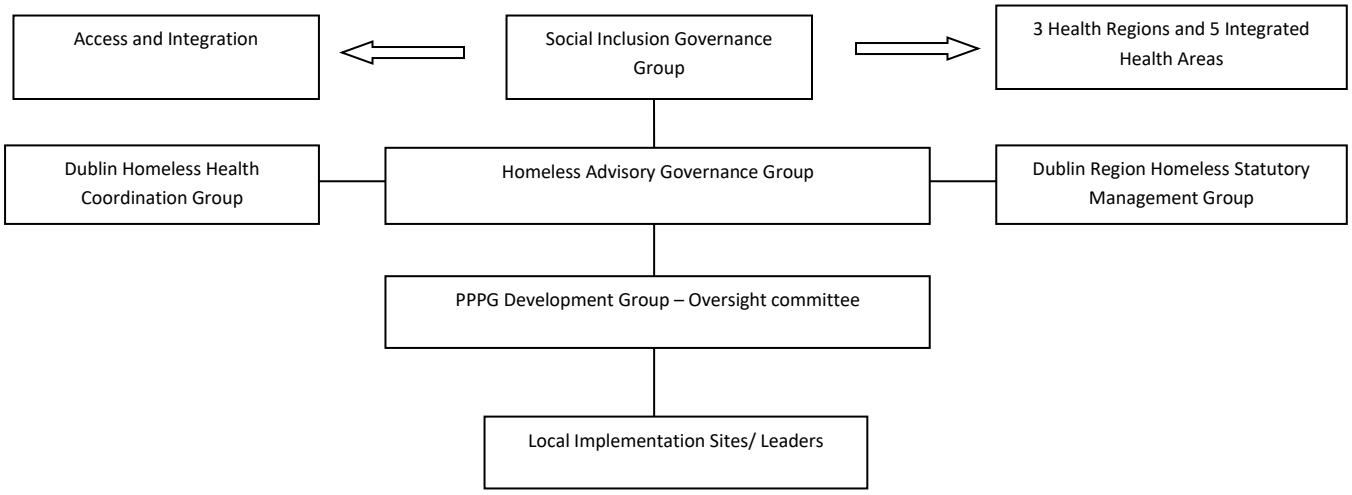
2.4 Outline of Protocol recommendations

Please refer to Protocol recommendation outlined in Part A.

3.0 GOVERNANCE AND APPROVAL

- The draft protocol document has been reviewed by the PPPG Development Group/Dublin Homeless Hospital Discharge Oversight Committee to ensure that it is in line with the National Homeless Hospital Discharge Protocol published in June 2016; is standardised and represents all stakeholders/sectors accurately, and; that there is an explicit link between the protocol and the supporting evidence and analysis.
- Formal governance arrangements for the protocol at the regional level are established and documented (refer to Appendix III for Membership of the Approval Governance Group) and see diagram 3.1 below.
- A signed PPPG Checklist will accompany the final protocol document on submission to the appropriate relevant governance process in order for the PPPG to be approved and to meet National Clinical Effectiveness Committee standards.
- Governance and approval arrangements must be described at local implementation sites and must include reporting into the overall governance structure outlined in Diagram 3.1 below.

Diagram 3.1 – Protocol advisory governance structure: [1]



4.0 COMMUNICATION AND DISSEMINATION PLAN

A communication and dissemination plan has been developed to ensure effective communication and collaboration with all stakeholders. Communication is channelled through representatives listed in the Stakeholder register (see Appendix) throughout all stages and agreed by the PPPG development group/oversight committee. The protocol will be easily accessible by all users through the PPPG repository.

The following standards must be met by local implementation sites to ensure effective communication and collaboration with stakeholders locally:

Standards:

- A communication plan is developed
- Plan and procedure for dissemination of the PPPG is described.
- The PPPG is easily accessible by all users (e.g. PPPG repository).

[1] This governance structure will evolve alongside the development of health regions and the creation of standards and guidelines for regional implementation. HSE Social Inclusion will focus on planning, enabling, performance, and assurance.

