EVALUATION OF THE HOMELESS HOSPITAL DISCHARGE FUND

JANUARY 2015
# Evaluation of the Homeless Hospital Discharge Fund (HHDF)

## Contents

**Summary and recommendations** 3

**Section 1: Background and report outline** 8
  1.1 Introduction and context
  1.2 Methodology
  1.3 Homeless hospital discharge typologies

**Section 2: Partnership working** 13
  2.1 Project set up and promotion
  2.2 Embedding pathways and protocols
  2.3 Identifying and accessing patients
  2.4 Improving outcomes for clients

**Section 3: Patient experience** 27
  3.1 Client group
  3.2 Experience of hospital
  3.3 Experience of hospital discharge process
  3.4 Client experience of support
  3.5 Suitability of accommodation

**Section 4: Project outcomes and cost** 38

**Section 5: Long term sustainability** 40
  5.1 Continuation funding
  5.2 Integration with health and housing services

**Section 6: Recommendations** 43

**Appendices** 45

Appendix 1: Full list of project typologies
Appendix 2: Outcomes data request from Homeless Link
Appendix 3: Example hospital discharge protocols

**PRODUCED BY**
Homeless Link’s Policy and Research Team

**ACKNOWLEDGEMENTS**
This report was commissioned by the Department of Health. We would like to thank all the project staff and clients who took part in interviews and shared their experiences during the evaluation.
Summary and recommendations

Summary

Homeless Link was commissioned by the Department of Health to evaluate a £10 million programme allocated to the voluntary sector to develop pilot projects to improve hospital discharge procedures for homeless patients. The aim of the evaluation was to examine the programme as a whole rather than outcomes achieved by individual projects.

This report presents these findings. It has examined the different models that have been developed, their outcomes and feedback from clients and staff on their experiences of the projects. The evaluation was carried out from February to July 2014 and has conducted telephone discussions with staff from all 52 projects to clarify project set up, 30 semi-structured interviews and one focus group with clients using the service, an online survey with staff working on the project, nine semi-structured interviews with staff and a commissioner in the area, outcomes data collection and cost effectiveness analysis.

A total of 52 projects received a share of £10 million from the Department of Health in September 2013. Projects were to be delivered by the end of March 2014. Projects can be categorised into nine typologies. These are: i) Housing link worker (22 projects); ii) nursing link worker; (2 projects) iii) housing and nursing link workers (4 projects); iv) pathway model (6 projects); v) housing link worker and bed spaces (8 projects); vi) nursing link worker and bed spaces (2 projects); vii) housing and nursing link workers and bed spaces (1 project); viii) pathway model and bed spaces (2 projects); ix) accommodation only (5 projects).

Overall the 33 projects who returned complete data produced the following outcomes: 69% of patients were discharged into suitable accommodation out of total discharges; 55% of patients received health support on discharge; 58% of patients received housing support on discharge; and of those patients that were admitted into hospital, only 28% were readmitted within 30 days of a prior admission. Complete data was not available or provided by some projects. While some areas had baseline data, there was no consistent baseline data available to compare this to homeless patients’ outcomes prior to the projects starting.

The evaluation found that the success of projects is largely dependent on good relationships and effective partnership working with a range of agencies from the project inception. 85% of projects that responded to the staff survey reported that liaison between their project and other organisations went ‘very well’ or ‘quite well’. Where partnerships and multiagency working were already established staff reported better working practices, in particular pathway models were effective in this way.

Partnership working is divided into four main areas:

- **Project set up and promotion** – One of the requirements to receive funding was that partnerships were established across health and housing. Those projects with existing partnerships prior to bidding for funding were more inclined to promote better working practices. Those that had no existing relationships prior to submitting the bid often struggled to start on time, were slow to get referrals and faced problems with recruiting staff with the specialists skills required. Once projects were established they needed proactive promotion by both housing and health staff to raise awareness and remind people to refer to the projects. Where projects faced challenges it was often in large hospitals or where projects were working across large geographical areas.
Embedding pathways and protocols – More effective pathways used one clear referral route for clients and would have a single point of contact. 39 out of the 41 projects that responded to the survey had either produced a new or had developed an existing homeless hospital discharge protocol. Some projects reported data sharing problems, experiencing resistance to data sharing and there were limits to staff accessing IT systems within hospitals. In other cases information could not be shared outside the hospital, including with accommodation projects such as hostels or temporary accommodation. Despite this, 29 out of 41 project respondents said that they had improved data sharing or had a data protocol in place by the end of the project.

Identifying and accessing patients – 84% of projects felt that they worked ‘very well’ or ‘quite well’ with local hospitals. Good practice examples included attendance at hospital team meetings, participating in ward rounds, having a member of the hospital discharge project staff based at the hospital and participating in training for hospital staff. Where there were challenges in getting to and working with patients this was usually where hospital staff were reluctant to engage with the project due to their short term nature. Staff also struggled to get access to the wards, or could not find a workspace at the hospital, or there was lack of awareness that the project existed.

Improving outcomes for clients – The majority of survey respondents to the staff survey (70%) reported that the process of accessing accommodation for clients worked ‘very well’ or ‘quite well’. Temporary accommodation was easier to secure than long term options and this was largely dependent on the local housing market (problems were most acute in London and the South East) and the relationship that projects had secured with local authority housing departments or local housing providers. Access to benefits such as the hardship fund or rent deposit schemes also helped projects secure longer term accommodation options for clients on discharge from hospital. Projects that were linked to accommodation were able to discharge higher proportions of clients into suitable accommodation. Similar to other single homeless people, those clients in the projects faced a number of barriers including non-priority need, history of rent arrears, no local connection, lack of suitable accommodation due to multiple needs or dual diagnosis, high support needs, physical health needs (i.e. ground floor access) or lack of affordable accommodation in the area.

Whilst most projects worked with rough sleepers and those with multiple and complex needs, in addition they were also working with newly homeless people or those at risk of becoming homeless when entering hospital. In some cases patients who were admitted to hospital had already tried to access accommodation through their local housing options or homelessness team and had been refused help. The project or link workers were then brokering a role with the local authority housing team during the hospital admission to secure suitable accommodation on discharge.

Overall, clients reported a positive experience whilst in hospital, which is in contrast to the findings of a report by Homeless Link and St Mungo’s in 2012, *Improving hospital admission and discharge for people who are homeless*, which found that many clients felt poorly treated by hospital staff because of their homelessness, or because of substance misuse problems. The experiences shared for this evaluation included not feeling judged or being prejudiced either because they were homeless or because they had been admitted into hospital for health reasons linked to their substance misuse.

The hospital discharge process was a slightly more mixed experience. The clients that spoke to us about positive experiences were supported through the discharge process, received sufficient notice about when

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1Homeless Link and St Mungo’s, *Improving hospital admission and discharge for people who are homeless*, March 2012
they were going to be discharged and where they were going. Having a clear housing outcome was key in reassuring the client about their discharge process. Where people reported a negative experience of their discharge this was often down to a breakdown in communication by hospital staff. The client was either not told when or where they were going on discharge or the staff didn’t know until the last minute and the process felt rushed and could cause some distress for the client.

The range of support provided to clients by projects varied. Out of the 41 projects that responded to the survey all of them provided an assessment of the client’s needs, 33 provided advocacy and support, 21 provided medical support after discharge and 7 provided peer support. Where support on discharge was provided this on the whole was intensive and personalised in nature which many clients described as a ‘lifeline’. The support included housing related support such as helping to set up housing and other welfare benefits, but also health and wellbeing support including ensuring GP registration and accompanying people to doctors and hospital appointments, getting prescriptions and linking people to adult social services, counselling and in-house care.

17 out of 41 projects reported receiving extra funding to continue their project beyond the life of the DH grant. Out of these only one had received funding which exceeded the Department of Health level, seven received comparable funding to the level they had received and seven had received less. Most of the projects that had secured continuation funding had done this through partnership working across health and homelessness teams in their area. This included setting up a working or steering group, putting in joint bids and establishing strategic joint working processes at the governance and operational levels. Partners that were included in this process included the Clinical Commissioning Group (CCG), commissioner for drugs and alcohol, adult social services, NHS trusts, local authority housing or homelessness team.

The short time frame of the projects also meant that applying for funding was difficult. In successful cases they started making contacts and looking for alternative funding almost as soon as the Department of Health grant had been awarded. At the time of the evaluation, four projects were still yet to get underway or were still in very initial stages of delivery, and as such data from these projects was not available for inclusion.

Recommendations

Based on the findings from the evaluation, the following recommendations are included to inform future planning and delivery of initiatives to improve homeless people’s discharge from hospital.

Future investment

- Future investment of hospital discharge projects and arrangements should be jointly commissioned by a range of health, housing and adult social care partners. There are clear benefits to CCGs, Public Health, local authorities and other partners combining resources to maximise sustainability and ensure arrangements are delivered and understood by all partners working in health, housing and adult social care.

- Local commissioners should consider longer term funding (i.e. greater than 6 months) when commissioning new hospital discharge projects. This would reflect the time needed to recruit and train staff, set up partnerships and embed practice. Capital expenditure programmes for intermediate or respite care facilities can provide much needed accommodation options for those leaving hospital, but in particular need longer lead in times to secure, purchase, refurbish or build suitable accommodation.

Effective practice
Based on the evaluation, components of effective models for future replication include:

- Integrating housing and clinical staff into the discharge team. Better outcomes and more positive working practice were reported where both a housing and nursing link worker was in place.

- Having a model which combines access to accommodation alongside link workers. Outcomes data showed that where this was available, more clients were discharged into appropriate accommodation (93% compared to 71% overall). We recommend a model where either accommodation is linked to the project set-up (either bespoke units or ring-fenced beds in existing projects) or they have links already established with a local housing provider or rent deposit scheme so suitable accommodation can be easily accessed.

- Enabling better communication and engagement with patients by hospital staff at the point of discharge. Patients were less anxious and described a more positive experience when they were told about being discharged at least 24 hours before it took place. This should include the details of the accommodation they are being moved to, the exact time of discharge and the transport arrangements which have been put in place. This should also apply when patients are being moved from one hospital facility to another.

- Making intensive support available for clients once they have found accommodation is important to improve their recovery and discharge process. This should include a full assessment of client’s needs, a package of housing related and health support to increase tenancy sustainment and improve health outcomes.

- Clarification of the client group that projects are intended to work with (i.e. rough sleepers, those at risk of homelessness, groups with specific needs such as mental health or substance misuse issues, hostel residents). Referral processes and protocols should be tailored according to target these groups.

**Partnership working**

- Partnerships need to be secured from the outset of any future approaches. There needs to be a commitment to multi agency working from developing proposals right through to ongoing delivery and plans for tendering or securing continuation funding.

- Promotion and integration of the project needs to occur across different strategic levels. This should include integration into the local area’s overall health and wellbeing agenda and strategy, and reflected in the health priorities for the area. On the ground this should include training and awareness of the homeless hospital discharge protocol, regular multidisciplinary meetings, access to all hospital wards for project staff and clear information available on the project remit and how and where to refer patients.

- Stronger links should be forged with Adult Social Services. Projects most frequently reported difficulties with social services and issues included the need for clarity on thresholds, problems getting social services to take responsibility for clients that needed social care, and a reactive rather than proactive approach. This could be achieved by hosting part of the project within a local authority setting.

**Information sharing**

- There needs to be agreed practice about how homeless patients will be identified and recorded from the earliest point of contact in hospital so that support can be coordinated throughout the different stages of the discharge pathway.
Partners need to have an agreed set of monitoring data to collect so that outcomes can be demonstrated more effectively. This needs to be collected on an ongoing basis to provide baseline data as well as show outcomes and effectiveness. At a minimum this needs to include number of hospital admissions and readmissions or contact with hospitals to receive healthcare, length of stay in hospital, accommodation status on admission, accommodation status on discharge, if they are receiving ongoing housing or medical support post discharge.

Information sharing agreements need to give project staff access to appropriate IT systems so that client data can be shared safely effectively from the outset of the project.

Consent from patients to share data should be incorporated into admission protocols to help improve data sharing agreements and remove barriers for staff working outside of hospitals.

Staff training

More intensive work and training for A&E staff is needed to mitigate against the high turnover and shorter contact time with A&E staff. The creation of a homeless champion with the A&E department could be one way of achieving this.

Training with hospital/medical staff needs to be included as part of the project set up to help define the client group, definitions of homelessness and sharing of key housing and homelessness contacts.
Section 1: background and report outline

1.1 Introduction and context

Homeless people have poorer health outcomes than the general population, and an average age of death 30 years below the national average.\(^2\) Living on the streets or without a stable home can make people vulnerable to illness, poor mental health and drug and alcohol problems.\(^3\) Homeless people often seek medical treatment at a later stage during illness, leading to costly secondary health care and worsened health outcomes. Exacerbated by this is the reduced potential for recovery due to many homeless people returning to insecure accommodation or even rough sleeping after medical treatment. In some cases, accommodation may be lost during hospitalisation, resulting in a decline in a patient’s housing situation on discharge.

The circumstances described above clearly reflect the impact of a lack of access to appropriate healthcare and housing on a marginalised group. The impetus to address these issues are driven by both the need to reduce inequality and to lessen the inflated costs that delayed healthcare and poor housing inevitably lead to further down the line. Research carried out in 2010 showed that the total cost of hospital usage by homeless people is estimated to be about four times higher than the general population.\(^4\) Looking at inpatient costs only, the difference is eight times higher among homeless people.

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)\(^5\); 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.

