

# **Cornwall Homeless Patient Hospital Discharge Service**

## **Evaluation Report**

**December 2017**

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## Executive Summary

This paper sets out the achievement of the Homeless Patient Hospital Discharge Service so far, the challenges it has faced, and Shelter's ambitions and aspirations for future funding.

Due to the success of the service Shelter funded the Homeless Patient Adviser post until March 2017. Our national priorities and continued cuts to statutory funding meant we were not in a position to fund the service. As part of Cornwall Housing's Rough Sleeper Reduction Strategy, extra funds were identified from their reserves and certain services were funded for an extra year. This included the Homeless Hospital Discharge service which was awarded funding for a further year, which will run out in March 2018.

**We are seeking sustainable long-term funding from bodies that have a vested interest in the service and who continue to benefit from the cost savings and positive client outcomes. By funding the service, commissioners can play a key role in shaping and flexing the service to meet strategic objectives and the needs of the local population in Cornwall.**

We look forward to building on the huge success of the service; continuing to set a quality benchmark across the country by building on the knowledge and expertise gained in the last 3 years in Cornwall and the range of advice services we deliver within health settings across the country.<sup>1</sup>

### The features of the service

**Since the start of the Cornwall Patient Hospital Discharge Service in January 2014 over 600 patients have been discharged with a support plan in place, with a third of all patients discharged into accommodation.**

Dedicated support to homeless patients ensures they are discharged into secure and safe accommodation<sup>2</sup>, with support plans to reduce the length of stay in hospital and community support to ensure risks or readmission are reduced.

### The impact of the service

Since January 2014 609 patients were discharged with a support plan and 415 moved into alternative, suitable accommodation. Between 2014 to 2015 the service has made a cost saving of **£280,500**<sup>3</sup> across the Royal Cornwall Hospitals NHS Trusts (RCHT).

Addressing housing needs early can prevent unnecessary, prolonged, length of stay and access to appropriate accommodation can reduce the risk of unplanned re-admissions, alongside an increase of the likelihood of recovery from an illness.<sup>4</sup> Our experience tells us that in order to sustain a home, a holistic approach that addresses multiple and underlying causes is needed.

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

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<sup>1</sup> Shelter Advice Services (Health Settings) **(a)** Social Prescribing service in Newcastle **(B)** Outreach Housing Advice Workers (with a focus on family health) based in London and **(C)** Housing Adviser based at Birmingham Childrens Hospital.

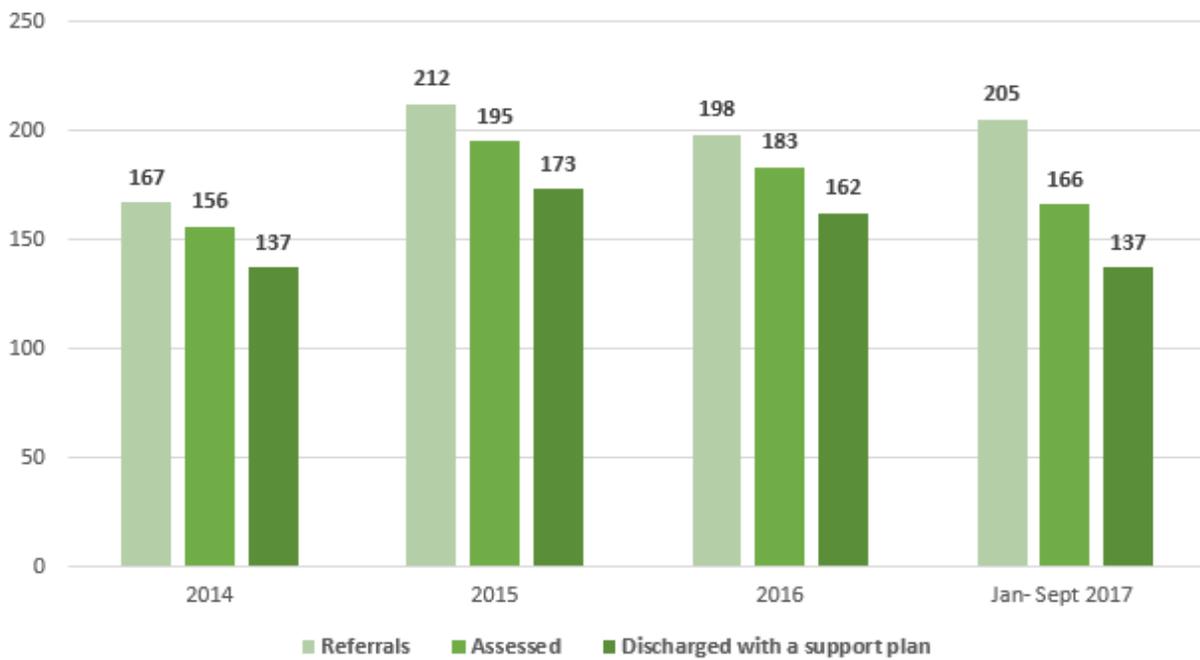
<sup>2</sup>Safe and suitable accommodation has been defined as: Crisis Accommodation/Private Rented/Hospital Discharge Beds/Social Housing/Supported Accommodation/Emergency Accommodation.