Steps to meet these standards

- Determine the dissemination methods which are effective and best suited to address identified needs and barriers.
- Develop a system to manage approved PPPGs in line with good governance and document control practice.
- Develop a communication plan to support the stages of PPPG development, dissemination and implementation. Include the most effective methods of distribution to all relevant staff, service users and other stakeholders. Outline implementation and audit processes including awareness training/support to staff.
- Once the PPPG is approved by the appropriate senior management/relevant governance processes etc., it must be appropriately disseminated to all stakeholders for implementation within the organisation/division/service.
- Establish good governance structures to ensure that the learning from the PPPG development and implementation process is shared appropriately within the organisation/division/service.

5.0 IMPLEMENTATION

5.1 Regional Implementation

Members of the PPPG development group will oversee work packages that ensure the effective implementation and evaluation of the protocol at a regional level. The oversight committee/PPPG development group will support local implementation sites to review implementation, develop implementation plans in line with the PPPG framework and manage data collection and reporting of outcomes regionally.

5.1 Local protocol implementation plans

Local protocol implementation plans should be developed in line with standards outlined by the HSE Framework for developing PPPG's (see below).

Standards required for Implementation

- Written implementation plan is provided, with timelines, identification of responsible persons/units and integration into service planning process.
- Barriers and facilitators for implementation are identified, and aligned with implementation levers.
- Education and training is provided for staff on the development and implementation of evidence based PPPGs (as required).

- There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.

Steps to meet these standards

- Develop an implementation plan, including identification of responsible person(s), specifying the actions to implement the PPPG and timeframes for implementation.
- Identify and record barriers and facilitators for implementation and use of the PPPG.
- Align the implementation plan with the service plan and budgetary process.
- Outline the supports required for education and training for staff on the implementation of the PPPG.
- Establish good governance structures including strong leadership for the effective implementation of the PPPG being developed.

6.0 MONITORING, AUDIT AND EVALUATION

Local implementation sites will be required to describe a plan and identify lead person(s) responsible for the Monitoring, Audit and Evaluation processes (outlined below), and must meet the required standards for Monitoring, Audit and Evaluation outlined by the HSE Framework for developing PPPG's

6.1.1 Monitoring

Monitoring can be defined as a systematic process of gathering information and tracking over time. Monitoring provides a verification of progress towards achievement of objectives and goals (HIQA, 2012).

6.1.2 Audit

Audit is a formal review that usually includes planning, identifying risk areas, assessing internal controls, sampling of data, testing of processes, validating information and formally communicating recommendations and corrective action measures to both management and the board/or appropriate governance structures http://www.ahia.org/. Clinical Audit is defined as a quality improvement process that seeks to improve outcomes through systematic review against explicit criteria and the implementation of change (HIQA, 2012).

6.1.3 Evaluation

Evaluation is defined as a formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved (HIQA, 2012).

6.1.4 Standards required for Monitoring, Audit and Evaluation

- Process for monitoring and continuous improvement is documented.
- Audit criteria and audit process/plan are specified.
- Process for evaluation of implementation and effectiveness is specified.

6.1.5 Steps to meet these standards

- Establish good governance structures, including strong leadership for the monitoring, audit and evaluation of PPPGs.
- Develop a monitoring, audit and evaluation plan for continuous improvement. The plan must include details of timelines and lead person(s) responsible for these processes. (Link with the appropriate person(s) with the expertise within your area to assist you with these processes, as appropriate).
- Outline specific outcomes which the PPPG aims to achieve (in terms of benefit/healthcare outcomes/service improvement/risk reduction etc.) and outline how these outcomes can be measured (there may be short-term and long-term outcomes).
- Develop mechanisms to evaluate the effectiveness of the PPPG in meeting its defined purpose, objective(s) and outcome(s).
- Communicate the findings to the relevant stakeholders (as appropriate). Good governance structures must be in place to ensure there is continuous improvement in the development, implementation, monitoring, auditing and evaluation of PPPGs (i.e. PPPG Development Group, project sponsors or appropriate governance group, quality and safety groups/committees etc.).