Despite the social and economic benefits, only 39% of local areas in 2010 indicated that they had specific policies dictating protocol for the admission and discharge of homeless people.\(^6\) Furthermore, only 27% of those who were classed as homeless received help with housing before being discharged.\(^7\)

To help address this, the Government’s first report from the Ministerial Working Group on tackling and preventing homelessness, *Vision to end rough sleeping: no second night out nationwide*, included a commitment to improve hospital discharge for the homeless.

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\(^3\) Homeless Link, *The Unhealthy State of Homelessness*, 2014 [http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf)


\(^6\) Homeless Link 2010. The survey was sent to all Local Authority Housing Leads as well as Public Health Directors. Results based on 141 responses.

As a first step, Homeless Link and St Mungo’s were commissioned by DH to explore how the system of hospital admission and discharge was working for homeless people, and what more needed to be done to improve where the system is failing to discharge homeless people into appropriate accommodation.

The report, *Improving hospital admission and discharge for people who are homeless*[^8], published in May 2012, showed that more than 70% of homeless people had been discharged from hospital back onto the street, without their housing or underlying health problems being address. This was further damaging their health and increasing costs to the NHS through ‘revolving door’ admissions.

In order to address this, the Minister for Public Health, Anna Soubry MP, announced Government investment of £10 million in May 2013 for the Homeless Hospital Discharge Fund. The Fund was open for voluntary sector organisations, working in partnership with the NHS and local government, to bid for money to improve hospital discharge procedures for people who were homeless. Bids were invited for both capital and revenue funding to secure appropriate facilities for those requiring ongoing medical support after hospital discharge and specialist training and support for homeless people leaving hospital.

The Fund has been specifically designed to support the set-up of innovative, voluntary sector-led projects. The Fund has two overarching aims which are to:

- Ensure safe discharge from hospital after treatment
- Secure appropriate facilities for those requiring ongoing medical support after hospital discharge to allow time for recovery.

A total of 52 projects were provided with funding, with projects intended to commence in October 2013 and run for a total of six months until the end of the financial year. The Department of Health recognised the challenge of delivering projects within a short time frame but a key determinant driving this was the policy intent to make progress in improving discharge arrangements for homeless people.

Homeless Link was commissioned by the Department of Health to evaluate these projects, considering how they had performed against their intended objectives and their cost effectiveness in terms of their outcomes. This report comprises of the findings from this evaluation. The evaluation was not intended to evaluate each individual project, but rather looks at the different models that have been developed (typologies), what these cost, and the outcomes associated with each model. The evaluation also incorporates feedback from clients and staff on their experiences, and provides recommendations for future development of homeless hospital discharge projects.

The evaluation report is split into a six sections. Section one sets out the nine typologies identified from the 52 funded projects and their structures. Section two examines the partnership and multiagency working between housing and hospital staff and explores the challenges and good practice developed during the projects. Section three looks at the support provided to clients as part of the hospital discharge process and evaluates the client experience during their hospital stay and after they have been discharged. Section four looks at the project’s outcomes and costs. Section five examines the long term sustainability of the projects and progress after the funding stream has ended. Finally section six sets out recommendations for the development of appropriate hospital discharge arrangements for homeless people in the future.

[^8]: Homeless Link and St Mungo’s, 2012 [http://www.homeless.org.uk/sites/default/files/site-attachments/HOSPITAL_ADMISSION_AND_DISCHARGE_REPORTdoc.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/HOSPITAL_ADMISSION_AND_DISCHARGE_REPORTdoc.pdf)
1.2 Methodology

On the award of the contract the evaluation was carried out during February to July 2014 and data collection comprised of the following:

- Telephone discussions with staff from all 52 projects to clarify set-up, determine progress and discuss the evaluation.
- 30 semi-structured interviews and one focus group with clients who have been involved with projects.
- An on-line survey sent to all project contacts and forwarded to other relevant staff exploring what worked well and what could be improved. Responses were received from 48 members of staff representing 41 projects (79% representation of all projects that received funding).
- Eight semi-structured telephone interviews with staff to discuss in detail issues raised in the online survey and one interview with a Public Health commissioner who had funded a year continuation of the hospital discharge project in their area. More commissioners were approached to complete interviews but they declined to participate due to time constraints.
- Data collection from projects on their outcomes. Returns were received from 38 projects (73 % representation of all projects that received funding), where missing projects had either not started, had delayed starts or had not collected data.
- Cost-effectiveness analysis using outcome returns data and actual expenditure reports. Complete records were available from 26 projects in total (50% representation of all projects that received funding).

There are some constraints that need to be noted as part of the evaluation in relation to the projects timings, set up, quality of the data and methodology. Firstly some projects were delayed in starting. Whilst funding was originally given for six months some received extensions and were still running when the evaluation was being carried out, others had only been up and running for as little as two months and in four cases the projects had not been started at all at the point the evaluation was being carried out. This has been taken into consideration throughout the evaluation, but can complicate comparison of the typologies.

Secondly, the quality and completeness of outcomes data varied greatly. The cost effectiveness analysis could only be carried out with data from 26 projects due to non-returns or incomplete data. Thirdly, recruitment of clients to take part in interviews was secured by project staff, whilst their experiences varied it was not designed as a representative sample and it should be noted that there may be a skew towards more engaged clients. Finally, telephone interviews with staff were from a self-selecting sample and may be biased towards staff who worked on the more successful projects and wanted to share their positive experiences.

1.3 Homeless Hospital Discharge Typologies

Nine main typologies were derived from the 52 project and are outlined in figure 1 and table 1 below (full details can be found in appendix one). The projects were categorised into typologies reflecting how the funding was being used to deliver the project. When categorising the projects, primary consideration was given to the type of staff employed and whether funds were used to secure temporary accommodation for clients post-discharge. After data collection was completed some projects were assigned to different typologies based on further information and whether the funds had been used as initially intended.
Projects with funding to purchase accommodation only tended to be associated with projects employing project workers (four out of the five projects). However, they were categorised separately for two reasons; although associated they were separate bids with separate funding, and most of the accommodation projects were not operational at the time the evaluation took place. The associated projects were therefore unable to use the accommodation initially and in terms of outcomes are comparable instead to projects without accommodation provision.

Funding allocated to the projects ranged from £19,702 to £3,664,902. Projects varied significantly in terms of the target client group, scale and size, resources available, geographic spread (some were working in more than one local authority area), partnership arrangements and the health and housing contexts they were working in. Smaller projects had been allocated money to develop protocols and working practices that could be integrated into existing services once the funding had finished, whereas larger amounts of money went to capital expenditure projects which were purchasing accommodation, or refurbishing existing facilities to provide respite care. The types of activities projects were involved in included:

- Help to access primary care services
- Assistance in identifying and accessing temporary and permanent accommodation
- Individual patient assessment plans
- Housing and health related floating support on discharge
- Volunteer peer advocates
- Admissions and discharge protocols
- Training for NHS staff on homelessness issues
- Rehabilitation centre
- Respite and intermediate care facilities
- Refurbishing accommodation for patients being discharged
- Developing a patients’ charter
- Ring fenced hospital beds
- Aftercare outreach service
- Production of promotional material and information
- Data collection
- Relationship building
Figure 1: Homeless Hospital Discharge Project Typologies

Table 1: Homeless Hospital Discharge Project descriptions

<table>
<thead>
<tr>
<th>Typology</th>
<th>Description</th>
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<tbody>
<tr>
<td>Housing link worker(s)</td>
<td>Link workers with a housing background aim to bridge the gap between hospitals and homelessness accommodation, and may have referral rights into local hostels or temporary accommodation. Where possible, they assess a client while in hospital and then refer the client to appropriate accommodation and other support services.</td>
</tr>
</tbody>
</table>
Section 2: Partnership working

The success of projects was largely dependent on good relationships and effective partnership working with a range of agencies from project inception. Partners included a range of agencies involved at the front line and strategic level; for example health and wellbeing boards, adult social services, private landlords, hospitals, CCGs, local authority housing teams, social landlords, mental health teams, drug and alcohol teams, GP and primary care, public health. Where partnerships and multiagency working were already established, staff reported better working practices and in particular pathway models were effective in this way:

“We have excellent relationships with ward staff and the hospital based social work team. Prior to the establishment of our service and the [name of project] service hospital staff were regularly faced with enormous difficulties in finding appropriate referral routes and this resulted in people being discharged on to the streets or inappropriate accommodation. These staff are extremely appreciative of our service and this enhances good working practices and communication.”
“this [client referral] worked well because our partner agency already has an established discharge service at one of the hospitals we worked with. They had all the necessary contacts, were based in the hospital and knew the local systems there which saved us a lot of start-up time”

Three quarters of survey respondents reported that liaison between their project and other organisations went ‘very well’ or ‘quite well’. Only one respondent felt that relationships were ‘very poor’ (Chart 1). Furthermore, an even larger majority (85 per cent) reported that through their project they had improved liaison and developed better working relationships with organisations.

Chart 1: Thinking about liaison between your project and other organisations, how well did this work?

源: HHDF staff survey
N=41

Positives reported by projects included establishing strong relationships, building on existing ways of working, and clarifying roles and responsibilities. The benefits of these improvements were assumed to continue after projects with no further funding had come to an end.

“Initially slow, but became really good with regular phone conversations and meetings taking place. There was initial difficulty establishing which organisation had an obligation to provide what service i.e. housing and nursing care following discharge but things improved. Bringing people from different disciplines together has been great despite some tension initially. Working together in this way enabled the sharing of actions and responsibilities which can only be positive”

Working with GPs was seen as important for ensuring support for clients when they left hospital and preventing unnecessary A&E attendances.

“Links to GPs was also a strong factor in ensuring set-up and support on discharge”

“The [area name] Borough has a specialist G.P for Homeless clients; where clients do not need to provide a permanent address to gain access to a G.P. This meant clients were able to see a doctor to access necessary prescriptions on discharge or access to other necessary treatment without unnecessary A&E visits.”
Problems engaging with other agencies was one of the most common challenges reported by staff and was frequently cited as an area for improvement. Dependent on how the project had been set up and who the lead partner was affected which agencies were difficult to engage with, for example some housing link worker projects reported challenges engaging with local hospitals, other projects described barriers in working with local authority housing teams to access accommodation in the area. Support from other agencies was required throughout the lifespan of projects, and can be divided into four main areas: project set up and promotion, embedding pathways and protocols, identifying and working with patients and improving accommodation outcomes for clients (see table 2).

This section examines the challenges and effective practice and challenges identified by project staff under these four subsections.

**Table 2: Summary of partnership working**

<table>
<thead>
<tr>
<th>Project set up and promotion</th>
<th>Buy-in from a range of agencies was essential in order to establish projects and get them set up and running. The benefit of the pathway model was apparent at this stage as projects already benefited from the support of key partners. In other cases relationships had to be initiated or developed, delaying the point at which projects were able to get off the ground.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embedding pathways &amp; protocols (includes data sharing)</td>
<td>There was considerable variation in terms of existing protocols and agreements regarding hospital discharge for homeless patients. In most cases however, projects aimed to develop protocols and relied on the co-operation of medical staff to ensure they became operational. There was also variation in terms of protocols and agreements around data sharing.</td>
</tr>
<tr>
<td>Identifying and accessing patients</td>
<td>Projects relied on suitable patients being referred to them, and on being able to work with patients prior to their discharge. Buy-in from hospital staff was again essential for this to occur. Project workers with nursing backgrounds had a notable advantage in these cases where they were more readily able to obtain support from clinical staff.</td>
</tr>
<tr>
<td>Improving accommodation and support outcomes for clients</td>
<td>In order to support clients and meet their needs, project workers depended on effective relationships with local housing providers and other health and social care agencies for a range of reasons; referring clients to floating support and outreach services after discharge, accessing accommodation and primary care for clients.</td>
</tr>
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</table>

### 2.1 Project set up and Promotion

**Effective practice**

Strategic buy-in from a number of organisations meant that some project workers were able to forge positive relationships with key members of staff quickly and easily. This was notably the case for projects that adopted a pathway model, and for projects that were able to gather support from other agencies at the bid writing stage. The quick turnaround required for submitting a bid may have been prohibitive for some projects, but such an approach would be recommended for future bids. In particular, support from medical professionals helped establish the project and encourage hospital buy-in from the beginning:

“I do think having a qualified medical person setting up the project helped and paved the way for project workers going forward.”
“Due to the original bid of the role from a combination of Hospital and Community NHS staff with the involvement of members of the Complex Discharge Team and leads in the Social Work department the role quickly and easily formed strong relationships with key members within the hospital and support services in the community. This allowed for a positive working environment and strong communication across key teams who engage with those who are homeless on discharge.”

Other projects were able to establish relationships fairly easily after projects had started. Frequently, respondents reported that hospitals were willing and able to engage with projects. Having the project championed by senior members of hospital staff, e.g. consultants or CEOs, was highly influential in gaining support and effective communication with different agencies and members of staff across these groups was also essential:

“The hospital has been very welcoming, information across all departments, training of teams within the hospital; there has been a lot of willingness to engage and support this service’.

“Good use of internal communication mechanisms proved effective at sharing the objectives of the new team and why we needed hospital staff on board to help us achieve them.”

In order to win support for their projects, staff worked hard to promote what they were doing. A number of methods were adopted for awareness-raising. Successful projects seemed to combine different approaches and promoted throughout the duration of the project. A reoccurring challenge was the need to promote projects not only when they were launched, but on an ongoing basis. Respondents reported that hospitals need frequent reminding about the project and about the correct protocol to follow for homeless people. Reminders were particularly necessary for large hospitals and in cases of high staff turnover.

“Liaison with the local psychiatric hospital remains a challenge mainly due to recent service re-modelling and staff sickness. Talks have begun again.”

