Why Invest?

From hospital to home: improving hospital admission and discharge for people who are homeless

Having somewhere to go when we leave hospital is something most of us take for granted. Suitable accommodation is needed to help us recover from medical treatment and prevent any health conditions worsening. Yet many homeless people are discharged back to the street or to accommodation which cannot meet their ongoing medical needs.

If we consider that people experiencing homelessness have much poorer health and end up in hospital more than the general population, this becomes even more problematic. Living on the streets or without a stable home can make people vulnerable to illness, poor mental health and drug and alcohol problems. At the same time, difficulties accessing help at the right time to address these problems can mean they can deteriorate until they reach a crisis point, leading to greater use of expensive hospital services.

With many homeless people using hospital, providing the right support from the time they are admitted right through to discharge is vital to increase recovery and reduce the risk of readmission. Getting the admission and discharge process right improves people’s health and saves money:

- Addressing housing needs early on can make discharge more timely and prevent unnecessarily prolonged length of stay
- Patients discharged at a clinically appropriate time and to suitable accommodation are more likely to recover from an illness, and reduce the risk of unplanned re-admissions to hospital within 28 days – one of the key indicators the NHS has to report on.

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1 Homeless Link, The Unhealthy State of Homelessness, 2014
2 It is estimated homeless people use hospitals at a rate be four times higher than the general population. Looking at inpatient costs only, the difference is eight times higher among homeless people.
Putting this into practice

Guidance has encouraged local partners to work together and develop protocols for homeless people entering and leaving hospital. Despite this, research in 2012 found that more than 70% of homeless people were discharged from hospital back onto the street, without their housing or underlying health problems being addressed. This was further damaging their health and increasing costs to the NHS through ‘revolving door’ admissions.

In May 2013 the Government invested £10million in a national Homeless Hospital Discharge Fund. Voluntary sector organisations, working in partnership with the NHS and local authorities, could bid for capital and revenue funding to improve hospital discharge procedures for people who were homeless.

A total of 52 projects - delivered between 2013 and 2014- were awarded funding. Evaluation of the programme provides further evidence of the benefits that can be achieved if local areas work together to improve their discharge practice:

- 69% homeless people had suitable accommodation to go to when they were discharged
- This rose to 93% of homeless people in projects which combined NHS and housing staff
- 72% were not readmitted within 28 days of discharge
- 71% agencies reported improved data sharing across housing, the NHS, and voluntary sector
Homeless Link

- 84% voluntary sector agencies reported good working relationships with the NHS
- Patients reported higher standards of care, with non-judgemental treatment and improved support throughout and after their time in hospital
- Staff reported improved working links across housing and the NHS, better access into accommodation and ongoing medical care, and some projects could already show cost savings through reduction in A&E use.
- 4 in 10 (43%) pilots had already secured continued funding to sustain the service, in most cases with joint investment the CCG and Local Authority

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 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 staff from the discharge project were helping her with this. Helping her in her own tenancy was a key part of dealing with it:

“To be blunt [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, taking her to hospital and doctors’ appointments, picking up prescriptions and helping her with her benefit claims.

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

How you can save money and change lives

“We have been able to work with homeless 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.” (local partner)
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Every effective discharge saves the NHS and local authority money, through avoiding unplanned repeat admissions and costs of someone becoming homeless, on top of the difference it will make to somebody’s own health and housing situation. But it requires local agencies to come together to develop an effective pathway and make sure this can be sustained.

Our evaluation found key elements to making it work:

- Involving the local authority housing team, NHS staff, local health commissioners and the voluntary sector from the start is key to getting an effective pathway off the ground
- Adequate joint investment from LA and NHS partners (including Clinical Commissioning Groups and Public Health) helps make most effective use of resources
- Clear information sharing agreements so that patient care and support can be consistent across agencies
- Ensuring all partners understand accommodation options locally and how to access these. Embedding a housing worker within the discharge team, designating bed spaces for those leaving hospital, funds to help pay for rent in advance, and packages of support for people once they are in accommodation all proved effective in the projects undertaken.

As an elected member, local authority housing lead, Clinical Commissioning Group, Public Health practitioner or homelessness agency there is an opportunity to improve your practice locally, saving money and changing lives, starting with three simple steps:

- Review your current hospital discharge and admission pathway: talk to local agencies and homeless people, and examine what local data is telling you about hospital use and discharge outcomes
- Use existing homelessness forums and commissioning groups to develop new ways of working and identify opportunities to invest in improvements
- Include hospital discharge as part of your annual health and housing planning, and undertake routine monitoring of the discharge outcomes for homeless people within your existing performance frameworks.

Finding the right accommodation for people at this time of crisis can be hard, particularly against increasing pressure to budgets, and a shortage of suitable housing in many areas. But the evaluation provides further evidence about what can be achieved.

“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.”

To download the full report please visit: www.homeless.org.uk