<sup>3</sup> Figures based on reduction in Bed Stays for RCHT in 2014 and 2015.

<sup>4</sup> Homeless Link: Review of Hospital Discharge Fund 2015, page 1

Our dedicated worker with a housing expertise has resulted in:

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



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## Key highlights

**A third of homeless patients had suitable accommodation to go to when they were discharged between December 2014 to September 2017.**

**78%** patients were discharged with a support plan.

**168** rough sleepers accessed the service from 2014 to September 2017. Based on the 2013 - 2016 rough sleeping count (281), a significant proportion of that group became known to the project.

**13%** of patients were placed in the dedicated hospital discharge accommodation.

**10%** of patients were placed in alternative supported accommodation.

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*“(The Cornwall Service) is of huge benefit to the patients as it ensures that they do not have to stay in hospital any longer than necessary and that they are being given good, precise and up to date information by professionals who really know the system.”*

Occupational Therapy, Acute Mental Health Ward, Bodmin Hospital, Cornwall Partnership NHS Foundation Trust

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## Introduction

Since September 2015 the Patient Liaison Adviser continues to play a critical brokerage role between housing and health professionals in Cornwall. Based on the original Homeless Hospital Discharge Fund objectives, the service continues to:

- Assess patients who are homeless, or who may be homeless upon discharge, on admission to hospital
- Provide housing advice and a planned discharge from hospital into suitable accommodation
- Reduce the number of delayed discharges (bed-blocking) which result from patients being homeless or not having a suitable home to return to.

Our Patient Liaison Adviser works closely with hospital staff to identify patients who need help to address complex housing needs. To do this we deliver specialist housing advice complemented by intensive resettlement support. We support patients who are clinically stable but unable to be discharged from hospital due to crisis, or risk of crisis, as a result of hardship. Engagement with clients and service data evidences crisis is often caused by:

- Patients exhibiting multiple complex needs.<sup>5</sup> Since the start of the service in 2014 on average **41% of clients accessing the service have mental health issues**. There was an increase of 26% between 2016 to September 2017. This is often the main barrier to a safe and secure discharge and presents an on-going challenge to health professionals
- uninhabitable property in disrepair
- inappropriate accommodation
- temporary accommodation (or lack of) on admission to hospital
- lack of food or money.

Through this service and in partnership with a range of stakeholders, Shelter continues to provide specialist housing advice tailored to patients in a variety of circumstances and act as their advocate to statutory bodies. For example, patients who are non-priority homeless will be given advice to access suitable recovery accommodation, PRS access schemes, benefits, debt and welfare advice and access to the Enabling Fund Which allows the project worker to provide financial assistance to a patient, to ensure that their discharge is not delayed. The Homelessness Reduction Act will be implemented as of April 2018 in all Local Authorities. This places more emphasis on public bodies to refer clients when needed and this post will help to fulfil that duty and enable seamless join up of support.

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*“The work (the adviser) allows us to focus on mental health, without (the adviser) we would spend much of our clinical time attempting to navigate a very complicated homelessness process.”* Adult Psychiatric Liaison Nurse, Wellbeing Centre, Royal Cornwall Hospital, Triliske

### Current hospital discharge accommodation providers: an update

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<sup>5</sup> **Definition:** Homeless individuals have multiple and complex problems relating to drug and/or alcohol dependency, poor physical and mental health, contact with the criminal justice system, and histories of institutional care and traumatic life events. Good practice briefing: Housing first Bringing permanent solutions to homeless people with complex needs, Shelter, December 2008, page 1

Accommodation Provider	Number of bed spaces	Level of support
St Petroc's (Year 1)	Two fully furnished rooms in shared house. One fully furnished room in shared flat.	Visits from staff a few times a week, providing 2-3 hours a week.
St Petroc's (Year 2)	Four fully furnished rooms, own shower room, shared kitchen	Support staff based in on site office, available at varying times. Concierge security from 7pm to 7am every night.
St Petroc's (Year 3)	Four fully furnished rooms, own shower room, shared kitchen	Support staff based in on site office, available at varying times. Concierge security from 7pm to 7am every night.
Coastline	Fully furnished two-bedroom flat	Support provided at around 2 hours per day, per client from Monday to Friday. Visits from staff over weekend, CCTV monitored 24 hours a day.

Following on from the previous evaluation published in July 2015, the decision was taken by St Petroc's Society and agreed by the steering group to only use the property in Pool for the discharge beds and stop utilising Helston bed spaces given the locality and access issues for clients with limited mobility.