“Initial referrals were slow - clients not being identified as homeless via hospital staff. Ongoing efforts to promote service through nurses and hospital staff and to identify homelessness in patients. More frequent referrals at present following this - continued effort is needed”

Furthermore, awareness needs to be aimed at several levels, from management to practice staff. The requirement for continual promotion can be taxing for projects where resources are limited, or where promotion was assumed to be required for the early stages of the project only. The following are examples of successful approaches:

- Actively promoting project four weeks prior to opening
- Letters introducing the project sent to key people prior to project start
- Speaking to key groups of staff and having initial ward meetings with current ward staff
- Training sessions with hospital staff e.g. ‘homelessness awareness sessions to discharge coordinators and ward staff’
- Presentations to hospital staff about the project
• Advertising in all relevant areas; wards, A&E, discharge lounge, patient advice and liaison service (PALS)

• Posters, leaflets and contact cards displayed

• Comprehensive information provided about the project e.g. all wards having leaflets, contact details and a comprehensive folder with eligibility criteria and supporting paperwork

“More homeless referrals were made to the service. The worker and myself promoted the service daily around the hospital as well as organised access via the hospital IT dept a daily NFA activity on the computer which is refreshed every 30 minutes, this enabled us to know where all NFA patients are throughout the hospital and in A&E dept. The worker was then able to contact ward and flag up to staff to ask patient if they would like a referral made to the service which worked very well and increased awareness to all wards.”

“[in response to positive patient referral processes] Having the workers based within the local authority housing department. Having Hospital Liaison Nurse at [name of hospital]. Both projects require continued presence on wards and promotion of service.”

By the end of the pilot projects, 91% of survey respondents reported that their project had improved awareness and understanding of homeless people’s needs among hospital staff.

Challenges

The short time period to set up and establish projects once funding had been allocated caused problems for a number of projects.

“a six month project I think is an incredibly tight time scale to get a project up and running.”

Linked to this were issues with recruiting staff to projects quickly enough to enable them to start and provide the specialist skills and knowledge that was required to work within both a health and housing context.

“A two week lead in time to mobilise the pilot was not realistic. This was a two year project that essentially had to be delivered in six months. This required additional resources and a huge commitment from the staff involved. Six months also gave us little time, post mobilisation to prepare for the funding cliff edge at the end of March (which is now August as the DH agreed us to roll over a slight underspend till the end of summer).”

For some projects, getting their local hospital(s) to support their pilot was a challenge. This could be due to logistical issues, for example, working with large hospitals or covering a wide geographical area. Large hospitals required more time for communication and ensuring that all wards and staff were on board and knew what to do:

“Contact with each of the wards is difficult due to the size of the hospital and numbers of staff — this has on occasion led to late referral of patients who are homeless and this coming to the attention of the necessary coordinators at a late stage, resulting in the necessary planning being far more difficult. We are looking at how we can improve this.”

In some cases, a lack of support was attributed to resistance towards the project on the part of individual staff members, or departments. A couple of projects reported that hospital staff resisted engaging with the projects. Several projects reported that they had lower numbers of referrals than expected from A&E and this was partly attributed to a lack support from staff who either were unaware of the projects, did not see their use or saw them as a short term option due to their limited funding period. If patients were not referred from A&E then
they were more at risk of slipping through the net and being discharged back on to the street especially if they were not admitted to other wards in the hospital. For those that are admitted to other wards on the hospital the delay in referring patients to projects meant that valuable time was lost especially if sourcing and securing appropriate discharge accommodation was problematic in that area.

“The main enduring barrier has been referrals not being made until a patient is on a ward. The A&E and MAU [Medical Assessment Unit] wards rarely make referrals and they should be able to capture this information on admission.”

Where A&E were responsive and willing to work with projects, referrals were quicker leading to a better service.

“The relationship with the A&E Department has worked very well, with daily contact and swift identification of people who are homeless and possibly requiring support and intervention of our hospital discharge worker. This is assisting in earlier contact at the start of the admission.”

The main implications of a lack of buy-in were time and resources spent on promoting the project, and a smaller number of referrals than expected. Trying to get the message across and build relationships was a time-consuming process that delayed some projects getting started; in some cases projects were just gaining momentum by the time the funding came to an end.

“We certainly received a lot less referrals than anticipated and a lot of the first part of this project was taken up with developing communication and getting the right information to the right people. This took far longer than anticipated”

Most of the accommodation only projects (i.e. capital expenditure) had not opened their accommodation at the point the evaluation was undertaken. Four out of the five accommodation-only projects were linked to revenue expenditure projects and link workers but they had not opened the accommodation at the point the revenue projects were running due to the time needed to secure or refurbish accommodation. In one case the project had not started at all due to problems with finding hospital space that was both affordable (in terms of leasing or costs associated with refurbishment) and near to the hospital and in the local catchment area.

| Table 3: Summary of good practice and challenges of project set up and promotion |
|---------------------------------|-------------------------------------------------|
| Effective practice              | Challenges                                      |
| Buy-in from key partners prior to obtaining funding | Working with large hospitals with numerous wards |
| Key partners involved from bid-writing point onwards | Working with a number of hospitals or agencies    |
| Partnership approach e.g. joint action plans | Working across a large geographical area          |
| Project championed by key members of staff e.g. medical professionals | Individual staff members unwilling to engage    |
| Effective communication         | Departments or wards reluctant to engage          |
| Proactive promotion             | Negative perception of homeless people among    |
|                                 | hospital staff                                   |
|                                 | Recruiting staff for short-term (six month) contract |
|                                 | Finding accommodation for respite and intermediate care facilities |

2.2 Embedding pathways and protocols

Effective practice

9 In this section pathway refers to how projects have navigated their patients through the admission and discharge process rather than referring to ‘The Pathway project’ based in London.
The need to improve hospital discharge pathways for homeless people is evident from the literature (see section 1). The majority of projects (39 out of 41 projects) either produced a new or developed an existing homeless hospital discharge pathway (see appendix three for an example protocol). Successful referrals tended to result from a clear and streamlined referral process agreed with hospital staff. Where protocols were agreed, referrals tended to come through quickly and easily with projects reporting that they had as many as, or more than, expected.

“Consistency of message, who we can work with and in what circumstances, was critical so that expectations and terms of reference were managed.”

“Some issues of unrealistic expectations (from local authority homelessness teams, social services and hospital staff) but these were overcome through regular communication and having a single point of contact.”

Some projects reported that prior to the funding being awarded for the pilots there were pathways set up but there tended to be pockets of good practice and pathways were not always adhered to. Clients would often be referred to the main hostel on discharge but the funding has enabled clients to access more tailored support for their needs. The pilot projects had also improved awareness of the existing protocols in place.

“I think it’s raised awareness of the actual already in place protocol, so that obviously always a bonus. We do get - I think there’s a lot of people now in the social work field who are more clued in to what actually should happen and who you should refer to. All ward staff are obviously now aware of where to refer to and the emergency numbers, for housing and those kind of things that previously they wouldn’t have really know about – they’d just kind of been discharged and hoped for the best.”

Other good practice examples that were cited by projects include having one point of contact at the hospital, a clear definition of the client group they were working with and time limits on referrals (at admission stage or within 72 hours of this).

“A smaller project allows more time for one on one intensive support to be given to each client tailored to their support needs. It also provides a much calmer and focused atmosphere critical for respite. It also has the multiagency partnership working with the hospital and health care teams crucial to recovery. As well as this it provides necessary housing support such as life skills, managing tenancies and signposting to external agencies to ensure a client is fully set up to succeed and reducing the chance of readmission or become homeless again and increasing independence and control of lifestyle.”

Despite the challenges of data sharing (see below), 85 % of survey respondents reported that they had improved the process of data collection for clients involved in the project. Nearly two-thirds (63 per cent) felt that their project helped to improve data sharing between organisations or helped develop a data sharing protocol (Chart 2). A number of approaches were adopted to improve information sharing:

- An explicit data-sharing protocol
- Senior support for data-sharing agreements
- An explicit consent form agreeing to data-sharing
- Patients with NFA or in insecure or temporary accommodation flagged on the hospital IT system
- Mapping of frequent attenders
- Honorary contract for voluntary project staff to allow access to wards and patient records

“One of the A&E departments (out of two) was very supportive, and started a book to collect details of all NFA patients and whether they consented to being contacted.”
The worker & myself ... organised access via the hospital IT department a daily NFA activity on the computer which is refreshed every 30 minutes, this enabled us to know where all NFA patients are throughout the hospital and in A&E dept. The worker was then able to contact ward and flag up to staff to ask patient if they would like a referral made to the service which worked very well and increased awareness to all wards.

**Chart 2: Data collection and sharing**

![Chart showing data collection and sharing](chart2.png)

Source: HHDF staff survey

N=41

**Challenges**

Responses to the staff survey indicated that an inadequate approach to homeless hospital discharge had previously been the case in many areas. Processes could vary; in some areas there was no protocol or procedure, in others only a limited protocol for certain groups, and with existing protocols often not adhered to. Consequently, many projects worked towards producing or developing hospital discharge pathways for homeless patients. Out of 41 projects which responded to the staff survey, only two projects were not involved in pathways (Chart 3). Due to some projects working with more than one hospital, projects may work on both producing and developing pathways.
Chart 3: Projects involved in pathway production or development

<table>
<thead>
<tr>
<th>Number of projects</th>
<th>Production of a new homeless hospital discharge pathway</th>
<th>Development of an existing homeless hospital discharge pathway</th>
<th>Did not produce or develop homeless hospital discharge pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>23</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Source: HHDF staff survey
N=41

Developing or implementing pathways successfully can depend on staff and departments having the flexibility to adapt their practice and culture to new ways of working. Although in many cases, hospital staff were willing to engage, there were reports of resistance to this, most commonly from A&E. This could be due to the time pressures on hospital staff, with some projects feeling that nurses in A&E were failing to engage housing services due to the four hour time restraints.

“Referrals from Emergency Department are minimal. Suggestions have been made for reception staff to ask additional questions with regards to a patient’s accommodation, such as: ‘Is this address a permanent address?’ or ‘Are you able to return to this address?’, however, we have been met with resistance/reluctance to any changes to their existing protocol.”

Where pathways were not adhered to, projects reported fewer numbers of referrals than expected, with referrals being made at the last minute leaving project staff little time to plan and arrange accommodation. A number of projects reported receiving referrals at the last minute, often only being informed about the patient on the day of discharge. This would cause pressure on housing and bed spaces and reduce options for clients. One project reported that for referrals that came very late in the day they were unable to do anything other than signpost.

Again the short time for the project caused problems in terms of fully reviewing and developing pathways and protocols and being able to integrate these within practices within services.

“Discussions have taken place to review the protocol and up-date the information to include the [name of HHDF project] hospital discharge service but the 6 month pilot project was not enough time to fully review the document with all external providers and implement the changes and agree the roles and responsibilities of each provider.”

Project workers needed sufficient access to information about clients in order to identify clients, assess their needs and source suitable, safe accommodation. Agreements and protocols around information-sharing therefore needed to be developed where they were not already in place. Developing new processes was found to be time consuming. Some projects developed data sharing protocols and reported that this was a long,
bureaucratic process. Others revealed that where new systems had been developed, it had taken a while to get people set up and on the system.

Many projects revealed difficulties in terms of accessing and sharing information, particularly within the hospital setting. Some projects reported that it was difficult to get access to hospital clinical data which would be of use to project workers when referring clients to accommodation. In particular, there were some concerns that ineffective information sharing could lead to project workers not receiving information around risk, which is required when looking for suitable accommodation in the community. Bureaucratic barriers were often encountered even when there was a willingness to share information.

Data sharing and collection is critical for projects looking to evidence their work and make a case for further funding. Due to the short nature of the projects and the fact that many projects had to establish protocols and agreements regarding data, some projects felt they were not able to sufficiently evidence the impact of their work in time to apply for further funding.

Table 5: Summary of good practice and challenges of embedding pathways and protocols

<table>
<thead>
<tr>
<th>Effective practice</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Written information on how to refer</td>
<td>• Confidentiality agreements e.g. information not given out over the phone</td>
</tr>
<tr>
<td>• Clear definition of client group</td>
<td>• Resistance to data sharing at higher levels</td>
</tr>
<tr>
<td>• Clear description of project remit</td>
<td>• Limits on staff accessing existing IT systems</td>
</tr>
<tr>
<td>• Streamlined with minimal paperwork for hospital staff</td>
<td>• Different systems used by different organisations</td>
</tr>
<tr>
<td>• Time limits on referrals (e.g. at admission or within 72 hours)</td>
<td>• Existing systems not adequate, e.g. database does not flag homeless hostels &amp; temporary accommodation</td>
</tr>
<tr>
<td>• One referral route</td>
<td>• Inadequate information for securing accommodation</td>
</tr>
<tr>
<td>• Single point of contact</td>
<td>• Pertinent information not able to be forwarded to hostels</td>
</tr>
<tr>
<td>• Explicit consent form for information sharing</td>
<td></td>
</tr>
</tbody>
</table>

2.3 Identifying and accessing patients

Effective practice

In order to work effectively with clients, projects needed to promptly assess their needs, preferably visiting them soon after admission or arrival in A&E. In particular, project workers needed to be able to access wards. This was also important for building working relationships with staff and raising awareness of the project. Despite some the challenges reported by some projects, the majority of survey respondents (84 per cent) felt that they worked ‘very well’ or ‘quite well’ with local hospitals (Chart 4).
Many of the responses from the survey indicated that getting on to wards was ‘easy’ and that wards and staff were accessible. This can largely be attributed to the fact that in most cases hospital staff were responsive, engaged and in many cases directly involved in delivering the project. This worked best if staff at all levels were aware of the project.

