Cornwall Hospital Discharge Partnership Project

This case study for the Housing LIN describes a county-wide multi-agency approach to establish a Homeless Discharge project in Cornwall initially funded by an award of £65,000 from the Department of Health. Partners originally got together in 2013 in a bid to obtain grant funding to kick start the project. An official launch in March 2014 with sign up to a robust protocol was the start of an invaluable new service and lifeline for the homeless with health problems.

The protocol covers adult patients who have settled accommodation prior to admission but will be unable to return to it for medical reasons, and adult patients who were homeless or living in temporary accommodation prior to admission. Partners signed up to the protocol which aims to reduce the number of delayed discharges due to housing need, reduce the number of patients discharged to no fixed address or inappropriate housing, and improve the health and reduce inequality for the homeless.

The success of the project is through the partnership approach with a Patient Liaison Officer, Colette Jolly, as the golden thread holding and linking everyone together. There are in excess of 90 rough sleepers in Cornwall, many of whom are admitted to hospital, often more than once across the space of a year. In today's society, it is not acceptable that people are leaving hospital with no plans in place to address their ongoing care and support needs.

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Introduction

The Homeless Discharge project was set up to develop and implement a county-wide multi-agency protocol, to ensure that no patient is discharged from hospital onto the streets or back to unsuitable accommodation without their underlying housing and health problems being addressed. Partners include Shelter, Royal Cornwall Hospitals NHS Trust, Homeless Link, Public Health Cornwall, Mental Health, Cornwall Housing, St Petrocs and Coastline Housing.

Coastline signed up as a key partner to the project in 2014. The aim is that the homeless patient hospital discharge service will link acute health care and community based support, to improve the health of anyone who is homeless or unsuitably housed at the point of admission by offering them appropriate advice, assistance and support with their accommodation needs.

The key agencies joined together and achieved grant funding to launch the project and fund the key worker for an initial 12 months. Subsequent funding was attained for the provision of a number of beds under the scheme. St Petrocs have provided four flats for some time but the project needed a further two flats in 2015. St Petrocs were unable to accommodate this and the partnership approached Coastline to provide the additional two units in the Camborne, Pool or Redruth area.

Coastline was able to provide the two flats from January 2016. They are furnished and accessible. The majority of clients have high support needs due to poor health which is frequently caused by alcohol or mental health issues.

The support provided varies depending on individual client needs but on average is about 10 to 12 hours per week per person.

There is a risk that should the LHA rate apply to homeless hospital discharge accommodation, then the rent and service charge would be reduced leaving the project non-viable. If that were the case then the exit strategy would be to close the units and re-let the properties as general needs housing.

The features of the service

Since the start of the Cornwall Patient Hospital Discharge Service in January 2014, almost 450 patients have been discharged with a support plan in place, with a third of all patients discharged into accommodation.

Dedicated support to homeless patients ensures they are discharged into secure and safe accommodation, with support plans to reduce the length of stay in hospital and community support to ensure risks or re-admission are reduced.