The service therefore has access to four rooms, all ground floor, one with wet room facilities, with ground floor kitchen. However, the challenge of offering accommodation to those who have complex needs remains. Many of our clients have ongoing and complex issues; ranging from alcohol and substance misuse addiction, are high risk, or entrenched rough sleepers. St Petroc's policies, in line with the supported housing they offer, means many of our clients are excluded from accessing services.

Funding for the remaining two bed spaces has been transferred to Coastline Homeless Service. Since May 2016 we have been able to offer accommodation to those clients who have the least choice and are often discharged back onto the streets.

St Petroc's Society have confirmed that capital funding provided by the Department of Health to set up the project has now been spent. There is no excess left despite it being possible for the majority of clients to reclaim Housing Benefit to cover charged rental liability during this period.

## Cornwall needs analysis

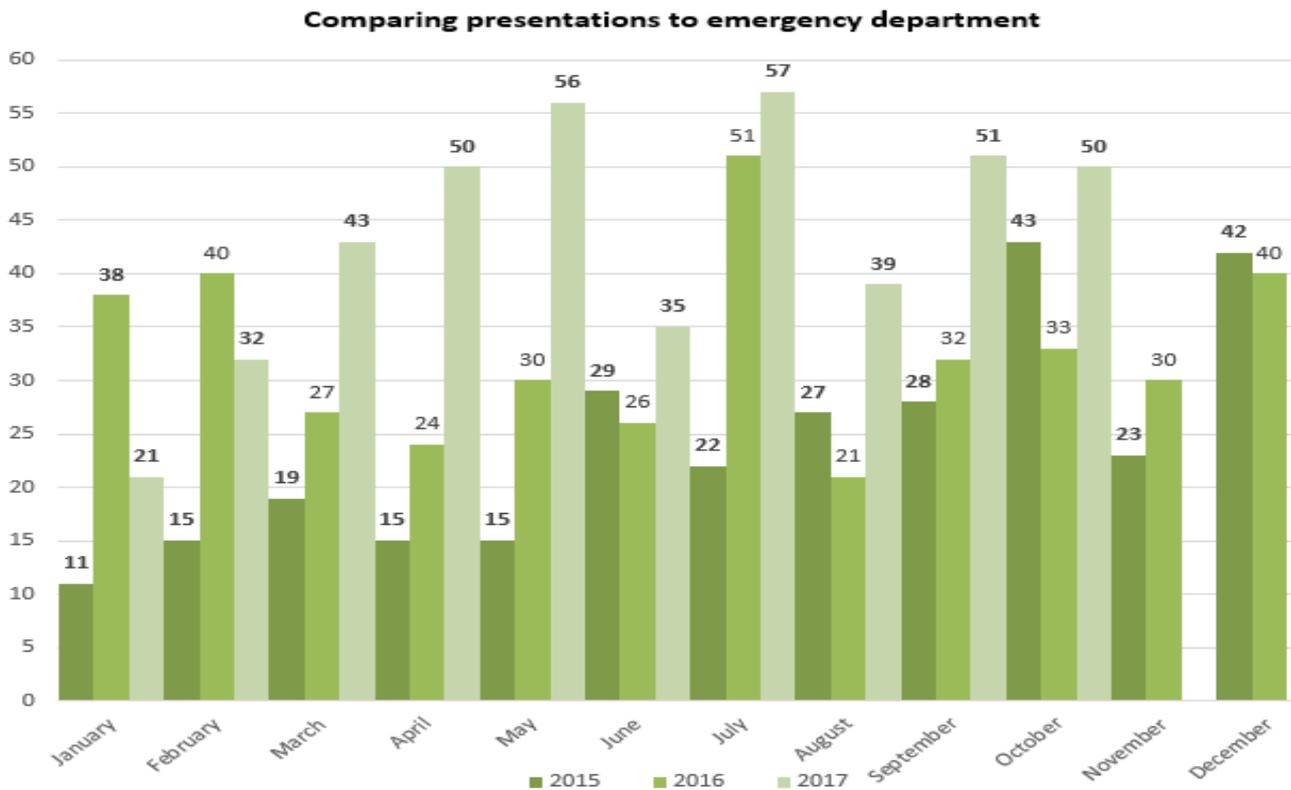
The links between housing and health can broadly be grouped into the following areas:

- **Bad housing:** damp / mould / serious overcrowding
- **Homelessness:** street homeless / temporary accommodation
- **Debt and benefits:** need for advice and guidance / fuel poverty
- **Independent living:** housing support<sup>6</sup>

Based on current service data 56% of clients accessing the service are rough sleeping, staying with family or living in the private rented sector. The most frequent reasons for hospital admissions are a result of medical issues outlined below which suggests that the main client group for this service have multiple complex needs:

- Psychosis
- Suicide threat/attempt
- Trauma
- Infection
- Alcohol/Substance collapse/fit.