“Many of the occupations within the ward, from reception to nurses, occupational therapists and physios, are aware of the service and regard it as a valuable asset to the discharge process for homeless patients”

A particular advantage was noted for projects with project workers from a nursing background. Several of these projects felt that having staff with a nursing background helped facilitate access to wards and hospital staff.

“Having a medically trained ‘lead’ certainly helped the process initially. I don’t know if ward staff would have been so willing to liaise with non-medical staff?”

In addition to accessing wards, many workers were able to involve themselves in the hospital process. A level of integration into the hospital setting was seen as advantageous in terms of being kept informed and being involved with patients at an early stage. Workers who created a ‘consistent’ and ‘constant’ presence were able to build up good working relationships with nursing staff and highlight the value of the project. Integration was achieved through a variety of means which included participating in ward rounds, attendance at hospital staff meetings and training, accessing a workspace at the hospital, including a slot on homeless discharge on the induction process for new staff, and allowing staff to observe positive outcomes for their patients.

“I believe being a consistent figure on the wards to staff; through ward rounds, direct contact for help and advice to nursing staff, and staff observing positive outcomes for their patients have all helped relations between the NHS staff and the post.”
“Being available to offer advice via phone/email to ward staff also helped to improve liaison.”

“Having bleeps and hospital extensions has also made it easy for staff to contact us.”

“Going forward, having a member of staff based at the hospital would have huge benefits.”

Needing to maintain high levels of liaison and links with hospital staff could be challenging for small projects, or projects covering large or numerous hospitals. One project reported that due to variation in the ability of wards and departments to identify and refer homeless patients, they would analyse their sources of referrals to determine where to focus communication efforts in the future.

“Work had to be done around awareness of issues surrounding addiction i.e. one patient’s methadone script was stopped whilst in hospital leading to self-discharge.”

Challenges

Gaining access to wards was reported to be problematic for some projects in the initial stages. In particular, getting non-clinical workers into the hospital if honorary contracts were required could be a long and bureaucratic process.

In some cases ward staff were described as being very busy and therefore not always able to respond fully, or as less engaged and able to remember the purpose of the project than others. In rare cases however, attitudes towards homeless people might have limited engagement with the project. One respondent reported issues with language used about homeless patients and attitudes towards them; ‘A case of deserving and undeserving’. Poor communication could also be an issue, and this could lead to a lack of referrals:

“Communication with hospital staff could have been improved, although HHDP staff attended weekly MDT/Pathway meetings, where discharges fell outside these meetings there was little notification from hospital staff and in these cases clients were picked up after discharge. This occurred in a significant number of cases and could have been resolved by more regular contact between teams and for team being mindful of informing one another.”

Maintaining awareness was also challenging due to the time-limited nature of many of the projects. Some respondents felt that a lower than expected number of referrals arose from a reluctance for nurses to refer due to the short duration, particularly towards the end of projects.

Table 6: Summary of good practice and challenges of identifying and accessing patients

<table>
<thead>
<tr>
<th>Effective practice</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emailing ID card to ward staff to facilitate access</td>
<td>Getting workers honorary contracts</td>
</tr>
<tr>
<td>Participation in ward rounds</td>
<td>Finding workspace</td>
</tr>
<tr>
<td>Attendance at (hospital) team meetings</td>
<td>Maintaining awareness of the project</td>
</tr>
<tr>
<td>Attendance at (hospital) staff training</td>
<td>Gaining access to hospital wards</td>
</tr>
<tr>
<td>Access to work space within the hospital</td>
<td>Reluctance by hospital staff to engage with the project due to their short term nature</td>
</tr>
<tr>
<td>Having a member of staff based at the hospital</td>
<td>Some negative attitudes by hospital staff towards homeless people</td>
</tr>
<tr>
<td>Being easily contactable</td>
<td></td>
</tr>
<tr>
<td>Offering help and advice to nursing staff</td>
<td></td>
</tr>
<tr>
<td>Good communication channels</td>
<td></td>
</tr>
<tr>
<td>A slot on homeless discharge being added to the induction process for new members of staff</td>
<td></td>
</tr>
<tr>
<td>Regular reminders about the project e.g. daily or weekly promotion, regular ward rounds</td>
<td></td>
</tr>
</tbody>
</table>
2.4 Improving outcomes for clients

Good practice
The majority of survey respondents (70%) reported that the process of accessing accommodation for clients worked ‘very well’ or ‘quite well’. Only a very small number found the process to be less than fair (Chart 5). This process was much easier for those projects that had their own accommodation:

"Clients came to our 8 bed self-contained residential service. As project is residential there were no issues around suitability or time frame on discharge from hospital as we are a purpose built project ready to accept clients that match criteria."

Accessing short-term accommodation for clients leaving hospital was easier than longer term accommodation. This is likely to reflect the fact that some projects had access to short-term accommodation as part of their bid, some local authorities would give priority to clients leaving hospital, and some clients with complex needs or previous evictions are more difficult to house long term.

"Many of the clients that we work with are in need of high level support and are therefore not ready for longer term accommodation."

"Availability of suitable accommodation was an issue, but by creating good working relationships with all local authorities and building on our existing relationships with local housing providers and landlords we were able to make suitable offers to all clients referred into the service."

"The project is based within the housing options team and this is key to the project working well."

"The local authority was also very helpful in prioritising cases that needed urgent accommodation."

Chart 5: Access to short-term and longer term accommodation for clients

Of those projects that returned data about the type of accommodation that patients were discharged into:
• 27% moved into hostel accommodation  
• 18% temporary accommodation  
• 15% into B&B or hotels  
• 11% into hospital beds or step down accommodation  
• 10% moved into the private rented sector  
• 8% went into specialist or supported accommodation  
• 7% moved into social housing and  
• 2% into residential or nursing care home  

Many projects reported that they managed to have most of their clients accommodated when they left hospital. Some projects accessed temporary accommodation with funds from the hospital’s hardship fund; others were able to use accommodation provided by local homelessness services. In some areas access was available through mainstream routes:

“We have been able to work with patients in hospital earlier, provide the right housing advice and secure accommodation using mainstream routes. The outcomes for the service show the success of the project and how the number of people being discharged without accommodation has fallen significantly.”

Knowledge of the housing system and good relationships with the local authority housing team helped projects to access suitable accommodation for clients.

“We found coming straight from hospital, LAs more likely to place in TA than if coming from the streets. They have also generally been more flexible about things like proof of address/ proof of benefits.”

 “[We found we had a] very good working partnership with [voluntary accommodation provider] and Housing Options who provided either hostel accommodation or bed and breakfast. Four people have since been permanently housed and doing well. I person went to [voluntary agency] on a 2 year program. Difficult to work with chaotic clients who were not at point of making significant changes but who still needed ongoing physical support.”

In addition to accommodation outcomes other support was offered to clients as part of the pilot projects. The range of this support varied. Chart 6 shows this variation in more detail, out of the 41 projects that responded to the survey all of them provided an assessment of client’s needs. Other support mainly included housing support, both direct access to accommodation or signposting to relevant housing agencies but it also included help with welfare benefits.
**Challenges**

The main intention of all projects was to ensure that homeless patients had suitable accommodation available to them on discharge. In most cases, short-term or temporary accommodation was secured prior to clients being offered, or supported to find, longer-term accommodation. This was often necessary due to lack of availability of properties and challenges housing clients. Single homeless people typically tend to be a difficult group to house, particularly if they are not eligible for assistance from the council. The same issues that usually arise when trying to house single homeless people arose for many of the projects which included:

- A lack of recourse to public funds
- No priority need
- A chaotic lifestyle — clients may need ongoing physical support but are not be able to make the significant changes required to maintain a tenancy
- A chequered housing history, such as previous evictions
- A lack of required information for paperwork
- Dual needs
- High levels of need e.g. support required around alcohol, drugs or mental health
- Specific requirements e.g. ground floor access
- Vulnerabilities, e.g. women, young people, elderly patients

“The role found key problems in the [name of town] Housing System which slowed discharge of clients, and in some cases found clients who could not be placed appropriately by [names of local housing provider].”
“[It is] very difficult to secure the customers’ tenancies in the private sector without any form of financial incentive for the landlord. [We] used commitment of six months of floating support to convince some landlords to accept customers with complicated housing histories.”

“There is a need for more bed spaces, more single let properties, reliable landlords and affordable accommodation.”

The word ‘suitable’ also raised a number of issues for projects. Where available suitable accommodation is defined as permanent accommodation but B&B, hostels and hotels were deemed preferable to discharging a patient on to the street.

“The word 'appropriate' in this question is critical and very important. On one hand we can say that a very high percentage of our patients were discharged to temporary accommodation which is favourable (to the authorities at least) to being discharged back to the streets. Unfortunately, temporary accommodation in [name of City], as in every city in the UK, is far from ‘appropriate’. This is accommodation run by private landlords, often it is arranged over several floors of a converted house, there is dampness, rooms are dirty, there is little or no support provided in the house, no community space, people feel intimidated by other residents. There is much more that could be said but in short, if a person is recovering from an operation or has a chronic condition these could not be described as ‘appropriate’ accommodation. It would be unfair to read this as a criticism of any person or group. The housing market in [name of City] is so inflated that it is terribly difficult for the Council to find any landlord to let their real estate to the homeless population. I heard that they recently tendered for housing providers for this purpose and got Zero applicants.”

“My biggest concern is that if the project was not in place only around 10-20% of the patients would have got the support they needed prior to discharge through the normal channels, and I am ecstatic that we were able to help the other 80-90 per cent. Also these individuals are now known to, and aware of services that they may have previously not engaged with.”

Due to clients’ often complex needs and requirements for ongoing support, good relationships with other agencies were key. The tendency for organisations to work in silos could create difficulties when trying to provide a holistic package of care for clients with a range of housing and health needs. As one respondent pointed out:

“As I was leading on the data collection in terms of housing, I think this was focused on too much on my part. Similarly Health professionals who were collecting data from hospitals and GP’s focused too much on health outcomes, not looking at housing. There could have been slightly more joined up thinking in this area.”

Projects most frequently reported difficulties with social services. Issues included the need for clarity on thresholds, problems getting social services to take responsibility for clients that needed social care, and a reactive rather than proactive approach. One project found that being based in the council made links with social services easier.

Being able to refer to other services was important for projects being able to end their work with clients knowing that their needs would continue to be met by existing services. In particular, it was essential that clients had access to primary care.

“Work with local GP practices proved a challenge at times also and occasionally hampered our work with this client group.”
Table 6: Summary of good practice and challenges of improving outcomes for clients

<table>
<thead>
<tr>
<th>Effective practice</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use of respite facility where needed</td>
<td>• Lack of time – patients admitted for short periods, late referrals, unplanned discharge, discharge from A&amp;E</td>
</tr>
<tr>
<td>• Ring-fenced beds</td>
<td>• Unrealistic discharge protocols, e.g. assessment within three days</td>
</tr>
<tr>
<td>• Funds to spot-purchase beds or pay for rent deposits / rent in advance</td>
<td>• Lack of specific types of accommodation and support, e.g. for disabilities, addictions</td>
</tr>
<tr>
<td>• Access to benefits, e.g. hardship fund</td>
<td>• Variation in LA rules regarding arrears, local connection and overall assessment of clients’ needs</td>
</tr>
<tr>
<td>• Good relationships with accommodation providers and landlords</td>
<td>• Poor relationships with housing providers and landlords</td>
</tr>
<tr>
<td>• Joint working with local housing team and providers</td>
<td>• Lack of suitable accommodation, particularly short-term/temporary accommodation</td>
</tr>
<tr>
<td>• LAs/providers prioritising homeless people leaving hospital</td>
<td>• Difficulty housing client group due to multiple needs, lack of eligibility, history of rent arrears</td>
</tr>
<tr>
<td>LAs being flexible in terms of paperwork required for homeless patients</td>
<td>• Pressures on the housing market in London and the South East</td>
</tr>
<tr>
<td>• Provision of a package of housing related and medical support on discharge including assessment of client’s needs, advocacy, and personalised support plans</td>
<td></td>
</tr>
</tbody>
</table>

Section 3: patient experience

In depth, semi structured interviews were held with 30 clients who had been supported by the projects funded by the programme. They were based in eleven different projects across all the English regions.

3.1 Client group

Projects reported working with a wide range of people who had varying experiences of homelessness. In the original bids projects specified the groups they intended to work with ranging from rough sleepers and those with no fixed abode to vulnerably housed people in houses of multiple occupation or temporary accommodation. For some projects, whilst the expectation was that they would only be working with the most entrenched rough sleepers, they described working with a different client group than originally expected:

“The client group was different from what was anticipated - not traditional chaotic homeless people, a lot of people with no alcohol/ substance misuse issues but complicated housing issues. There were some issues within the office with unhelpful colleagues who had a negative impression of homeless people”

“The biggest surprise I think, that happened to everyone, was that we expected to know most the people but actually a large percentage of them were unknown which means we were picking up homeless people from different sources that were not on the normal radar.”

Whilst most projects did also work with rough sleepers and those with multiple and complex needs, in addition they were also working with newly homeless people or those at risk of homelessness when entering hospital.
In some cases patients who were admitted to hospital had already tried to access accommodation through their local housing options or homelessness team and had been refused help. The project or link workers were then brokering a role with the local authorities housing team during the hospital admission to secure suitable accommodation on discharge.

3.2 Experience of hospital

Overall clients reported a positive experience whilst in hospital, which is in contrast to findings in 2012 which found that many clients felt poorly treated by hospital staff because of their homelessness, or because of substance misuse problems. This included not feeling judged or being prejudiced either because they were homeless or because they had been admitted into hospital for health reasons linked to their substance misuse:

“The staff were very good, I didn’t feel judged”

“They were just naturally pleasant and couldn’t do enough for me, you can tell when someone doesn’t want to be there can’t you? They didn’t get annoyed when I asked them for coffee.”

