



Providing support to homeless people when leaving hospital: Proving the case

This case study looks at the work of the Hospital to Housing Support Services in Plymouth and Bournemouth which was run by Bournemouth Churches Housing Association in partnership with Shelter in Bournemouth. Funded in 2013, the projects aim to provide advocacy and support to individuals who have come into hospital and are homeless or at risk of becoming homeless on discharge.

SERIO, an independent research unit at Plymouth University, was commissioned to undertake an early stage evaluation of both projects. This case study outlines the key achievements, learning points and good practice across the two projects.

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1. Introduction

Bournemouth Churches Housing Association (BCHA) applied for funds under the Homeless Hospital Discharge Fund 2013-2014. This Department of Health funding aimed to improve hospital discharge for the homeless after treatment and secure appropriate facilities for those requiring ongoing medical support after discharge.

BCHA received funding for a project – the Hospital to Housing Support Service - in Plymouth and, in partnership with Shelter, also received funding for Bournemouth and surrounding areas. The projects were due to run for 12 months but, due to delays in funding, they had to deliver with far shorter time scales.

2. Background

The Hospital to Housing Support Services aim to provide advocacy and support to individuals who have come into hospital and are homeless or at risk of becoming homeless (patients with No Fixed Abode – NFA). The overall objective of the service is to ensure that these people are supported into appropriate accommodation, and that they are engaged or re-engaged with appropriate health and community services.

The rationale for the two projects is that by providing this service at an early stage in the admission process, inappropriate discharge of these individuals, bed blocking, and re-admissions to hospital may be prevented.

The gap that the Hospital to Housing Support Services is attempting to fill is the lack of a coordinated approach to supporting a group of particularly vulnerable individuals by assisting them through a pathway of care across multiple agencies.

SERIO, an independent research unit at Plymouth University, was commissioned to undertake an early stage evaluation of both projects, part of which involved drawing out learning points from both projects.

This case study explores the key achievements and lessons learned from the Hospital to Housing Support Services in Plymouth and Bournemouth using findings from SERIO's evaluation. It concludes with areas of good practice experienced by the two services.

National context

Following various initiatives launched in the late 1990s the number of homeless people fell between 2003 and 2009. Despite this, from 2009 levels started to rise again. In 2011, the estimated number of people that approached their local authorities as homeless was 107,240; a 10% increase from 2010 (Deloitte, 2012).¹

Research has demonstrated that being homeless can have significant implications for the individual, including increasing the risk of long-term health problems. The Deloitte (2012) study found that up to 70 per cent of people who use homeless services suffer from mental ill health. There were also high levels of alcohol and drug dependency, which tended to exacerbate health problems. Due to a reduced access to normal healthcare services, many homeless people let their conditions deteriorate until a point where emergency care is required. Furthermore,

¹ www.qni.org.uk/docs/Homelessness_is_bad_for_your_health.pdf

research by CRISIS (2011)² indicates that the average age of death for a homeless person is 47 years old, 30 years younger than that of the general population.

In addition to the impact on individuals, research has started to focus on the cost of homelessness. Research by Homeless Link (2013) estimated that each homeless person represents a cost of £26,000 per year to the public fund.³ Therefore services that prevent homelessness and help a transition away from this situation will likely result in a saving to the public purse.

Deloitte (2012) found that homeless people attend A&E up to six times as often as the general population, are admitted four times as often and once admitted tend to stay three times as long in hospital due to acute health issues and complex needs. Also, one in ten homeless people who do access A&E will do so at least once a month. DoH research in 2010⁴ found that overall the total cost of hospital usage by homeless people is estimated to be £85.6 million per annum. This figure is around four times higher than the cost associated with a similar sized group of non-homeless people. The same DoH (2010) report found that inpatient costs represent the majority of the care provided to this client group, and are approximately eight times higher than for the comparison group, possibly because the homeless have an average length of stay in hospital three times as long as the general population. In total this equates to over £2,100 per person, compared with £525 for the general population (Deloitte, 2012).

A joint report by Homeless Link and St Mungo's in 2012 found that when homeless people finally leave hospital, more than 70 percent will be discharged straight back onto the streets without their housing issues being addressed⁵, which will likely result in readmission due to the conditions being adverse to recuperation.

Despite the circumstances described above, the DoH (2010) report highlighted that in 2010 only 39 percent of Local Authorities indicated that they had specific policies dictating protocol for the admission and discharge of homeless people; furthermore only 27 percent of those who are classed as homeless received help with housing before being discharged. A report by the Centre for Health Service Economics & Organisation (CHSEO) in 2011 showed that projects and models which have been implemented to improve admission and discharge practice have demonstrated cost benefits in two different ways: firstly the average length of stay will change due to a reduction in 'bed blocking' as homeless people are more likely to be discharged sooner if their housing and next steps are adequately catered for (however some may stay longer if this is deemed necessary)⁶; and secondly if patients are discharged at a clinically appropriate time and to suitable accommodation they are in a position to more ably recover from an illness, and thus there are fewer emergency readmissions to hospital within 28 days.