6.1.6 Activity Metrics

The following **activity metrics** have been identified to monitor and evaluate protocol outcomes at a regional level and should be considered in monitoring, audit and evaluation plans at local implementation sites:

General:

- % of staff who have read, understood, and agreed to adhere to the protocol, and have been trained in its implementation (Target 85%)

Hospital:

- Homelessness identified and recorded at triage or initial assessment
- Number of patients experiencing homelessness presenting to ED
- % of homeless ED attendances leaving before assessment being completed

- Mean LOS
- Readmission rate
- % referred to MSW/homeless discharge coordinator/homeless liaison team
- Time from admission to referral to MSW/homeless discharge coordinator/homeless liaison team
- Time from referral to review by MSW/homeless discharge coordinator/homeless liaison team
- Time from review by MSW/homeless discharge coordinator/homeless liaison team to communication with accommodation provider/CPS/LA
- % of patients experiencing homelessness having MDT assessment (integrated assessment)
- % of patients experiencing homelessness identified as having complex medical discharge needs (e.g. 24 hour access, wheelchair access, personal care needs etc)
- % of patients experiencing homelessness with an integrated care plan in place prior to discharge
- % of patients experiencing homelessness with an identified key worker or case manager identified in the community prior to discharge
- % of patients linked to PHN for weekend calls where services are not available within their accommodation (Note PHN service only accepts clients up to 12.00 noon on the Friday before the weekend).
- % of patients experiencing homelessness leaving AMA
- Use of 1:1 care attendants (and why)
- Use of 1:1 security specials (and why)
- Adverse incident reports

CPS/Local Authorities:

- % of homeless individuals discharged from hospital to accommodation
- % of homeless individuals discharged to accommodation that meets their needs[2]
- % of homeless patients with complex medical needs who fall under the remit of other local authority supports, outside of the Dublin region.

Care in The Community:

- Percentage of times where discharge plans are followed and continuity of care is maintained post-discharge for people experiencing homelessness (Target 85%)

[2] Accommodation that meets the needs in this context refers to housing that complies with the NQSF for homeless services in Ireland and meets the specific needs of homeless patients, ensuring their safety, health, and well-being.

7.0 REVISION/UPDATE

Revision/update refers to the process to ensure that the learning from the PPPG development and implementation process is used to amend and update or revise the original PPPG as new evidence emerges.

Update of the PPPG will be carried out every three years unless the need to revise the PPPG is identified By: audit, evaluation, serious incident, organizational structural change, scope of practice change, advances in technology, significant changes in international evidence or legislation etc. If there are no amendments required to the PPPG following the revision date, the detail on the version tracking box must still be updated which will be a new version number and date.

As new evidence emerges from local implementation sites the PPPG will be amended accordingly with approval from the PPPG development group and oversight committee members. Version control updates will be completed on the PPPG Template cover sheet.

8.0 REFERENCES

1. Department of Health and Children. (2002). *Homeless preventative strategy: A strategy to prevent homelessness among patients leaving hospital and mental health care; adult prisoners and young offenders leaving custody; young people leaving care*. Dublin: Stationery Office.
2. Department of Health, National Clinical Effectiveness Committee. (2015). *Standards for Clinical Practice Guidance*. Dublin DoH.
3. Department of Housing, Planning, Community and Local Government. (2016). *Rebuilding Ireland: An action plan for housing and homelessness*. Government of Ireland.
4. Health Information and Quality Authority. (2012). *National Standards for Safer Better Healthcare Dublin*. HIQA www.hiqa.ie
5. Health Service Executive. (2014). *Integrated Care Guidance: A practical guide to discharge and transfer from hospital 2014*. Document reference number QPSD-D-037-2. V.2.
6. Health Service Executive. (2016). *HSE's National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPG's)*. Document reference number QPSD-D-015-1. V.1.
7. Health Service Executive. (2016). *National Hospital Discharge Policy for Homeless Persons*. National Social Inclusion Office.
8. Health Service Executive. (2024). *National strategic plan to improve the health of people experiencing homelessness in Ireland (2024-2027)*. https://about.hse.ie/publications/national-strategic-plan-improve-health-people-experiencing-homelessness-ireland/

9. Health Service Executive, National Social Inclusion Office. (2018). *Homeless Hospital Discharge Feasibility Study*. Yellow Harbour (report available on request).

10. Health Service Executive National Integrated Care Advisory Group. (2014). *Integrated care guidance [PDF]*. HSE. http://hdl.handle.net/10147/638515

11. Kushel, M.B., Vittinghoff, E., and Haas, J.S. (2001). *Factors associated with the health care utilization of homeless persons*. JAMA, 285, 200–6.

12. Mental Health Commission. (2009). *Mental Health Commission Code of Practice 2009: Code of practice on admission, transfer and discharge to and from an approved centre*. Document reference number COP – S33(3)/01/2009 V.1.