“Very well I have no complaints, I was in the renal unit for several week and they conducted many tests I was under 5 consultants who treated me very well and I could have a laugh and a joke with them. The nurses we very friendly and I have even recommended one nurse for an award for what she did for me considering she was only a student.”

“Fine especially the nurses you feel like you are being treated like a human being I felt like I had done something stupid and that they should be annoyed with me as I was wasting their time when they could have been doing something else”

“I was treated very well by staff from the time I went in, I remember the nurses were constantly asking me if I was OK or needed anything. They made me comfortable and I felt safe.”

“When I left, because I’m only across the road, you see them at the bus stop and that and they’re always saying ‘When are you coming back?’ I’m not I don’t want to, thanks, but some of the staff used to come in and sit and do their paperwork instead of sitting at that part of the desk, it was that much of a laugh.”

In some cases people were pleasantly surprised about their experience of hospital which was based on previous bad experiences or were unsure about what the hospital stay would involve. This was particularly prevalent among those people who had been admitted due to mental health issues:

“I was surprised how, it’s hard to put, I’ve got a Dickensian sort of [view of] mental hospitals, but I was surprised how good it was. They were nice people. If I worked there I’d do the same thing. I was respected, they listened to me when I said things, it was just how I would of have liked it to be.”

“The last time I didn’t have any help I didn’t want to go home then either but I had seen the man from the council and he couldn’t do anything so I had no choice but to go back home. This time I was given options and I am so much of a different person for having those options if it wasn’t for [support worker] and [name of hospital discharge project] I would have gone back home and would probably be in hospital again. It wasn’t just the drugs, I have had a lot of childhood issues and that house just wasn’t good for me.”

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10 Homeless Link and St Mungo’s, Improving hospital admission and discharge for people who are homeless, March 2012
“My experience in [City] was different previously I was put in an isolated room but this time I was on a ward and felt more comfortable as I didn’t feel like an outcast and was treated fairly.”

Where the hospital episode was related to drug or alcohol use people were expecting to be treated badly and weren’t:

“I found them supportive even though they knew I was an alcoholic they understood it to be a disease. They were all very good and understanding I didn’t have any problems with the staff at the [name of hospital] Hospital they were very kind and treated me exactly the same as anyone else.”

However there were some cases where service users did not feel they had been treated positively during their hospital stay. In most cases this was linked to staff resources and time pressures in the hospital and feeling they were taking up precious bed spaces:

“The main thing I picked up on was that there are not enough nurses and the doctors are leaving all the responsibility to the nurses. It got to the stage that you would ring the bell and no one would answer as they knew you were going to ask them to do something they were overstretched and the doctors were nowhere to be seen so really it was the nurses running the ward. The only time you would see them was on the morning.”

“I felt the consultant treated me with distain, I think he is under pressure to keep bed spaces and needs to move people on. You are talking about people who are unwell and something like that could destroy them... They just want you to reach a point where they can get you out of the front door which is OK if you have somewhere to go.”

In a small number of cases their personal background did have an impact on the way they were treated by hospital staff:

“I could sense it especially towards the end you could tell by their attitude and when they started asking how’s the accommodation going. I knew they were trying to get rid of me and with my injuries being drink related they were unsympathetic I suppose if I was an elderly people who had just fallen down the stairs it would have been different. As soon as the alcohol team and [project name] came in they knew about my issues and who they were.”

3.3 Experience of hospital discharge process

The hospital discharge process was a slightly more mixed experience. The clients that spoke to us about positive experiences were supported through the discharge process, received sufficient notice about when they were going to be discharged and where they were going. Having a clear housing outcome was key in reassuring the client about their discharge process. Feeling equipped to leave the hospital also assisted the process and this included talking through a care plan, providing transport home and buying basic food and equipment to set up the tenancy and make them feel safe and secure.

“Yes, they were worried about me being on my own and were waiting to sort something out with [support worker]. I have had problems in the past. Trying to find people you can trust to look after you is hard, I have had a carer before and they dash about for an hour and you only get half hours work out of them….I was given a bag of groceries which did help and it meant I didn’t have to rush out and buy stuff. I was taken home by a small ambulance as I didn’t have any family who could take me.”
“I was told that the hospital had spoken to [support worker] who was sending transport for me. [Support worker] turned up 15 minutes later and explained that a taxi would be waiting for me at 2.00pm to take me to the hotel. From my point of view it was a very well planned discharge.”

Where people reported a negative experience of their discharge this was often down to a breakdown in communication by hospital staff. Case study one shows an example of where a breakdown in communication caused a problem with the hospital discharge process for the client. The client was either not told when or where they were going on discharge or the staff didn’t know until the last minute and the process felt rushed and could cause some distress for the client. As one person explains below they were happy with their care in hospital but the discharge process was not to the same standard:

I: Is there anything that could have been differently with hospital discharge support?

P: On the hospital, I am not qualified to answer, in terms of treatment and consideration they get an A plus. On the discharge, that gets a D minus I didn’t realise it was chaotic and I should have asked more questions.

The transfer between hospitals sometimes caused issues with the discharge process and communication flow:

“I was then transferred to one in [city x] and that’s when everything went wrong at the hospital. In [city y] they had a link worker who was dealing with my no fixed abode situation. They were linking me with private landlords and taking me to projects and I was assured they would not discharge me without anywhere to go. Unfortunately when I was transferred to a hospital close to here all that stopped and they were unaware of the work that was being done and I was discharged with literally nowhere to go.”

However, where clients felt did not feel happy with the discharge process the intervention of hospital and housing support staff helped to improve the process:

“I had a couple of nurses who stood up to their boss and said will someone do something for him? I was in a state but they still discharged me on that day but the following day a lady from social services rang me and then the rough sleeper’s team came and picked me up from the motor way services.”

### 3.4 Client experience of support

Not all clients were able to access support on discharge from hospital. In some cases clients refused the help and further support that was offered to them at the point of hospital discharge. In many cases the support that was provided to clients was personalised and followed an individual support plan. This support was used to set up and access tenancies as well as floating/outreach support. Link workers employed by the projects tended to work with a small number of clients and were able to arrange weekly visits and in some cases a daily phone call. There tended to be greater support provided when the client had recently been discharged from hospital. In addition to helping to secure accommodation, support included housing related support such as helping to set up housing and other welfare benefits, securing furniture and kitchen utensils and equipment but also health and wellbeing support including ensuring GP registration and accompanying people to doctors and hospital appointments, getting prescriptions and linking people to adult social services, counselling and in house care.

In many cases this support provided a life line for clients:

I: Does the support you have had made you feel more able to move on now?
P: Yes I do not think I could of done any of it alone, I would be dead now honestly which I don't even want to think about it. I had nothing but the clothes I was wearing for a week or two the kids and my sister didn’t even know I was in hospital. I have had a lot of help.

Support workers were key in terms of brokering the relationship to obtain accommodation and supporting the client through the process of securing accommodation:

“I asked about where I would live after I left hospital and she got me this place, she's been very good, she has helped.”

“I couldn’t criticise them they got me this accommodation, they rung up regular, and [support worker] is always on the phone calling to see how I am, I've had phone calls when I didn't expect phone calls, every time I have mentioned a problem the guys chase it up. My rent was paid late I told [support worker] who sorted this out for me they have done everything I have asked of them.”

“Communication between [Hospital discharge project] and the Council could be better [support worker] really needed to fight my case with them. [Support worker] is a phone call away I still call him now although he is backing off a bit now as I am in supported accommodation and will be getting somewhere else soon as I am working now. [Support worker] is now looking in the private rented sector for something for me.”

The role of the support worker was also vital in helping people adjust to day to day life once they had been discharged from hospital:

“I was very anxious, the psychiatric ward I was on for weeks was like a prison so coming out was weird as I had been enclosed for so long. I did find it hard to adjust because when I was at home I stopped in a lot. If I needed to go out and do things [support worker] would support me to do it if she wasn’t there I probably wouldn’t have come out of the house.”

“He’s helped out, because my feet and that if I’ve got no money and I need appointments, he’ll put money on my Oyster and turn around and say 'right, you need to go on the bus to go here'. I needed a saucepan and stuff like that, he got me one. He’s a really good person to have like working with you because I’m not, normally I just get on with things and if I’ve got to stay on the street I've got to stay on the street but I don’t want to stay on the street and he’s turned round and said no, no that’s not going to happen, one way or the other I will get sorted. If I was going to doctor’s appointments he’d come with me, he’d meet me at the doctor’s appointment.”

The support not only covered practical advice but also support concerning mental health and wellbeing:

“As long as I want to I think [regarding staying in the property], they have done their bit and got me to the point where I am quite self-sufficient but I still like to see them and have a chat about things. I still get a bit low and it is nice to talk to an outsider. I think that is probably them going the extra mile with me and I don’t think I could ever say thank-you enough”

The support provided through the project also helped to raise awareness to clients about support and advice services that are available in their local area.
3.5 Suitability of accommodation

The suitability of the housing people were discharged to varied greatly mostly dependent on the local housing market but also the relationship the project had with local housing teams. A lot of people moved into interim or temporary housing first before being moved into permanent accommodation. Accessing accommodation on the behalf of clients was the biggest issues projects had.

“I was in the hotel for 3 months and I was stuck in a rut and [support worker] had called a lot of places trying to get me somewhere and in the end I stayed with a friend. He got in touch and the next day took me to the council again and we filled out a homeless application. He bought me food and asked if I was OK there and..."
how long I could be there for. I told him a week and then [support worker] found the place in [name of supported accommodation], he took me there for an interview twice and then he helped me move in to the supported accommodation."

The suitability of the accommodation also needed to be tailored to the individual. In one case a patient who had a leg amputated and was engaged on a drug detox programme was about to be discharged to a mixed hostel with no wheelchair. The hospital discharge project intervened and secured a ground floor adapted flat in social housing (see case study two). For some people bed and breakfast accommodation, although a temporary stop gap, was not suitable for improving emotional wellbeing:

“No this place is just a B&B there is no support here for my health conditions need to get on the doctors and my probation they should let me make a phone call it’s OK here.

I am hoping to progress from here then on to the next place and from there to my own place that is my goal.”

“B&B’s are lonely places when you are not feeling your best you feel very isolated as quite often they are not in the area you are from, mine was only 2 miles away so I was lucky. Within a couple of days [the support worker] had sorted something out, I was in [name of town] for 5 weeks, imagine if they had known then they would have had plenty of time to arrange something.”

For people recovering from alcohol or drug related illness or injury it was really important for them to be housed somewhere away from previous acquaintances and temptation. In many cases being discharged into a hostel was not appropriate.

“Of course I am treating this as a stepping stone and waiting for something to come through either from [name of hospital discharge project] or from my other help. It will be a definite move on, I have only been sober for 2 weeks against 6 years of drinking time wise it’s a drop in the ocean, saying that I don’t want to be here too long surrounded by other alcoholics, I would rather not be surrounded by temptation.”

Feelings about the accommodation that people were placed in also varied. While longer term accommodation was viewed more positively, for clients who had previously been rough sleeping, or in unsafe or unstable accommodation, being placed in a hotel or bed and breakfast accommodation was a marked improvement:

“I feel comfortable, safe and life is a lot better than it was. But I deserve it as I had 5 years of hell. I haven’t won the lottery I’ve just got a bloody roof over my head. The 3 most important things for me are a walk in shower, a bed, and a dry environment it is what makes me feel human again.”

As identified in the previous section a number of barriers were identified which prevented projects form securing suitable accommodation for clients at the point of discharge. These were similar to many of the barriers that are identified by the single homeless population as a whole.

“There is nothing bad I can say about my treatment only that the system worked, but only when I reached a critical point. That was the only thing that upset me that it had to reach the point where I was nearly dying to get any form of housing. I should have been here weeks ago but the council wasn’t interested even though they had letters from my doctor explaining about the blood clots on my lungs, I also had [support worker] and probation on their case but they just didn’t want to know.”
Case study two

Angela, 46 had been a heroin user for 13 years and for the past ten years had experienced homelessness, lived in hostel accommodation and had frequently moved between private rented homes. She was admitted to hospital when an abscess ruptured on her groin which led to her having her leg amputated. Angela felt she was treated well in hospital by the nursing staff which had differed from previous hospital experiences:

“Oh the nurses were brilliant, they were absolutely brilliant with me. They couldn’t do enough for me, they did everything me, they bent over backwards for me.”

During her hospital stay Angela was visited by two link workers from the hospital discharge project and a social worker at the hospital. The hospital was going to discharge Angela to a hostel with no wheelchair but the intervention of the link workers from the hospital discharge project prevented this from happening. They arranged for Angela to move in to a social tenancy which was a ground floor flat and had been adapted for wheelchair use.

Angela had decided to go on a methadone programme during her stay in hospital and the hospital discharge project was helping her with this and being in her own tenancy was a key part of dealing with it:

“To be blunt it [my health] was crap so was my lifestyle, I was on drugs 24 hours a day I wasn’t eating I wasn’t sleeping. I’ve been off them for 18 weeks and I’m loving it, I have reduced my methadone intake from 90 ml to 10ml yesterday.”

The link workers have continued to provide support for Angela which included taking her to hospital and doctors’ appointments, picking up prescriptions and helping her with her benefit claims.

“[name of support worker] does everything, he comes and picks up my prescription for my methadone and drops it off at the chemist, he does everything.”
Section 4: Project Outcomes and Cost

One of the aims of the evaluation was to provide evidence on the cost, and cost-effectiveness of projects. This required data about financial inputs, expenditure and outcomes achieved from across the different projects.