### NFA presentations to Emergency Department



This graph shows the number of presentations to the emergency department of those reporting to be NFA or using the day centres as a care of address for 2015, 2016 and 2017. It is each presentation rather than each

<sup>6</sup> Commission on Housing and Wellbeing: A Blueprint for Scotland's Future', 2015

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person, so one patient has had 53 presentations between 2015 – 2017. **What it does show is that 2017 has had a marked increase in the number of people presenting to ED stating they are homeless in 2017.**

### **Supporting evidence**

Cornwall County Council's 2015 Homelessness Strategy and Homeless Review outlines the links between people with multiple complex needs and homelessness, a group who reflect the service profile to date.

Since 2013 the number of rough sleepers officially counted in Cornwall have been high<sup>7</sup>, this group has complex needs and are shown to have worse outcomes than other groups in the population in terms of physical and mental health and substance abuse. The increasing presence of rough sleepers had been an real issue in Truro in 2016. Cornwall County Council along with the Mayor tasked the Drugs & Alcohol team to set up task force to look at solutions. The team includes Shelter, the Anti-Social Behaviour team, DAAT, St Petrocs, Addaction, Police and Konnect Cornwall plus others.

The Moorfield Project was aimed at supporting chaotic rough sleepers who are sleeping at a multi car park in Truro. St Petrocs run a Cold Weather Provision from Mid-December to Mid-February. They open up office doors overnight offering floor space to 19 people. Alongside this Shelter's Homeless Patient Adviser offered solutions for some of the clients by utilising discharge beds.

There is an increasing proportion of households approaching Cornwall Housing threatened with homelessness from the private rented sector.

### **Private Rented Sector poor housing conditions: impact on safe discharge support packages.**

Conditions in the private rented sector are worse than in any other form of tenure. 33% of private rented homes fail to meet the Government's Decent Homes Standard, compared to 20% of owner occupied homes and 15% of social rented homes.<sup>8</sup> Shelter's research found that over 6 in 10 renters (61%) have experienced at least one of the following problems in their home over the past 12 months: damp, mould, leaking roofs or windows, electrical hazards, animal infestations and gas leaks. 10% of renters said their health had been affected because of their landlord had not dealt with repairs and poor conditions in their property in the last year.<sup>9</sup>

### **Current Position of the Private Rented Sector in Cornwall<sup>10</sup>**

Cornwall has particular challenges around the age of the housing stock and the lack of thermal comfort in many homes. Currently:

- 94,000 private sector dwellings fail the Decent Homes Standard, mainly because of the lack of adequate heating and/or insulation and excess cold;
- 18,050 dwellings failed the disrepair standard;
- The worst conditions are in the private rented sector which also houses a high proportion of households in receipt of benefit (51%)

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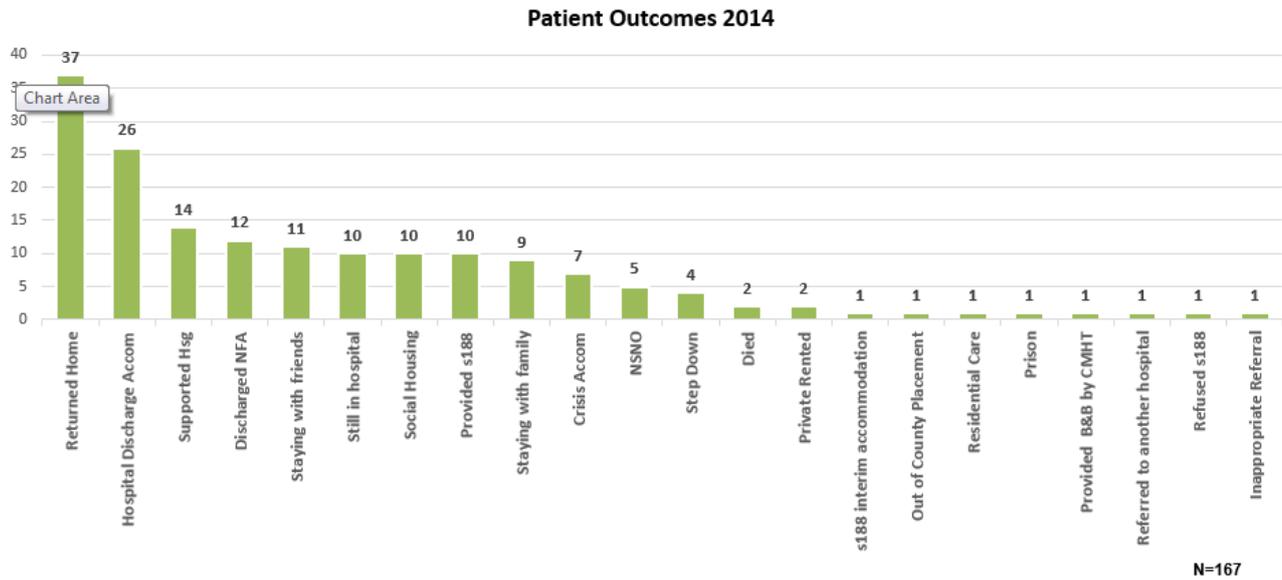
<sup>7</sup> Rough Sleepers count: 2013 (77), 2014 (40), 2015 (65), 2016 (99) =281