13. Ní Cheallaigh, C., Cullivan, S., Sears, J., Lawlee, A. M., Browne, J., Kieran, J., Segurado, R., O'Carroll, A., O'Reilly, F., Creagh, D., Bergin, C., Kenny, R. A., and Byrne, D. (2017). *Usage of unscheduled hospital care by homeless individuals in Dublin, Ireland: a cross-sectional study*. BMJ open, 7(11), e016420. https://doi.org/10.1136/bmjopen-2017-016420

14. O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015). *Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities*. Dublin: The Partnership for Health Equity.

15. One2one Solutions. (2023). *Final Report of the Dublin Hospital Homeless Discharge Protocol and Inclusion Health Services Evaluation*. [Unpublished manuscript].

16. Padgett, D.K., Struening, E.L., Andrews, H., et al. (1995). *Predictors of emergency room use by homeless adults in New York City: The influence of predisposing, enabling and need factors*. Soc Sci Med, 41, 547–56.

9.0 APPENDICES

Appendix I Stakeholder Register

Appendix II Membership of the PPPG Development Group and Original Development Group

Appendix III Membership of Approval Governance Group

Appendix IV Signature Sheet

Appendix V Feasibility Study Key Recommendations

Appendix I

Stakeholder Register

This register provides a list of key services and contacts essential for the effective implementation of this protocol. When making referrals, follow the referral process exactly as outlined. The stakeholder register is organized into seven sections:

1. Local Authority and Housing Supports
2. Social Inclusion Case Management Supports
3. Specialist Homeless Health Projects
4. Hospitals
5. NGOs
6. Peer Support Programmes
7. Service Directory/Service Area Finder

To access the register, email **Sinead.Maguire6@hse.ie .**

Appendix II:

Membership of the PPPG Development Group

Please see below listed members of the PPPG Development Group and original development group

Ciaran Browne National Lead – HSE Acute Operations	Signature: _____ Date: _____
Joseph Doyle National Lead for Social Inclusion, (HSE National Social Inclusion Office)	Signature: _____ Date: _____
John Dermody Homeless Network (nominee)	Signature: _____ Date: _____
Naomi Nicholson Homeless Network (nominee)	Signature: _____ Date: _____
Bevin Herbert Senior Executive Officer| Housing and Community – DRHE	Signature: _____ Date: _____
Cathal Daly Administrative Officer I Housing & Community – DRHE	Signature: _____ Date: _____
Maxine Radcliffe Nominee from CHO 7 HSE Social Inclusion (Concepta De Brun)	Signature: _____ Date: _____
Brian Kirwan Nominee from CHO9 HSE Social Inclusion	Signature: _____ Date: _____
Lee Collins Nominee from CHO6 HSE Social Inclusion	Signature: _____ Date: _____
Dr Enda Barron Safetynet Primary Care	Signature: _____ Date: _____
Sinead Grogan Safetynet Primary Care	Signature: _____ Date: _____
Michael Hennessy Service Improvement Lead, HSE Mental Health (nominee for National Mental Health)	Signature: _____ Date: _____
Antonia Bura Research and data officer, Homelessness (HSE	Signature: _____ Date: _____

National Social Inclusion Office) **Chairperson** Sinead Maguire Programme Manager – Inclusion Health and Homeless Hospital Discharge Protocol	Signature: _____ Date: _____

Appendix III:

Membership of the Approval Governance Group

Please list all members of the relevant approval governance group (and title) who have final approval of the PPPG document.

Ciaran Browne National Lead – HSE Acute Operations	Signature: _____ Date: _____
Sinead Maguire Programme Manager – Inclusion Health and Homeless Hospital Discharge Protocol	Signature: _____ Date: _____
Bevin Herbert Senior Executive Officer| Housing and Community – DRHE	Signature: _____ Date: _____
Cathal Daly Administrative Officer I Housing & Community – DRHE	Signature: _____ Date: _____
Jonathan Faye Watt HSE Social Inclusion Coordinator, CHO7	Signature: _____ Date: _____
Brian Kirwan General Social Inclusion Manager, CHO9 HSE Social Inclusion	Signature: _____ Date: _____
Lee Collins Social Inclusion Manager, CHO6 HSE Social Inclusion	Signature: _____ Date: _____
Dr Eileen Sweeney Consultant Psychiatrist, HSE Mental Health (nominee for MH operations)	Signature: _____ Date: _____
Catherine Elliott Lewis Housing Coordinator , HSE Disability Services	Signature: _____ Date: _____
Antonia Bura Research and data officer, Homelessness (HSE National Social Inclusion Office)	Signature: _____ Date: _____
Caro Theunisz Programme Manager, Homeless Health (HSE National Social Inclusion Office)	Signature: _____ Date: _____

Chairperson: Joseph Doyle National Lead for Social Inclusion, (HSE National Social Inclusion Office)	Signature: _____ Date: _____

Appendix IV:

This sheet is to be used at local implementation sites for recording purposes.