We received completed outcome data returns from 33 projects and the outcomes below are based on returns from these projects.

Overall the 33 projects who returned complete data produced the following outcomes:

- 69% of patients were discharged into suitable accommodation out of total discharges
- 55% of patients received health support on discharge
- 58% of patients received housing support on discharge
- Out of those patients that were admitted into hospital only 28% were readmitted within 30 days of a prior admission

Complete outcomes data and along with expenditure returns were provided by 26 projects in total. Others either had not collected this data or it was not complete enough for analysis. The data which was provided allowed us to look at the following three typologies in more detail (there was insufficient evidence from the remaining five typologies):

- Accommodation and link worker
- Housing and nursing staff
- Housing link worker

Broken down by typology the outcomes are as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>% discharged into suitable accommodation</th>
<th>% received health support on discharge</th>
<th>% received housing support on discharge</th>
<th>% readmitted into hospital within 30 days of a prior admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation and link worker</td>
<td>93%</td>
<td>68%</td>
<td>64%</td>
<td>22%</td>
</tr>
<tr>
<td>Housing and nursing staff</td>
<td>93%</td>
<td>89%</td>
<td>92%</td>
<td>23%</td>
</tr>
<tr>
<td>Housing link worker</td>
<td>68%</td>
<td>55%</td>
<td>62%</td>
<td>30%</td>
</tr>
</tbody>
</table>
The outcomes suggest that improved accommodation outcomes for clients are most likely to occur when there is either accommodation available to the project (accommodation and link worker typology) or there is both a housing and housing professional working on the project to ensure a smooth transition from hospital to a home (housing and nursing staff worker). The housing and nursing staff worker also demonstrates improved health and housing support outcomes. This supports the evidence we received through the staff survey and telephone interviews.

In terms of expenditure per client, we looked at the revenue expenditure made by projects and therefore capital costs were excluded. The average cost per client across all projects that returned expenditure and outcomes data was £2543.39. The costed case studies below show how cost per client can vary dependent on their health, personal circumstances and nature of the hospital admittance.

There are a number cautions that should be drawn when analysing the outcomes data and looking at costs of projects. In terms of the timing of the evaluation we were not able to work with projects at their inception so could not collect baseline data and there is not data available at the local level or in the timeframe of the homeless hospital discharge fund project that could be used as a baseline indicator. The quality of data collected by projects varied. At the point of completing the evaluation those projects that were delayed in starting were unable to return complete data. We would recommend that any future investment in the programme should collect baseline and ongoing data which will help inform the service performance and help projects evidence their case for future funding.

Costed client case studies

The examples below were provided to us by two projects as part of their individual evaluations and illustrate some of the potential cost savings that can be made through hospital discharge interventions.

Client 1: BRICCS Bradford Respite and Intermediate Care Support Service, Horton Housing Association

Prior to being admitted to BRICCS one client had been admitted seven times in relation to drinking and substance use. On this basis the costs attached to their admittance are:

- 7 x A&E visits costing £115 = £805
- 1 x overnight stay in hospital = £283

Total cost of patient = £1,088 before admitted to BRICCS

Since being admitted to BRICCS the client’s alcohol consumption has reduced and they have not used A&E.

[Source: Bevan Healthcare CIC and Horton Housing Association, Interim evaluation of Bradford Respite and Intermediate Care Support Service (BRICSS)]

Client 2: Hospital to Home Brent, Ashford Place

A client has a history of using A&E services over the course of 14 years. Data from 2009 to 2014 logged a total of 219 A&E attendances and 43 admissions. Due to the number of aliases the client used this is likely to be an underestimation of hospital use. Based on this data an approximation of cost is listed below:
219 x A&E visits costing £108 = £23,652
43 x hospital admissions lasting an average of 6.2 days = 266.6 days
266.6 days x cost of hospital stay (£225 per day) = £59,985
Total cost = £83,637 over five years

Through the Ashford Place project the client was referred to Social Services who arranged and funded their accommodation whilst they await the outcome of their priority need housing application. Whilst being engaged with Ashford Place, the client has only been admitted to hospital once, due to an epileptic seizure.

[Source: Hospital to Home in Brent, Project Report October 2013 – April 2014]

A database provided by new economy Manchester provides some further examples of the costs related to health and can be used to estimate further cost savings provided by hospital discharge interventions. For more information please see: http://neweconomymanchester.com/stories/832-unit_cost_database

Section 5: Long term sustainability

5.1 Continuation funding

17 out of 40 projects reported receiving extra funding beyond the Department of Health grant period. Out of these only one had received funding which exceeded the Department of Health level, seven received comparable funding to the level they had received and seven had received less. In the case where enhanced funding levels had been awarded this represented just over 50% increase and had been awarded by the local authority on the basis that the project had made substantial cost savings to them in terms of the cost of a homelessness application.

Funding has come from four main sources: the local authority, CCG, Public Health and local housing provider (see chart 7).

Chart 7: Number of projects with continuation funding and sources of funding

<table>
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<th>Funding sources</th>
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<th>2</th>
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<th>4</th>
<th>5</th>
<th>6</th>
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<th>8</th>
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<tr>
<td>CCG &amp; Public Health</td>
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<td>Housing Provider</td>
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<td>Enhanced</td>
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<td>Reduced</td>
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<td>Reduced</td>
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<td></td>
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<td>7</td>
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</table>

Source: HHDF staff survey, N = 17
There appears to be no link between the scale of projects and continuation funding. The size of the projects that received continuation funding varied from those that had received low levels of funding, five of the projects that had received additional funding had originally been awarded below £50,000. One of the projects had originally received over £1 million and had been given comparable funding to continue.

Projects tended to be extended for twelve months or until March 2015 (7), a further three for six months and two had been funded for three months. One had received funding until the local rough sleeping services are tendered when the service will be incorporated into them (1) and one respondent gave no reply. Two projects mentioned that further funding at a later date would depend on demonstrating outcomes. In some cases the timing of commissioning cycle affected when and how much funding was given to projects.

In terms of those that hadn’t received continuation funding, reasons can be defined in four broad categories:

- Project had been delayed so the DH contract had only just begun
- They were in the process of applying and were unsure of the outcome
- Funding applications had been refused
- No funding was available in their area

“I’ve got a meeting at some point this week with the operations director to see what we can possibly do about getting additional funding, even if it’s just to maintain it for a while whilst we can put in a proper bid, which is what we’re hoping to do. Because it seems like such a valuable service, I mean keeping a relationship with our resettling teams is good isn’t it?”

The commissioning cycle also caused problems for people trying to secure future funding for their service:

“The timeframes for the pilot did not sit in line with CCGs commissioning deadlines for 14/15 i.e. the money was released too late to approach them as they had already allocated their money. We applied to [name of grant charity] for funding, they agreed to match fund an expanded version of the project for another year. They liked the project and saw it fit in with their aims of reducing health inequalities for excluded groups, but felt [organisation name] was financially healthy enough to put up the other half, suggesting we draw on our reserves to pay for it. [organisation’s name] leadership team decided it was no possible financially to draw on reserves to match fund the project.”

5.2 Integration with health and housing services

Most of the projects that had secured continuation had done this through partnership working across health and homelessness teams in their area. This included setting up a working or steering group, putting in joint bids and establishing strategic joint working processes at the governance and operational levels. Partners that were included in this process included the CCG, commissioner for drugs and alcohol, adult social services, NHS trusts, local authority housing or homelessness team.

“The CCG set up a meeting of all the parties working on homeless healthcare in the city. This became a working group. We were required to provide reports and case studies to the working group and from here the commissions were worked out. Typically time frames were short and we were not able to spend as much time honing the contract as we would have liked but the work has continued.”
“We worked with the hospital, CCG, and primary care services to provide the necessary outcome based evidence / information to prove need.”

“The project was originally six months, so [name of local authority] have funded an additional six months. The CCG have asked me- I went to a CCG meeting last week and they’ve asked me to put a funding bid together for an extension of the role. They want it to also begin to include A&E to a standard degree, so they’re going to be approaching A&E about that and about their involvement within this service. There’s also a possibility of linking it in with the current homelessness GP in the [name of town] area so there’s a way of immediately following that client into mainstream community’s and primary services.”

Funding was also dependent on the priorities and working relationship with the CCG, as one project explained that had not secured additional funding:

“Because they were approached in the CCGs for funding. We weren’t actually involved in those meetings, sadly because there was a feeling that was told that the CCGs were reluctant to fund any kind of housing work. We, [name of organisation] is not a housing provider per say, we are British social landlord but that is only a fraction of the work that we do.”

Having the project integrated into other services and health and wellbeing strategies increased the chances of continuation funding. In cases where it has been included this has involved the project looking at the areas health priorities and aligning the projects outcomes to these, such as included reduction in health inequalities and giving people decisions in health.

“It’s been a real sort of success for the city. And I don’t know if you know, but the whole city has embraced it as part of its plan for the city. So possibility different, I don’t know from other areas, it’s not seen as a project, it’s seen as a part of the city sun visionary plan which is that there should be health and care in the city where the poorest get the healthcare the fastest. So it’s been written into the health and wellbeing strategy for the city by name and obviously some funding has been provided. But it’s about how we develop and build this for the future really.”

The short time frame of the projects also meant that applying for funding was difficult. In successful cases they started making contacts and looking for alternative funding almost as soon as the Department of Health grant had been awarded. If projects had staff turnover, particularly at the senior level this could be a barrier in terms of longer term sustainability.

I: Did you try to obtain funding or were there barriers or-?

P: I wasn’t aware of any. Again we had that difficulty that it had been my previous CEO that originally bid for the project and then left afterwards so it was more her bag in that sense of ongoing funding, ie I wasn’t aware of any additional sources or where to go in that sense. I suppose there was a barrier there for not knowing if there were additional resources out there. But no we weren’t able to obtain any further finances for it.
Section 6: Recommendations

Based on the findings from the evaluation, the following recommendations are included to inform future planning and delivery of initiatives to improve homeless people’s discharge from hospital.

Future investment

- Future investment of hospital discharge projects and arrangements should be jointly commissioned by a range of health, housing and adult social care partners. There are clear benefits to CCGs, Public Health, local authorities and other partners combining resources to maximise sustainability and arrangements are delivered and understood by all partners working in health, housing and adult social care.

- Local commissioners should consider longer term funding (i.e. greater than 6 months) when commissioning new hospital discharge projects. This would reflect the time needed to recruit and train staff, set up partnerships and embed practice. Capital expenditure programmes for intermediate or respite care facilities can provide much needed accommodation options for those leaving hospital but in particular need longer lead in times to secure, purchase, refurbish or build suitable accommodation.

Effective practice

Based on the evaluation, components of effective models for future replication include:

- Integrating housing and clinical staff into the discharge team. Better outcomes and more positive working practice were reported where both a housing and nursing link worker was in place.

- Having a model which combines access to accommodation alongside link workers. Outcomes data showed that where this was available, more clients were discharged into appropriate accommodation (93% compared to 71% overall). We recommend a model where either accommodation is linked to the project set-up (either bespoke units or ring-fenced beds in existing projects) or they have links already established with a local housing provider or rent deposit scheme so suitable accommodation can be easily accessed.

- Enabling better communication and engagement with patients by hospital staff at the point of discharge. Patients were less anxious and described a more positive experience when they were told about being discharged at least 24 hours before it took place. This should include the details of the accommodation they are being moved to, the exact time of discharge and the transport arrangements which have been put in place. This should also apply when patients are being moved from one hospital facility to another.

- Making intensive support available for clients once they have found accommodation is important to improve their recovery and discharge process. This should include a full assessment of client’s needs, a package of housing related and health support to increase tenancy sustainment and improve health outcomes.

- Clarification of the client group that projects are intended to work with (i.e. rough sleepers, those at risk of homelessness, groups with specific needs such as mental health or substance misuse issues, hostel residents). Referral processes and protocols should be tailored according to target these groups.

Partnership working
Homeless Link

- Partnerships need to be secured from the outset of any future approaches. There needs to be a commitment to multi agency working from developing proposals right through to ongoing delivery and plans for tendering or securing continuation funding.

- Promotion and integration of the project needs to occur across different strategic levels. This should include integration into the local area’s overall health and wellbeing agenda and strategy, and reflected in the health priorities for the area. On the ground this should include training and awareness of the homeless hospital discharge protocol, regular multidisciplinary meetings, access to all hospital wards for project staff and clear information available on the project remit and how and where to refer patients.

- Stronger links should be forged with Adult Social Services. Projects most frequently reported difficulties with social services and issues included the need for clarity on thresholds, problems getting social services to take responsibility for clients that needed social care, and a reactive rather than proactive approach. This could be achieved by hosting part of the project within a local authority setting.

Information sharing

- There needs to be agreed practice about how homeless patients will be identified and recorded from the earliest point of contact in hospital so that support can be coordinated throughout the different stages of the discharge pathway.

- Partners need to have an agreed set of monitoring data to collect so that outcomes can be demonstrated more effectively. This needs to be collected on an ongoing basis to provide baseline data as well as show outcomes and effectiveness. At a minimum this needs to include number of hospital admissions and readmissions or contact with hospitals to receive healthcare, length of stay in hospital, accommodation status on admission, accommodation status on discharge, if they are receiving ongoing housing or medical support post discharge.

- Information sharing agreements need to give project staff access to appropriate IT systems so that client data can be shared safely effectively from the outset of the project.

- Consent from patients to share data should be incorporated into admission protocols to help improve data sharing agreements and remove barriers for staff working outside of hospitals.

Staff training

- More intensive work and training for A&E staff is needed to mitigate against the high turnover and shorter contact time with A&E staff. The creation of a homeless champion with the A&E department could be one way of achieving this.