<sup>8</sup> Consultation response: Shelter's response to the review of property conditions in the private rented sector, March 2014, page 3

<sup>9</sup> Safe and Decent Homes: solutions for a better private rented sector Report, Shelter (British Gas), December 2014, page 7

<sup>10</sup> Cornwall Local Plan: Housing Evidence Base Private Rented Sector Housing Evidence Base Briefing Note 16

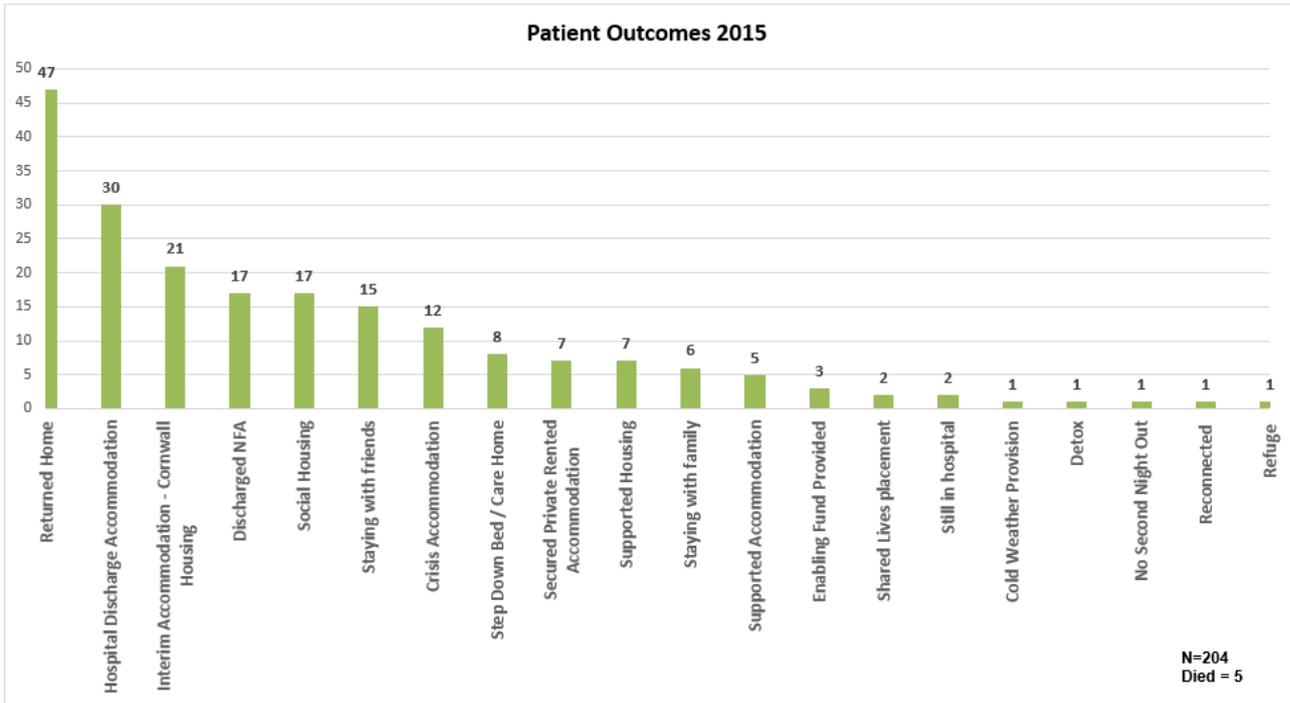
## Patient outcomes



With the assistance of our dedicated Patient Liaison Adviser:

- 38% of patients secured suitable accommodation.<sup>11</sup>
- 22% of patients were assisted to return home.
- 16% of patients were placed in a dedicated Hospital Discharge Accommodation.
- Only 7% of patients were discharged as NFA.

<sup>11</sup> Secured accommodation defined as HDA (26), Supported Housing (14), Social Housing (10), Crisis Accommodation (7), NSNO (5), Private Rented Sector (returning home) (2) N=64 patients in total.