Signature Sheet

I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:

Print Name	Signature	Area of Work	Date

Appendix V:

Feasibility Study: Key Recommendations

The feasibility study proposed 7 recommendations for consideration in the development of an approach and protocol for homeless hospital discharges. They are summarised as follows:

SUPPORT AND BUY-IN FROM SENIOR MANAGEMENT AND FRONT-LINE STAFF IN HOSPITALS

This is one of the most significant factors in the success of a Homeless Hospital Discharge Protocol as Senior Management by-in affects middle management engagement, budgetary implications and effective roll out within all relevant hospital departments and community agencies. This in turn will shape the attitudes and culture of front line staff.

CARE COORDINATION – ASSIGNMENT OF A KEY WORKER AND MULTI-DISCIPLINARY TEAM

Continuity of care

To facilitate successful homeless discharges that reduce hospital readmissions, the gap between primary and secondary care for homeless people needs to be addressed. The research has highlighted that the discharge planning process must be thought of as part of a continuum of care, starting with assessment and treatment, and ending with service coordination back in the community. To support continuity of care, a full assessment of patient needs and a care plan including the availability of intensive support on discharge should be accessible to all involved agencies via a suitable technological platform (see 'Interagency Technology Solution' in recommendation below). Effective interagency communication and collaboration and close working relationships is also shown to greatly enhance the continuum of care.

The National Rehabilitation Framework (see 'Policy Context' pg2) provides guidance to services to plan practically and implement an integrated and coordinated approach to recovery. It provides guidelines around standardised protocols –screening, assessments, care planning, case-management. Agencies based in Cork, Ireland have demonstrated effective outcomes from pilot implementation of an integrated approach based on this framework which may be a model to consider for adaptation.

Dedicated person responsible for homelessness in hospitals

It is recommended that a dedicated person or team responsible for homeless hospital discharges is allocated in hospitals. This person/team would be responsible for the inpatient care coordination and discharge planning of patients identified as homeless as well as integration of homelessness/NFA into existing data systems; management/reporting of homelessness data; contribution to staff training/awareness etc. The dedicated person would contribute to the evaluation and development of a protocol via an implementation group or network that would feed into the homeless hospital discharge oversight committee. Better outcomes and more positive work practice are reported when housing and a nursing link worker are integrated into the discharging team.

Assignment of a key worker

The needs of a homeless person can be complex, both medically and socially. In successful best practice examples that were reviewed, the early engagement (from hospital admission) of a Key Worker gave focus and ownership to the development and coordination of an overall plan which catered for patient's individual needs post-discharge. This individual is the point of contact for the homeless individual and work begins immediately on the discharge process with appropriate agencies in community services and an allocated multi-disciplinary team.

Assignment of a Multi-Disciplinary Team (MDT)

Upon early identification of a person being of NFA and a Key Worker being engaged, to facilitate better discharge and after-care of the homeless person, assigning a specialist multi-disciplinary team (MDT) is an essential next step. This team may include medical and nursing, allied health, mental health, addiction, housing and/or social workers dependent on individual needs. There is no prescribed model as to whether the key worker / MDT is positioned within hospitals, homeless services or HSE primary care services and this would be dependent on local resources and service context.

LONG TERM SUSTAINABLE SOLUTIONS

Where possible, arrangements should be made on admission to ensure appropriate accommodation is accessed at discharge. While limitations in the availability of suitable accommodation must be recognised, a consistent recommendation was that consideration should be given to homeless people securing longer term supported accommodation (not emergency one-night accommodation) as this would significantly increase the chances of a more successful recovery and prevention of over-utilisation of secondary care services. This requires an integrated, partnership approach between health service-providers and local authorities to identify and communicate health and housing needs and source suitable housing, where available. Ideally, a model is recommended where accommodation is linked to the project set-up (either bespoke units or ring-fenced beds in existing units) or the hospital already has links with an established housing provider or rental scheme so accommodation can be easily accessed. In the Dublin context, housing solutions may include prioritisation of beds within Housing First, step-up/step-down facilities (interim solution to support improved care planning & access to appropriate accommodation), Supported Temporary Accommodation (STA) or Long-term Temporary Accommodation (LTA), wheelchair accessible/24-hr supported beds within emergency accommodation, as appropriate. Options could be explored further under a Service Level Agreement (SLA) between the HSE and DRHE.