- Training with hospital/medical staff needs to be included as part of the project set up to help define the client group, definitions of homelessness and sharing of key housing and homelessness contacts.
Appendices

Appendix 1: full list of project typologies

There were 52 projects in total. The different models of provision described by projects have been grouped into nine typologies and full details are listed below:

<table>
<thead>
<tr>
<th>Housing link worker(s)</th>
<th>Project Description</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HD003a</strong></td>
<td>Inreach and Outreach Pathway Care (linked with Hospital Discharge Support Housing)</td>
<td>Stonepillow</td>
</tr>
<tr>
<td><strong>HD009</strong></td>
<td>Beds for All</td>
<td>YMCA Bedfordshire</td>
</tr>
<tr>
<td><strong>HD021</strong></td>
<td>Tamworth Links Project</td>
<td>Brighter Futures</td>
</tr>
<tr>
<td><strong>HD023</strong></td>
<td>Coventry Homeless Hospital Discharge Project</td>
<td>Coventry Cyrenians</td>
</tr>
<tr>
<td><strong>HD033a</strong></td>
<td>Three Flow, linked with three flow lodge</td>
<td>Hestia Housing and Support</td>
</tr>
<tr>
<td><strong>HD034</strong></td>
<td>H4 Hospital</td>
<td>Helping the Homeless into Housing (H3) / Stockport Homes</td>
</tr>
<tr>
<td><strong>HD045</strong></td>
<td>Emergency Department Homeless Support Oxfordshire</td>
<td>Elmore Community Service</td>
</tr>
<tr>
<td><strong>HD054</strong></td>
<td>Bay6</td>
<td>Community Housing Aid</td>
</tr>
<tr>
<td><strong>HD073a</strong></td>
<td>Plymouth Hospital to Housing Support Service</td>
<td>Bournemouth Church Housing Association</td>
</tr>
<tr>
<td><strong>HD078</strong></td>
<td>Bournemouth Hospital to Housing Support Service</td>
<td>Bournemouth Church Housing Association</td>
</tr>
<tr>
<td><strong>HD083</strong></td>
<td>Links</td>
<td>YMCA Crewe</td>
</tr>
<tr>
<td><strong>HD091</strong></td>
<td>Penrose Steps</td>
<td>Penrose Synergy</td>
</tr>
<tr>
<td><strong>HD095a</strong></td>
<td>Hospital to House Caseworker</td>
<td>The Brick Homeless Project</td>
</tr>
<tr>
<td><strong>HD096</strong></td>
<td>Wakefield Cathedral</td>
<td>Wakefield Rent Deposit Scheme (WRDS)</td>
</tr>
<tr>
<td><strong>HD100</strong></td>
<td>Implementation of GM Hospital Discharge and Homelessness Prevention Protocol Part 2: Bolton Borough: Effective discharge arrangements for homeless people from A&amp;E</td>
<td>Urban Outreach (Bolton)</td>
</tr>
<tr>
<td><strong>HD110</strong></td>
<td>Hospital Discharge Project (Tameside)</td>
<td>New Charter Homes</td>
</tr>
<tr>
<td><strong>HD042</strong></td>
<td>Croydon Routes — from hospital to community</td>
<td>Thames Reach Housing Association Ltd</td>
</tr>
<tr>
<td><strong>HD011</strong></td>
<td>Integrated Hospital Discharge Service — Nottingham</td>
<td>Framework Housing Association</td>
</tr>
<tr>
<td><strong>HD048</strong></td>
<td>Coventry &amp; Rugby, and Warwickshire Homeless Hospital Discharge</td>
<td>Midland Heart</td>
</tr>
<tr>
<td><strong>HD084</strong></td>
<td>The Wellsprings Health Improvement Service</td>
<td>The Wellspring</td>
</tr>
<tr>
<td><strong>HD020a</strong></td>
<td>Hospital Discharge Homelessness Prevention Protocol</td>
<td>Saint Petroc's Society</td>
</tr>
<tr>
<td><strong>HD014</strong></td>
<td>Homeless Hospital Discharge Worker — Herefordshire</td>
<td>St Peter's Night Shelter</td>
</tr>
</tbody>
</table>

Pathway model – navigators
### Homeless Link

| HD093     | Homeless Patient Pathway Plan — Birmingham and Sandwell | Trident Reach the People Charity |
| HD088     | Hospital to Home — Lambeth (H2H Pilot)                 | Broadway Homelessness and Support |
| HD080     | Homeless Hospital Discharge Project                     | The Passage                      |
| HD052a    | The Homeless Accommodation Leeds Pathway (HALP)         | CRI West Yorkshire Street Outreach Service |
| HD039     | Hospital to Home — Hammersmith and Fulham (H2H Pilot)   | Broadway Homelessness and Support |
| HD024     | Pathway Plus                                            | Justlife Foundation              |

### Nursing link worker(s)

| HD040     | Hastings Integrated Hospital Discharge Project         | Sanctuary Supported Living       |
| HD010     | The Aftercare Setup Project                            | Trinity Winchester               |

### Nursing and housing link worker(s)

| HD060     | Healthy Futures                                        | Derventio Housing Trust (CIC)    |
| HD053     | Hostels Hospital Discharge Project                     | Brighton Housing Trust           |
| HD043     | Single Point of Contact for Hospital Discharge — Wolverhampton | People Potential Possibilities |
| HD099     | Health to Home                                          | Peterborough Streets             |

### Accommodation and housing link worker(s)

| HD025     | Liverpool City Region Hospital Discharge Project       | The Whitechapel Centre           |
| HD005     | Breathing Space                                        | Two Saints                      |
| HD057     | Newcastle hospitals navigation and respite project     | The Cyrenians                   |
| HD062     | Sunderland hospitals navigation and respite project    | The Cyrenians                   |
| HD032     | Hospital to Home in Brent                              | Ashford Place                   |
| HD085     | Greenwich Housing Options and Support Service — from hospital to community | Thames Reach                   |
| HD090     | Basis Beds (Hospital Discharge)                        | Aquila Way                      |
| HD064     | Milton Keynes Hospital NHS Foundation Trust — Homeless Discharge Link Project | Connection                    |

### Accommodation and nursing link worker(s)

| HD092     | Discharge Initiative Supporting the Homeless (DISH)     | First Stop Darlington           |
| HD019     | Hospital Community Link                                 | Brighter Futures Housing Association Ltd |

### Accommodation with housing and nursing link workers
Homeless Link

<table>
<thead>
<tr>
<th>HD056</th>
<th>Time to Heal Project</th>
<th>GEAR Project</th>
</tr>
</thead>
</table>

**Accommodation and pathway model**

<table>
<thead>
<tr>
<th>HD007</th>
<th>Bradford Respite/Intermediate Care and Support Service-pathway and accommodation</th>
<th>Horton Housing Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>HD082</td>
<td>The London Homeless Hospital Discharge Network, pathway and accommodation</td>
<td>St Mungo’s</td>
</tr>
</tbody>
</table>

**Accommodation only**

<table>
<thead>
<tr>
<th>HD003b</th>
<th>Hospital Discharge Support Housing</th>
<th>Stonepillow</th>
</tr>
</thead>
<tbody>
<tr>
<td>HD081</td>
<td>A Pathway medical respite centre for homeless people</td>
<td>The London Pathway</td>
</tr>
<tr>
<td>HD033b</td>
<td>Three Flow Lodge</td>
<td>Hestia Housing and Support</td>
</tr>
<tr>
<td>HD017</td>
<td>Friar Lane Homeless Alcohol Rehabilitation Centre — Lincoln</td>
<td>Framework Housing Association</td>
</tr>
<tr>
<td>HD020b</td>
<td>Cornwall Intermediate care and recovery Facility</td>
<td>Saint Petroc’s Society</td>
</tr>
</tbody>
</table>

**Appendix 2: outcomes request from homeless link**

The following data was requested of all projects to enable outcomes and effectiveness to be analysed.

**For each client over the project period:**

| 1. For the project’s duration how many times was the client admitted into hospital? |
| 2. How many times was the client readmitted into hospital within 30 days of a prior admission? |
| 3. On average, how long did the client spend in hospital during each admission? |
| 4a. Of these admissions, how many times was the client discharged into appropriate accommodation? |
| 4b. Please provide details of the accommodation the client was placed in. |
| 4c. If the client was not discharged into appropriate accommodation on any occasion, where did they go? |
| 5. Did the client ever self-discharge? If yes, please list number of occasions. |
| 6. After being discharged, did the client receive on-going support for healthcare? If yes, please provide details. |
| 7. After being discharged did the client receive support for housing? If yes, please provide details. |
| 8a. Is the client still receiving support from the project? If yes, please provide details. |
SECTION 1 - SUMMARY

1.1 Why is there a need for a Hospital Discharge Protocol?

The government expects all local authorities to have a strategy in place to prevent homelessness wherever possible. It has been identified in [City name] that the lack of a hospital discharge protocol has resulted in delays in discharging patients which is costly to the health and social care system. In a small number of cases there have also been patients discharged to the local authority offices where they have then been found to be ineligible for housing assistance and have had to be returned to hospital or left with the prospect of potentially sleeping rough.

“Admission to hospital should be seen as an opportunity to link homeless people or those in housing need to the relevant accommodation and services.”

Formulating a hospital discharge protocol is in the interests of both patients and hospital staff. Saving stress and anxiety for the patient and allowing staff to follow a straightforward process in order to assist in the resolution of a patient’s housing needs early, greatly reducing delays in discharge.

This protocol applies to hospital patients who normally and usually reside within [City name] City Council’s authority boundaries and who are patients in [City name] hospitals.

It is recognised that a significant but small group of people admitted to hospital have no safe or secure home to return to upon discharge, or have their hospital stay extended, because they:

- Were homeless before hospital admission with nowhere to stay and may have been sleeping rough
- Were in an institution such as prison
- Had a temporary arrangement – were living in a hostel or staying with friends or family – and either cannot go back, or there is no bed reserved for them on their return
- Had accommodation before admission but cannot go back there
- Have accommodation but it is no longer suitable, or requires adaptation following their treatment in hospital

The multiple and complex needs and lack of settled accommodation for some patients means that it can be difficult to identify and secure appropriate housing or services for them on discharge. Hospital staff may not always be familiar with relevant housing services/organisations or how they work. Therefore it is imperative to have a protocol in place that will enable hospital staff to identify early where a patient is homeless or in housing need and will also make it possible for hospital staff to contact the relevant agencies/organisations in order to resolve any housing issues prior to patient discharge.

As detailed earlier, any delay in discharging a patient is costly to the health and social care system in [City name] and to the individual. This delay in turn can put back the care of another patient, can exhaust staff and damage the relationship between organisations. It is also difficult for housing staff to find an available and appropriate solution to a housing issue at short notice without access to relevant and necessary information.

This Protocol outlines procedures designed to provide clear, consistent, definitive and unambiguous direction for all those involved in its deployment. It defines effective processes for the response to housing issues without adding to the burden of hospital staff workload by establishing clear roles and routes of communication.

Please ensure that all relevant hospital wards have electronic and paper copies of this protocol and, especially, the flowcharts.

1.2 Who has signed up to this Protocol?

Appendix 3: example hospital discharge protocols
This Protocol has been developed in partnership between [City name] City Council and [City name] & Stamford Hospitals NHS Foundation Trust for use by key agencies in [City name] that work with homeless people who may be admitted to hospital and those who may be discharged to homelessness without positive and professional interventions.

To date, the organisations that have signed up to this Protocol are:

- [City name] City Council Housing Needs Service
- [City name] & Stamford Hospitals NHS Foundation Trust
- [County name] Mental Health Partnerships NHS Trust
- Local housing provider
- [City name] Streets

1.3 Government Departments

The Department of Health issued guidance in 2003 that was explicit about the role of Hospital Trusts in ensuring that homelessness is prevented for patients leaving hospital:

“it is vital all hospitals consider the housing situation of patients to ensure that people are not discharged to inappropriate places, homeless or become homeless as a result of their stay in hospital.”

“All acute hospitals should have formal admission and discharge policies which will ensure that homeless people are identified on admission and their pending discharge notified to relevant primary care services and to homeless services providers. In addition, for patients in psychiatric hospitals/units a post-discharge care plan will be drawn up well in advance of discharge and procedures put in place to ensure that appropriate accommodation and continuity of care is in place for each person discharged.”

When it comes to homelessness, the governments focus is on preventative measures rather than reactive measures. To assist local authorities and their partners in developing protocols aiming to prevent homelessness for people leaving hospital, guidance has been issued on behalf of the Department for Communities and Local Government and the Department of Health along with Homeless Link, recommending steps for developing a protocol for hospital discharge. The guidance outlines that a Hospital Discharge Protocol will be fit for purpose providing it:

- Establishes a patient’s housing status on admission
- Includes procedures for obtaining patients’ consent to share information
- Includes procedures for ensuring that existing accommodation is not lost
- Identifies key external agencies to notify about a homeless person’s admission
- Develops the resources and training needed
- Involves voluntary sector agencies, primary care providers and local authorities throughout the discharge process

Identifying a person’s housing status on admission is essential for successful discharge. The protocol should clarify processes to deal with the different housing circumstances of individuals, including steps to ensure that where someone has accommodation it is not lost while they are in hospital, e.g. because rent is not paid or a hostel place is not kept open. Some homeless people, who are in contact with services, will have a key worker or named individual responsible for overseeing the implementation of an agreed support plan. Most homeless people will know the name or organisation of this person. The key worker should be kept informed of the progress of a person’s admission.