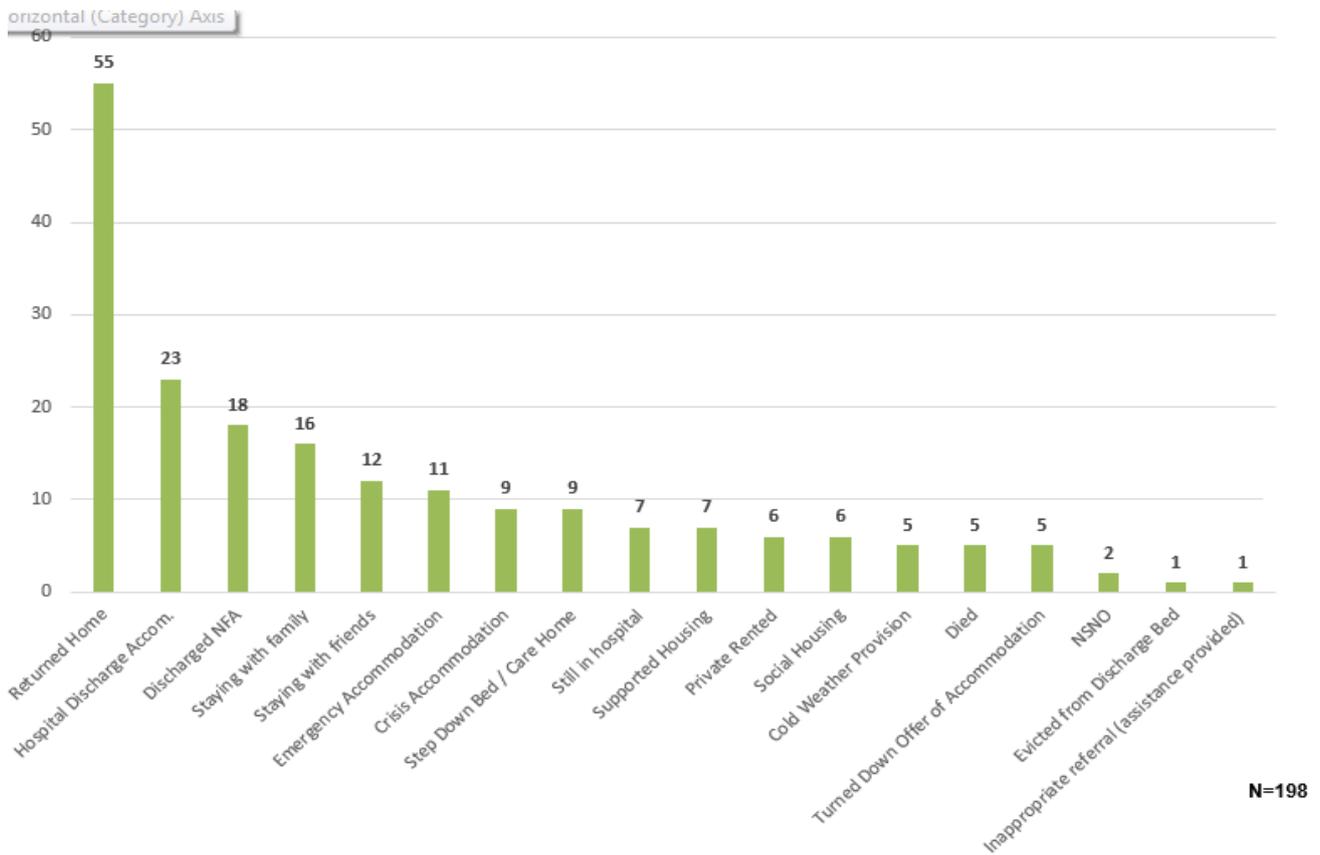


With the assistance of our dedicated Patient Liaison Adviser:

- 27% of patients secured suitable accommodation.<sup>12</sup>
- 23% of patients were assisted to return home.
- 15% of patients were placed in the dedicated Hospital Discharge Accommodation.
- 10% of patients were placed in interim accommodation through Cornwall Housing.
- Only 8% of patients were discharged as NFA.

<sup>12</sup> Secure accommodation defined as HDA (30), Crisis Accommodation (12), Supported Housing & Accommodation (12), Refuge (1) N=55 patients in total.