INTER-AGENCY TECHNOLOGY SOLUTION

Adopting a standardised inter-agency technology platform will significantly enhance the ability to track and monitor patient progress, highlight specific accommodation needs and share patient information for care planning purposes. It will also allow the HSE and DRHE to build critical data to enhance the ability to make informed decisions over time. The development of PASS 2 presents a viable opportunity for a potential inter-agency solution provided that the appropriate level of access is granted across all agencies and holistic care planning that includes health information can be integrated. Access to Salesforce.com, a cloud-based technology platform is currently in use by many of the NGO's and SafetyNet and could also be considered as part of the pilot. Other pathway tracking solutions used internationally (see Appendix 3) could also be considered to enhance work in the sector.

LOCAL HOMELESS HOSPITAL DISCHARGE PROTOCOL

A standardised protocol for all hospitals, including maternity and paediatric hospitals, should be developed that reflects an agreed standardised process across all agencies that is based on international best-practise and which can be adapted to suit local settings, resources in situ and service pathways. The protocol should be a clear and concise series of steps developed in line with HSE PPPG and the National Homeless Hospital Discharge Protocol and the target client group for referral pathways should be clarified (i.e. rough sleeper, long-term homelessness with mental health and substance use issues, those at risk of homelessness etc.). Best-practise examples e.g. development of a homeless hospital discharge protocol in Wales (See Appendix 2) should assist in informing an appropriate pathway and other recommendations in the report should be incorporated into protocol development. Resources should also be invested into developing and improving links to housing via the Hospital Inreach Liaison Service as the large volume of referrals is restricting efficiency and sustainable outcomes for patients who are

homeless and in need of long-term sustainable housing to support recovery. Clear structures should be planned for continued governance and review of a protocol to address ongoing challenges.

TRAINING AND EDUCATION

A consistent factor arising from the literature review across international models was hospitals which have or are developing improved service pathways for homeless patients being discharged from hospital, have developed and implemented training programmes. The needs of the homeless community are not always understood by staff and management; good training helps develop a better understanding and empathy towards homeless patients, resulting in better patient outcomes. Training in a homeless hospital discharge policy would also be necessary to ensure a clear, concise and streamlined process across stakeholders.

Existing training programmes and potential opportunities for joined up development and delivery of training across the sector will support successful development of an overall approach to enhancing homeless hospital discharges and strengthening care pathways. New and existing opportunities should be incorporated into the development of a training package in line with the Dublin homeless hospital discharge protocol pilot-project.

DATA COLLECTION

A standardised process should exist to capture homelessness data across all hospitals. It should be strongly encouraged within a protocol that issues related to accurate recording of homeless data are addressed at a local level as part of the implementation process. The development of a national standard identification process/minimum data set for homelessness at triage/pre-admission and assessment during admissions would be a major step forward in national data collection and ensuring key performance indicators are met.

Early identification of a homeless person at point of admission is crucial in enabling a multi-disciplinary team to assess the support required for a successful discharge with the appropriate after-care plan. The literature review of international best practice models has identified that early identification of person of NFA should be an integral part of training for all hospital staff. Less abscondments, less self-discharges and reduced re-admissions are some the key benefits of early identification of patient of NFA.

Conflict of Interest Declaration Form (Template – for Oversight committee to complete)

CONFLICT OF INTEREST DECLARATION

This must be completed by each member of the PPPG Development Group as applicable

Title of PPPG being considered:

_____

Please circle the statement that relates to you

1. I declare that I DO NOT have any conflicts of interest.

2. I declare that I DO have a conflict of interest.

Details of conflict (Please refer to specific PPPG)

_____
_____
_____
_____
_____

(Append additional pages to this statement if required)

Signature

Printed name

Registration number (if applicable)

Date

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG is required to furnish a statement, in writing, of:

(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the

fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.