1.4 The Principles of this Protocol

The organisations signed-up to this protocol will work under the principle that every effort should be made to ensure that a patient in housing need is not discharged from hospital before appropriate housing options are identified:

- People leaving hospital in [City name], will have their needs assessed in time to make appropriate referrals in advance of the date of discharge
- No agency will rely on a hospital bed being available in place of suitable housing/accommodation
- People leaving hospital in [City name] will have the best available and appropriate accommodation to meet their housing and support needs
- [City name] City Council Housing Needs Service, and the agencies signed-up to this Protocol, will make every effort to prevent patients becoming homeless during their hospital stay

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12Health & Social Care Joint Unit and Change Agents Team (2003). Discharge from hospital: pathway, process and practice, Department of Health.
13Department for Communities and Local Government (2006). Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation.
1.5 The key messages of this Protocol

Four points have been identified as being the key messages of this Hospital Discharge Protocol. They are:

1. To avoid, whenever possible, a patient being homeless on discharge from hospital
2. To implement the process to be followed by hospital staff at the time of a patient's admission to hospital
3. To seek assistance from other agencies to find accommodation and arrange support where a housing need has been identified
4. To provide information for both patients and staff to be displayed in hospital wards

1.6 Sharing information

There can be little doubt that success in resolving a patient’s housing needs as quickly as possible relies heavily on the ability of different agencies being able to share information with one another. However, before any contact is made to housing and other related professionals by hospital staff, patient consent must always be obtained.

Information should always be shared with the intention of assisting the service user to obtain the most appropriate services to meet their needs, whilst preserving their dignity and privacy.

Information can best be shared by:

- All agencies ensuring that the patient has completed a consent form - making sure that the service user has given written consent to information about them being shared in order to assist them in securing the correct services to meet their needs.
- Sharing information in a positive way that informs people about the needs of the service user and supports good decision-making, rather than trying to ‘sell’ their case.
- Ensuring that any information about known risks is shared – including to other service users, or to staff. Ensuring any risks are not hidden, even if this may lead to another agency making a decision that their services are not appropriate for the particular person at that time.
- Ensuring that information which is passed to other agencies is based on known facts, professional judgements, and close involvement with the service user.
- Basing good decision-making on documented information - this can be informal information which is constructive and supports other evidence, but can be verified.

Implementing the above points would ensure that the right information is available to the right person, in the right place and at the right time. With this being the case, the biggest beneficiary will undoubtedly be the service user.

1.7 Data Protection

Information should be shared with any agency which can assist the service user to obtain or retain appropriate housing and support. Any information shared with such agencies should always be in accordance with Data Protection legislation, and such agencies should have in place guidelines for staff about how and what information to share, how to store information, and what will happen if data protection rules are breached. The eight principles of good data protection, in respect of information held on computer and some paper records as outlined by current legislation, state that data must be:

1. “Processed fairly and lawfully
2. Obtained and processed only for specified and lawful purposes
3. Adequate, relevant and not excessive in relation to the purpose for which they are processed
4. accurate and, where necessary, kept up-to-date
5. Not kept for longer than is necessary
6. Processed in accordance with the rights of the individual and the professional as inferred by the Data Protection Act 1998
7. Kept secure against unauthorised or unlawful processing and against accidental loss, destruction or damage
8. Not transferred outside the EEA, unless that country ensures an adequate level of protection of the data subjects in relation to the processing of the data”14

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14 The Data Protection Act (1998) Schedule 1, Part I
1.8 Confidentiality

All organisations signed-up to this Protocol agree to ensure that information is not disclosed without the consent of the service user, and that it is not disclosed to people who are not entitled to have such information or do not intend to use it in the best interests of the service user. All parties will also agree to deal with any breaches of confidentiality by their staff or organisation.

SECTION 2 – PROCEDURES

2.1 Patients with Mental Health Needs

If a patient with mental health needs is likely to be discharged from [City name] City Hospital or Lucille Van Geest Centre with no accommodation available to them, ward staff should:

- Contact Sara Cleaves in the Housing Needs Service on 01733 864107 (subject to change) before the 8th day of admission, they will make arrangements to visit the patient with a view to providing advice of the best options available for them.
- Clarify with the patient’s Mental Health Team/Care Coordinator that the patient is able to live independently or in a supported housing setting and then note all relevant details to provide to the Housing Needs Service. Please note that Care Coordinators are absolutely critical to this process.
- Every patient with a serious mental illness should have a Care Coordinator. Care Coordinators are closely involved throughout the process in assessing the housing and support needs of a patient and identifying the most appropriate accommodation and support.
- The Care Coordinator will share with the Housing Needs Service a risk assessment and risk management plan, and work out a housing and support package, with the aim of securing the best available option without the patient having to be placed into temporary accommodation.

2.2 Patients under the age of 18

2.2.1 Patients under the age of 16

Any patient admitted to Hospital under the age of 16, that upon discharge will be homeless/threatened with homelessness should be referred to [City name] City Council’s Children Services. In such instances please contact Referral & Assessment on 01733 864180 (out of hours 01733 234724).

2.2.2 Patients aged 16 or 17

Any patient admitted to Hospital aged 16 or 17 that upon discharge will be homeless/threatened with homelessness should be referred to Sara Cleaves in the Housing Needs Service on 01733 864107 (subject to change) in the first instance. A joint assessment will then be undertaken by Housing Needs and the Adolescent Intervention Service (A.I.S) to determine if they can return to a family members home. If no suitable accommodation can be found a referral will be made to Children’s Services who will carry out an Initial Assessment to determine if the patient is deemed to be a “Child in Need”. The outcome of this assessment will then determine the most appropriate accommodation and support for the patient.

2.3 Asylum Seekers and Refugees

2.3.1 Asylum seekers who have not yet received immigration status

Asylum seekers who have not yet received immigration status in the UK are accommodated by a range of providers. The best contact point is the National Asylum Support Service (NASS). NASS is a section of the UK Border Agency (UKBA), which is itself a part of the Home Office. It is responsible for supporting and accommodating people seeking asylum while their cases are being dealt with. NASS can be contacted by calling the Asylum support contact centre on 0845602 1739 (where possible, obtain the patient’s NASS reference number from them prior to calling the contact centre).

2.3.2 Asylum seekers whose application for asylum in the UK has failed

Asylum seekers whose application for asylum in the UK has failed cannot be assisted into housing by a local authority or any other public sector housing mechanism. Families in this situation are supported by NASS (see contact details outlined in section 2.3.1), however single people may have no accommodation and could potentially face sleeping rough. In this instance hospital staff should contact Refugee Action - independent national charity that provides support to asylum seekers and refugees in the UK. They can be contacted on 0207 952 1511. Staff should also contact [City name] City Council’s Adult Care Services on xxxx (select option 1) for advice.

2.3.3 Asylum seekers who are unaccompanied minors (under the age of 18)
Asylum seekers who are unaccompanied minors (under the age of 18) are looked after children by [City name] City Council’s Children Services. In instances where a housing need is identified for such a person please contact Referral & Assessment on xxxxxx (out of hours xxxxxxx).

2.3.4 Refugees
A refugee is an asylum seeker whose application for asylum has been successful. Refugees are entitled to housing assistance in the same way as any other household. Therefore, if a housing need is identified on admission, a referral should be made to the Health to Home representative – [name of staff] (subject to change). They will carry out an assessment and determine a route in to suitable accommodation prior to discharge. This will reduce the number of delayed discharges due to no suitable accommodation being available.

2.4 Rough Sleepers
If a patient is identified as having been rough sleeping prior to their admission to hospital, hospital staff should make a referral to the Health to Home representative – [names of staff] (subject to change). They will carry out an assessment and determine a route in to suitable accommodation prior to discharge.

2.5 Patients discharging themselves
Patients who have no accommodation may be more inclined to discharge themselves from hospital or leave A & E before receiving any accommodation support. This of course makes it very difficult to engage them in drug or alcohol treatment (if applicable), treatment for mental health issues (if applicable) and/or engaging them in a programme to find suitable long term accommodation. Hospital staff are asked to attempt to encourage patients with an identified housing need not to leave hospital or A & E before they have been assessed by a member of the Health to Home team.

Having obtained the consent of the patient (see section 1.6 above), hospital staff should contact the Health to Home team – [name of staff] (subject to change) at the earliest time possible to inform them that there is a patient in hospital/A & E with an identified housing need that is likely to leave before any positive intervention can be implemented.

2.6 Patients with Drug/Alcohol issues
Patients with drug and/or alcohol problems may not yet be in contact with treatment agencies. The Transfer of Care Team in hospital will assess the care needs of a patient and if the patient has a possible need for personal care, arrange that this is provided.

SECTION 3 – ELIGIBILITY FOR WELFARE SERVICES

3.1 British Nationals returning from abroad
British nationals returning from abroad need to be habitually resident in the Common Travel Area – UK, Republic of Ireland, Channel Islands and the Isle of Man.

Anyone returning to the UK following a long stay abroad would need to be interviewed by the Housing Needs Service and assessed regarding their Habitual Residence in the UK. If s/he is not deemed to be Habitually Resident, [City name] City Council would not have a duty to assist and a referral would need to be made to Adult Social Care for an assessment under Section 21(a) of the National Assistance Act 1948.

3.2 EEA Nationals (Nationals of: Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxemburg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden).

If a person from any of the countries above is only exercising an initial right to reside (e.g. they have been in the UK for less than 3 months and are not economically active) in the UK with no restrictions they are not eligible for welfare services, this includes housing assistance.

In order for an EEA national to be eligible for welfare services they must be one of the following:

- A worker.
- A self employed person.
- A person who is employed, but temporarily unable to work due to illness or accident.
- A job seeker, who has previously worked and become involuntarily unemployed in the last 6 months.
- A family member of a person who is currently eligible for welfare services.
Please Note - Employment would also need to be deemed ‘genuine and effective rather than marginal and ancillary’ meaning that just being in work does not automatically confer eligibility for assistance.

If a client is not eligible for assistance a referral would need to be made to Adult Social Care for an assessment under Section 21(a) of the National Assistance Act 1948 xxxxxxx (select option 1).

If a client is eligible for assistance please refer to section 4.1.1

SECTION 4 – ACTIONS TO PREVENT HOMELESSNESS

4.1 Homeless Prevention – Action Checklist

4.1.1 General Wards

Prior to any contact being made to housing and other related professionals by hospital staff, patient consent must be obtained.

**STEP 1**

Establish the housing situation of the patient

On admission, hospital staff should ask every patient for their address.

Do you have permanent accommodation available for you to return to on discharge? Y/N, this is a compulsory question listed in the booking in pack from Cascard.

**STEP 2**

Ascertain whether or not the patient is from [City name] and why s/he may be homeless

If the patient has no accommodation, or is not confident they can return to the accommodation they had prior to admission to hospital, a referral should be made to the Health to Home team - Gill Collingwood, Sarah Oliver or Paula Holstead (subject to change) who will assess the patient on the ward and create a pathway to housing ready for the discharge date.

People from outside [City name]

For people who do not come from [City name], and do not wish to stay in the city, the Local Authority to which they wish to return to should be contacted for assistance.

4.2 Homeless Prevention - Other Key Actions

The following are key actions that should be implemented in all wards with a view to identifying early when a patient may be at risk of homelessness and taking relevant steps to assist in the prevention of that patient’s homelessness.

- Posters will be displayed in all wards, reminding patients that they can ask for help at any time if they are worried about possible homelessness upon discharge.
- On longer stay wards, hospital staff will establish whether or not the patient can return to suitable accommodation - as soon as possible after admission (and no less than a week before discharge).
- On short stay wards, hospital staff will establish whether or not the patient can return to suitable accommodation on admission – the longer the notice that housing agencies have, the more time to arrange supported or emergency accommodation.
- Patients may need to be advised that their welfare benefits (including Housing Benefit) may be reduced after 4 or 6 weeks in hospital. It is very important that action is taken to make sure that the patient is aware of this reduction so that rent arrears do not accrue during their stay in hospital.

4.3 Homeless Prevention – Outside of Office Hours
If you need to make a referral to the Health to Home team outside of ordinary office hours (09.00 – 17.00 Monday to Friday) please contact the Housing Needs out of hours service on xxxxxx
Homeless Link

The PIN UP
Policy, Information, role of NHSLA and Understanding Processes

Homeless Hospital Discharge Protocol

Understanding homelessness

Homelessness takes many forms and includes someone who:
- has no accommodation or has no legal right to stay – they have been rough sleeping or squatting
- is not confident, or can’t return to a given address, e.g. at risk of domestic violence, temporarily staying at a friend’s house, risk of losing their home, loss of a temporary hostel or bed and breakfast place
- has mental health needs, medical/care needs or any other reason which may prevent them returning to the given address, or it becomes unsuitable

Key messages

What to do if a patient attends A&E or assessment wards and you are concerned that they are homeless complete the details on the care and assessment document as soon as possible to identify the actual problem.

Make a referral as soon as possible to the Housing options centre (see flow chart for details), please ensure that you have sought the consent of the person before you refer them.

Information you will need to refer includes
- Name and DOB and contact number of the person.
- previous address and type of accommodation,
- details of any dependants,
- admission and discharge date if applicable,
- any agencies or support involved with the person
- any risks posed by the patient
- any ongoing health care needs

For inpatients with ongoing care needs make referral to social worker

For people attending A&E or very short stay admissions contact the housing options centre

Give a key contacts card to the person and refer/make an appointment as appropriate. See information leaflet with details of Services available
What we do
Homeless Link is the national membership charity for organisations working directly with people who become homeless in England. We work to make services better and campaign for policy change that will help end homelessness.

Let’s end homelessness together

Homeless Link
Gateway House, Milverton Street
London SE11 4AP

020 7840 4430

www.homeless.org.uk

Twitter: @Homelesslink
Facebook: www.facebook.com/homelesslink

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