## Patient Outcomes 2016

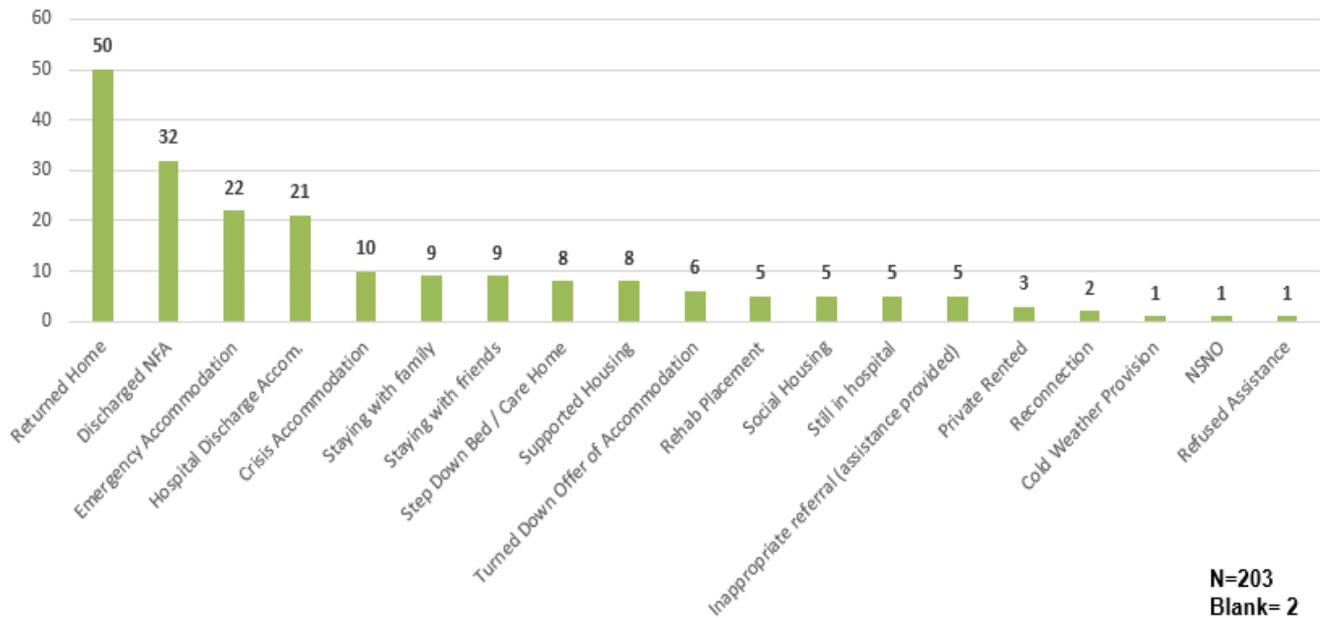


With the assistance of the dedicated Patient Liaison Adviser:

- 37% of patients were assisted to return home.
- 12% of patients were placed in a discharge bed.
- 8% of patients were placed in interim accommodation.<sup>13</sup>
- Only 12% of patients were discharged as NFA.

<sup>13</sup> Interim accommodation defined as Crisis Accommodation (8), Hospital Discharge Beds (9), No Second Night Out (2), N=12 patients in total.

## Patient outcomes January – September 2017



With the assistance of the dedicated Patient Liaison Adviser:

- 25% of patients were assisted to return home.
- 11% of patients were placed in emergency accommodation.
- 10% of patients were placed in a discharge bed.
- 27% of patients secured accommodation on discharge – crisis, supported housing, social, private rent, CWP, NSNO

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## Repeat Admissions

### 2014

- 64% of the patients referred to the project have had further admissions, which suggests a link between poor health and homelessness.
- Of those readmissions; 45% were within 30 days of the last admission, 52% were within 90 days of the last admission and 69% of the readmissions were as a result of the same condition.
- Of the 84 patients who had admissions prior to the referral to the project, 51% were admitted to hospital again.

### 2015

- 74 patients referred to the service had been admitted to hospital in the previous year, with 2 patients having had 11 previous admissions in the last year.
- 60 of the patients referred to the project, 122 have had further admissions, which suggests a link between poor health and homelessness.
- Of those 122 readmissions; 18 were within 30 days of the last admission, 35 were within 90 days of the last admission and 54% of the readmissions were as a result of the same condition.
- Of the 74 patients who had admissions prior to referral to the project, 39% were admitted to hospital again.
- The patient with the highest number of admissions (6 prior to referral to the service and 9 after the referral) has since been able to access funding for housing support to be provided by Independent Futures, which means they could access legal advice from Shelter, attend GP appointments and collect prescriptions regularly. As a result, there has been 1 admission, which was planned and a reduction in the number of calls to emergency services.
- There are 28 patients who have had 3 or more admissions, 8 of which have long term conditions which have led to the accommodation no longer being suitable or them unable to seek advice in the community as a result of their ill health. There is little that can be done to prevent such cases, but the service can start engaging with these patients before crisis point.

### 2016

- 33 patients referred to the service had been admitted to hospital in the previous year, with 1 patients having had 55 previous admissions in the last year.
- 24 of the patients referred to the project, had a further 44 admissions, which suggests a link between poor health and homelessness.
- Of those 44 readmissions; a total of 362 days spent in hospital. 16 were within 30 days of the last admission, 14 were within 90 days of the last admission.
- Of the 33 patients who had admissions prior to referral to the project, 45% were admitted to hospital again.
- The patient with the highest number of attendances, 55 to the emergency department, has a history of using acute hospital service as a way of coping, they move from area to area and are regularly attending emergency departments or being admitted to acute mental health hospitals having caused injuries to themselves or taking significant overdoes. These patients are difficult to support as they tend

to leave the area after a few months, maybe returning a few months later. With the same issues still unresolved.

- There are 20 patients who have had 3 or more admissions, all would fall into the complex needs category, which shows a link between chaotic lifestyles and poor health or reliance on acute services to provide support that community services are no longer able to offer.