Previous interventions have demonstrated these potential cost savings in action. For example, at the Arrowe Park Hospital in the Wirral, a link worker was hired to ensure that those who were homeless were accounted for in policy and supported during discharge. The DoH study in 2010 found that during the year there was a fall in the number of episodes (26%), admissions (18%) and bed days (26%). The amount of delayed discharges was also reduced, saving an estimated £45,000 in six months.

² www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf

³ <http://homeless.org.uk/sites/default/files/site-downloads/Value%20of%20the%20homeless%20sector.pdf>

⁴ www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/Healthcare_for_single_homeless_people.pdf

⁵ http://homeless.org.uk/sites/default/files/attached-downloads/HOSPITAL_ADMISSION_AND_DISCHARGE_REPORTdoc.pdf

⁶ www.chseo.org.uk/downloads/nhsbrief2-homelessdischarge.pdf

Funding

BCHA received £74,350 of funding from the Homeless Hospital Discharge Fund to support the project in Plymouth, and in partnership with Shelter received £76,045 for the Bournemouth project.

Each project used the funding to support two Advocacy and Support Workers. In Plymouth the case workers were both employed by BCHA and in Bournemouth one was employed by BCHA and one by Shelter.

3. Case Study One: Plymouth Hospital to Housing Support Service

The Hospital to Housing Support Service in Plymouth was funded from April 2013; however, due to the delay in funds being received, the project's operation didn't begin until October 2013. The research found that from October 2013 to March 2014 the service received 54 referrals, all of which were contacted by the Hospital to Housing Support Service within 24 hours of the referral being made. Across the six month operational period only four clients had been readmitted to hospital (within 28 days).

How it works and its impact

Referrals

The Hospital to Housing Support Service project workers receive referrals from hospital staff. The clients could then be referred to short stay accommodation in Plymouth before receiving support to secure appropriate long term accommodation. The research found that early referrals from the hospital impact considerably on the success of their engagement with the client, as well as the final outcome. Receiving referrals within 24 hours also had positive knock-on effects for other support agencies.

Protocol

A draft multi-agency protocol was developed by project staff in order to ensure that the processes of identifying the target group were clear to agencies providing referrals to the service. Plymouth wanted their protocol to ensure everyone who is homeless or at risk of being homeless was picked up by the project. The protocol is used as a working document for the project and developing this delivery model has been a key achievement for the service. The protocol is valuable as it stands but is seen as a work in progress and requires continued strategic consideration for it to be adopted by partner agencies.

Impact on Agencies

The research has highlighted that the Plymouth service has alleviated pressure on some external agencies.

The ability of project staff to obtain vital information from clients meant that other agencies could address their needs more effectively and it also freed up some of their time.

The research also highlighted, however, that cultural differences between partner agencies, such as those that take a more medical approach, can make joint working difficult.

Impact on Beneficiaries

The support received by the service beneficiaries extends beyond support around accommodation, but also addresses some of the more complex factors that may be contributing to an individual's readmission to hospital. The research found that the project workers often support patients by re-engaging them with their GP's, mental health or drug and alcohol services.

4. Case Study Two: Bournemouth Hospital to Housing Service

As with the Hospital to Housing Support Service in Plymouth, the Bournemouth service operational inception was in October 2013. However, in Bournemouth the project was only fully operational for 4.5 months, due to the delay in recruitment for one project worker post.

The research found that the project supported 45 clients over the first six months, with an increasing referral rate over time. Over 95% of clients have been successfully supported into some form of accommodation and only one person was readmitted to hospital (within 28 days).

How it works and its impact

Referrals

As with the project in Plymouth, the Bournemouth project workers receive referrals from hospital staff. In Bournemouth, however, because there is already an existing Leaving Hospital Support Service for older people (BCHA) established within the Royal Bournemouth Hospital, the BCHA project worker was able to be located within the hospital. The support from this existing service benefitted the efficiency of the project referrals not only by providing an established work-base location for a project worker but also in terms of raising awareness of the service amongst hospital ward staff.

Impact on Agencies

The location of the BCHA project worker within the hospital aided the referral process and in turn had an impact on alleviating the pressures of hospital staff. Prior to the service being in place, hospital staff were required to refer NFA patients to the housing department themselves and this delayed the process for the patient due to other work pressure on hospital staff.

However, the service did struggle to get engagement from the A&E department. If A&E were to engage with the service the project staff would be able to assist on alleviating the workload of staff there by supporting NFA patients. Previous research highlights that similar intervention has reduced A&E admissions by 25-30%.

Impact on Beneficiaries

The project supported several clients who would have otherwise been discharged back onto the streets. The research found, however, that for the majority of clients long term accommodation was not available to them on discharge and this often meant that unsuitable emergency or bed and breakfast accommodation measures were used in the interim.