The Impact of the Service

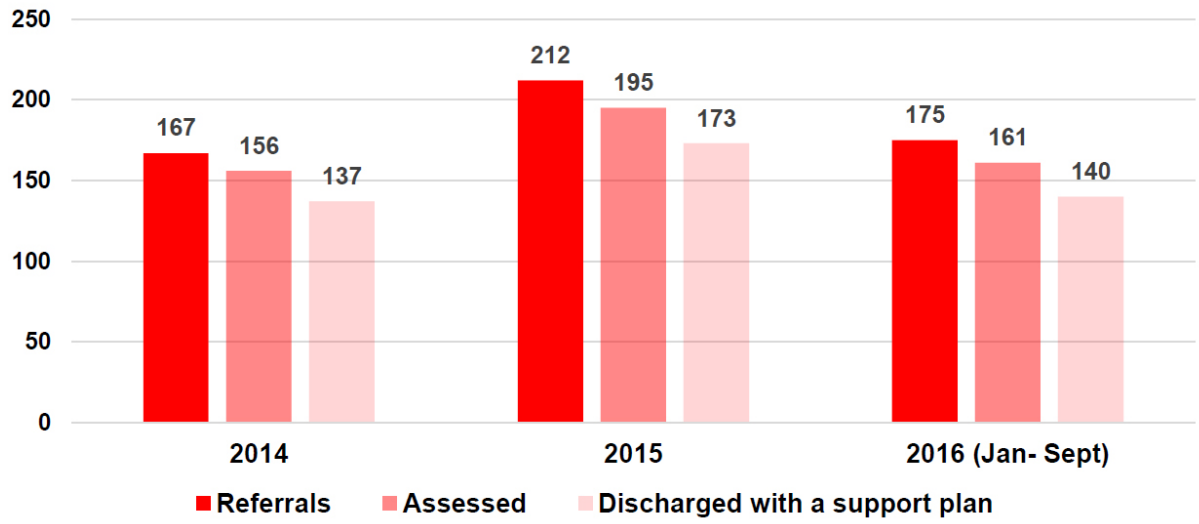
Since October 2015 over 170 patients were discharged with a support plan and over 75 into secure and suitable accommodation. Between 2014 and 2015 the service has made a cost saving of £280,500 across the Royal Cornwall Hospitals NHS Trusts.

Addressing housing needs early can prevent unnecessary and prolonged lengths of stay. Access to appropriate accommodation can reduce the risk of unplanned re-admissions and increase the likelihood of recovery from an illness. Our experience tells us that in order to sustain a home, a holistic approach that addresses multiple and underlying causes is required.

The service can significantly improve health outcomes for people who are street homeless or living in unsuitable accommodation. Without a home, clients' stability is dramatically weakened. This makes it incredibly difficult to improve their health.

The dedicated worker with a housing expertise has resulted in:

- a clear pathway in place allowing for discharge to begin at the point of admission;
- much more help and clarity around the process for those who are admitted that have no fixed abode;
- safe and effective discharge plans;
- staff being able to dedicate more time to other aspects of patient care;
- greater awareness and understanding of timescales, as well as options available to our homeless patients; and
- earlier interventions due to the changes that have been made.



Cornwall Homeless Patient Hospital Discharge Service Evaluation Report, December 2016

Key Highlights

- A third of homeless patients had suitable accommodation to go to when they were discharged between December 2014 and September 2016;
- 81% of patients were discharged with a support plan;
- 90 rough sleepers accessed the service from 2014 to September 2016. Based on the 2013-2015 rough sleeping count (182), a significant proportion of that group became known to the project;
- 13% of patients were placed in the dedicated hospital discharge accommodation; and
- 5% of patients were placed in supported accommodation.

Case Studies

ROH & TL - HDP Case Study

TL is a 52 year old White British Male and ROH is a 45 year old White British Female. TL and ROH had been living in a car for a number of weeks after finding themselves homeless. TL had been admitted to hospital following a severe asthma attack and a collapsed lung. It was at this point that Shelter became aware of the couple's situation and made a referral to Coastline's Hospital Discharge Project (HDP). Coastline accepted the referral and made provision for ROH and TL to be accommodated as a couple. ROH and TL moved into the HDP on 28th November 2016.

Once in HDP, support staff linked TL in with the Health for Homeless Team (H4H) situated within Coastline's daycentre as a matter of urgency, as it became apparent that TL's health was deteriorating. Support staff facilitated transport to enable TL to attend various hospital and GP appointments. TL was finally diagnosed with a cancerous tumour in his bronchial tree which was blocking his airway, the treatment for which would require an operation on the tumour and a course of radiation therapy.

TL and ROH's bed at HDP remained open while TL was admitted to hospital on various occasions for surgery and treatment. Staff provided transport to hospital for ROH to visit TL as well as linking the couple in with the Transport Access Patients service. Throughout this time emotional support for ROH was provided and support was available in the evenings and weekends.