As indicated in the Bournemouth Borough Council housing banding scheme those "applications who are homeless or are threatened with homelessness" are not a top priority need in

Bournemouth (Dorset Home Choice, 2014).⁷ These applicants are listed under the silver band category and deemed as having “a moderate housing need”. This policy resulted in several challenges for the service in Bournemouth.

Readmission Rates and Cost Savings

Data on cost savings in this area generally looks at the reduction in the average length of stay in hospital and in the reduction in the readmission rate. However for this research there was only data available on readmissions.

In 2011 – 2012 the emergency readmission rate (within 28 days) for the general population in England was 11.45% (Health and Social Care Information Centre, 2013).⁸ There isn't national data on the readmission figure for homeless people although Bournemouth Hospital data for 2012/13 shows that on average each NFA inpatient patient was readmitted four times within the year. The projects also found examples of individuals reporting having previously being readmitted over twenty times in a year.

On average each unscheduled homeless patient admission costs a hospital £3,399⁹ (The University College London Hospital). Data from the Royal Bournemouth Hospital indicates that 202 inpatient hospital episodes were made by NFA patients in 2013/2014. Using the national figure of each NFA admission costing £3,399, the total cost of these patients would be £686,598. The hospital data for 2012/13 shows a higher number of NFA inpatient episodes (351) which would cost £1,193,049, demonstrating a considerable potential for cost savings if NFA readmission can be reduced.

As each Hospital to Housing Support Service project costs approximately £75,000 to run, the project needs to prevent 22 readmissions occurring to reach a breakeven point.

Evidence from the Bournemouth Hospital to Housing Support Service shows that the project experienced only one readmission out of the 45 referrals it received, representing a readmission rate of 2.2% for this sample.

It should be noted, however, that at the time of the research the project had only had both workers and been fully operational for 4.5 months and the evaluators only had six months of data so caution should be taken when analysing efficiency saving figures.

Early indications are that these projects have the potential to reduce NFA patient readmissions and consequently result in considerable cost and efficiency savings. Once the projects have a years' worth of data this can be quantified further.

5. Learning points and good practice across the two services

Hospital Engagement

The research found that the engagement of the staff on all wards was key. Referrals came through the staff and a process of face to face meetings, daily visits to the wards and paper information left on wards helped ensure the flow of referrals. The Royal Bournemouth Hospital

⁷ Dorset Home Choice (2014) Bournemouth Borough Council Housing Scheme Bands www.dorsethomechoice.org/dorset-homechoice/content.aspx?wkid=102 [Accessed 19/05/2014]

⁸ www.hscic.gov.uk/catalogue/PUB12751/hes-emer-read-hosp-28-days-disc-2002-2012-rep.pdf

⁹ <http://londonpathway.org.uk/uploads/London-Pathway-Report-1st-12-Months.pdf>

had an established discharge project and this was beneficial in terms of relationships with hospital staff and the referral processes. However, the Plymouth project had to develop a referral process and relationships with the hospital.

Location of Workers

The Plymouth project couldn't secure office accommodation at Derriford Hospital within the project timescales; however, due to having an established discharge project, the Bournemouth project had access to on site accommodation. Being located in the hospital benefitted the service by enabling the project worker to create good links with hospital staff, be on hand to answer any queries and reduce time spent travelling between sites. Just being able to pop in to see clients helped the discharge process.

Access to short stay accommodation

In Plymouth, the project had access to short stay accommodation and so didn't refer clients on to Bed and Breakfast. As well as staff on hand and peer contact, short stay accommodation can provide additional support including access to specialist GPs and additional advice. In Bournemouth there was a lack of interim accommodation available and this often resulted in clients being referred to shorter term temporary accommodation such as Bed and Breakfast, which was not necessarily appropriate for their needs. Despite a good private landlord scheme, this type of accommodation wasn't found to be suitable due to the short term notice of referrals.

Additionally, the Bournemouth project experienced challenges in gaining access to housing for clients as homeless people are not categorised as a top priority in the council's housing allocation policy, whereas in Plymouth homeless clients are banded as a priority need.

Monitoring reduced pressure on services

The projects' worked well when they had the full support of other referral agencies. The entire process involved hospital staff, project staff, Housing Options, GPs and support for drug and alcohol addiction. At the time of the two evaluations, the project had started to show signs of alleviating the pressure and workload of other agencies; particularly hospital staff in Bournemouth and Housing in Plymouth. Understanding the impact on other organisations is useful in terms of securing on-going funding, and its value has been recognised by Plymouth City Council who have recently agreed to fund the local service until April 2015. This will allow a full 12 months data set and further evidence to be presented to local and national commissioners for future service delivery and health integration.

Note

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About SERIO: SERIO is an applied research unit at Plymouth University, providing specialist social, economic and market research across the South West and beyond. Through the provision of analysis and intelligence to public, private and third sector organisations our research helps our clients make informed decisions and develop effective policy and strategy.

More information may be found at: www.serio.ac.uk

About the Housing LIN

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing Learning and Improvement Network (LIN) is the leading 'learning lab' for a growing network of housing, health and social care professionals in England involved in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults with long term conditions.

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