To enable TL to remain at the property rather than in hospital, staff worked in partnership with the H4H GPs to ensure a hospital bed was provided for TL and that regular home visits from a GP were in place. Staff liaised with social services regarding a care package being put in place to ensure TL's care needs were met and in an attempt to reduce the strain on ROH who was completing the majority of TL's care. Links to Macmillan were made to provide additional guidance and support.

On accessing HDP neither client had benefits in place. With the support of staff they successfully applied for Housing Benefit, ESA, PIP and Carer's Allowance. Support staff ensured that while waiting for the outcome of their benefit applications the couple had access to the local food bank and clothes from the donation store at the daycentre. The couple have also been supported to apply for a Debt Relief Order to assist with their previous debt.

Due to TL's ongoing health/care needs, Coastline have extended the time TL and ROH can reside at the HDP which is usually a six week stay. Support staff are currently actively seeking appropriate move on accommodation, working closely with the Housing Options team and have confirmation that TL and ROH are eligible for a deposit/rent in advance. Staff have also assisted the couple to register on Homechoice and Coastline's HomeHunt scheme.

Without the HDP service, the outcome for the couple may have been very different. There is the possibility that the couple would have remained living in their car and TL's diagnosis may have been further delayed or not discovered at all. As a result of accessing HDP the couple have been provided with the appropriate support regarding their health/care needs, have received vital emotional support, have been able to access benefits and start reducing their debt.

HDP Case Study – EJ

EJ is a 34 year old White British Female.

EJ has been in and out of crisis accommodation over the past few years with various providers. She has a history of complex mental health needs for which she has received support from local mental health services. While in council provided B&B accommodation EJ attempted suicide which led to her re-admission to Bodmin Mental Health Hospital. During her stay, Shelter made referrals to supported accommodation providers including Coastline's Hospital Discharge Project (HDP). EJ's referral was accepted by Coastline following her being declined by all other providers in Cornwall.

EJ moved to the HDP on 5th December 2016. Coastline allowed EJ to bring her dog with her to the property as it was identified that leaving the dog would be very detrimental to EJ's mental health. When EJ first arrived at HDP she was very reliant on mental health services and the support of Coastline staff, requiring constant re-assurance. Support was provided throughout the week by supported accommodation staff including evenings and weekends and included both emotional and practical support.

Staff made daily visits and phone calls to EJ to provide emotional support. Through this support EJ's emotional health has improved, resulting in her relying less on the support of staff and becoming more independent. EJ has started engaging with activities delivered by Coastline, taking great enjoyment in attending the weekly art workshops. As a result EJ has sourced an art course with a local college and enrolled herself on this. This is a really positive step forward for EJ. She has also re-connected with her father and appears to be re-building their relationship, spending more time with him and building social networks.

Staff have also ensured that EJ has linked in with appropriate mental health services and registered with a local GP. Staff have referred EJ to CAB regarding debt advice and ensured that she is claiming the correct benefits. In regards to move on accommodation, EJ is currently in band B on Cornwall Homechoice and is actively bidding on properties. Support staff have been working closely with Shelter and Cornwall Council to secure independent accommodation for EJ. As a result of this partnership working there is a self-contained flat currently pending with the council for EJ which is a great positive outcome and a real shift to independent living.

Note

The views expressed in this paper are those of the author and not necessarily those of the Housing Learning and Improvement Network.

Acknowledgments

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About the Housing LIN

The Housing LIN is a sophisticated network bringing together over 40,000 housing, health and social care professionals in England and Wales to exemplify innovative housing solutions for an ageing population.

Recognised by government and industry as a leading 'knowledge hub' on specialist housing, our online and regional networked activities:

- connect people, ideas and resources to inform and improve the range of housing choices that enable older and disabled people to live independently
- provide intelligence on latest funding, research, policy and practice developments, and
- raise the profile of specialist housing with developers, commissioners and providers to plan, design and deliver aspirational housing for an ageing population.

For information about the Housing LIN's comprehensive list of online resources on housing and homelessness, visit:
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