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*“(The Adviser) attends the department and our short-stay ward to see patients directly, enabling earlier and safer discharge. (The Adviser) has been key to preventing ‘revolving door’ attendances with several individuals” Consultant Emergency Physician, Royal Cornwall Hospitals NHS Trust, Clinical Director, Peninsula Trauma Network*

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## Operational successes

Since it began, the Service has achieved some real successes despite facing a number of challenges in the nature of the service delivery. We have summarised the challenges faced and the successes achieved in the table below.

Theme(s)	Updated summary
<b>Integration of the Hospital Discharge team with clinical staff</b>	<ul style="list-style-type: none"> <li>■ Our dedicated Patient Liaison Adviser was able to record improved positive responses in working across multiple teams in health, social care and housing where communications had not previously existed.</li> <li>■ Our Adviser has continued to lead and implement the county-wide multi-agency protocol.</li> <li>■ Part of a weekly screening meeting held on the acute mental health wards to highlight any patients with housing issues.</li> <li>■ Now sitting within RCHT’s safeguarding team, allows both teams to share information and learning with mutual patients and has built stronger links within the main hospital site.</li> </ul>
<b>Delivery</b>	<p>We have used our expertise in delivering national programmes to make sure that this Service has been implemented successfully:</p> <ul style="list-style-type: none"> <li>■ <b>Advisor expertise:</b> as well as being a housing expert, our advisor is able to assist clients with many types of debt and welfare benefit issues.</li> <li>■ <b>Locations:</b> successfully operating out of three main locations, but also providing support for the community beds.</li> <li>■ <b>Integration:</b> the Service has integrated well with a range of departments across RCHT and CFT.</li> </ul>
<b>Referrals</b>	<ul style="list-style-type: none"> <li>■ <b>‘No wrong door approach’:</b> through accessing the Service, clients are signposted or referred on to a wide range of other services to help them address their wider needs.</li> <li>■ <b>Referral process:</b> the development of this process has reduced the level of client drop off between point of referral and Service contact.</li> </ul>

Theme(s)	Updated summary
	<ul style="list-style-type: none"> <li>■ <b>Signposting:</b> positive relationships have been built with external agencies and accommodation providers to ensure clients secure suitable accommodation and their wider needs are met.</li> </ul>
<b>Addaction joint working</b>	<ul style="list-style-type: none"> <li>■ Following on from the Moorfield Project, it became clear that many of the frequent attenders to the emergency department sit within the caseload of the drug and alcohol team. So to replicate the work undertaken by Shelter for housing issues, Addaction are piloting a service which provides in-reach to the acute hospital, targeting those that are regularly attending.</li> <li>■ Replicating the work undertaken during the Moorfield Project, Shelter and Addaction have been able to target patients and provide clear pathways to treatment that make use of the discharge beds prior to, or post treatment and sometimes as detox locations.</li> </ul>
<b>Guidance and training for NHS staff</b>	<ul style="list-style-type: none"> <li>■ The protocol was developed within the first 3 months of the service; building on existing protocols, guidance and good practice established elsewhere, but primarily drawing on local stakeholder and client input to reflect the unique geographical factors of service delivery in a large rural area.</li> <li>■ Partnership working has been a critical element of this service. Key members of operational staff and decision-makers in hospitals, mental health facilities and partner agencies, will be encouraged and supported to adopt the protocol to ensure agreed care pathways for discharged patients are consistent. Training and awareness raising events (e.g. induction, team meetings) helped staff to better understand the service available.</li> </ul>

## Wider benefits of the service

The Service supports clients to build the skills, knowledge and confidence they need to address the problems they face. We help people achieve sustainable outcomes which promote independent living and reduce their need for statutory services.

The learnings identified by Homeless Link's review of the Hospital Discharge Fund reflects the successes and challenges of the Cornwall Hospital Discharge delivery model.

*"The most successful projects were those which combined health and housing professionals in the homeless person's package of care, during and after the stay in hospital. However, the grants funded 6 month-long projects, and many reported difficulties with this short time frame. Whilst some have been given additional funding from local commissioners, there is a real risk that the good progress could be undone without a long-term investment strategy for these approaches."<sup>14</sup>*

<sup>14</sup> Homeless Link: Review of Hospital Discharge Fund 2015, page 1

## Client outcomes achieved through the Hospital Discharge Service

### Health

- Allowing clients to be discharged from hospital in a timely and safe way.
- Reducing the need for repeat admissions to hospital.
- Clients have an address so that aftercare appointments can be co-ordinated and GPs registered with.
- Accommodation is suitable for the needs of the client and promotes their recovery.
- Ensuring homeless patients that may otherwise be discharged too early remain until their conditions are appropriately treated.

### Economic wellbeing

- Income maximisation through assessing benefits and specialist debt management.
- People helped to address debts and manage money/finances effectively.
- Budgeting skills learning sessions.
- Access to hardship and grant funds.
- Affordability checks on properties.

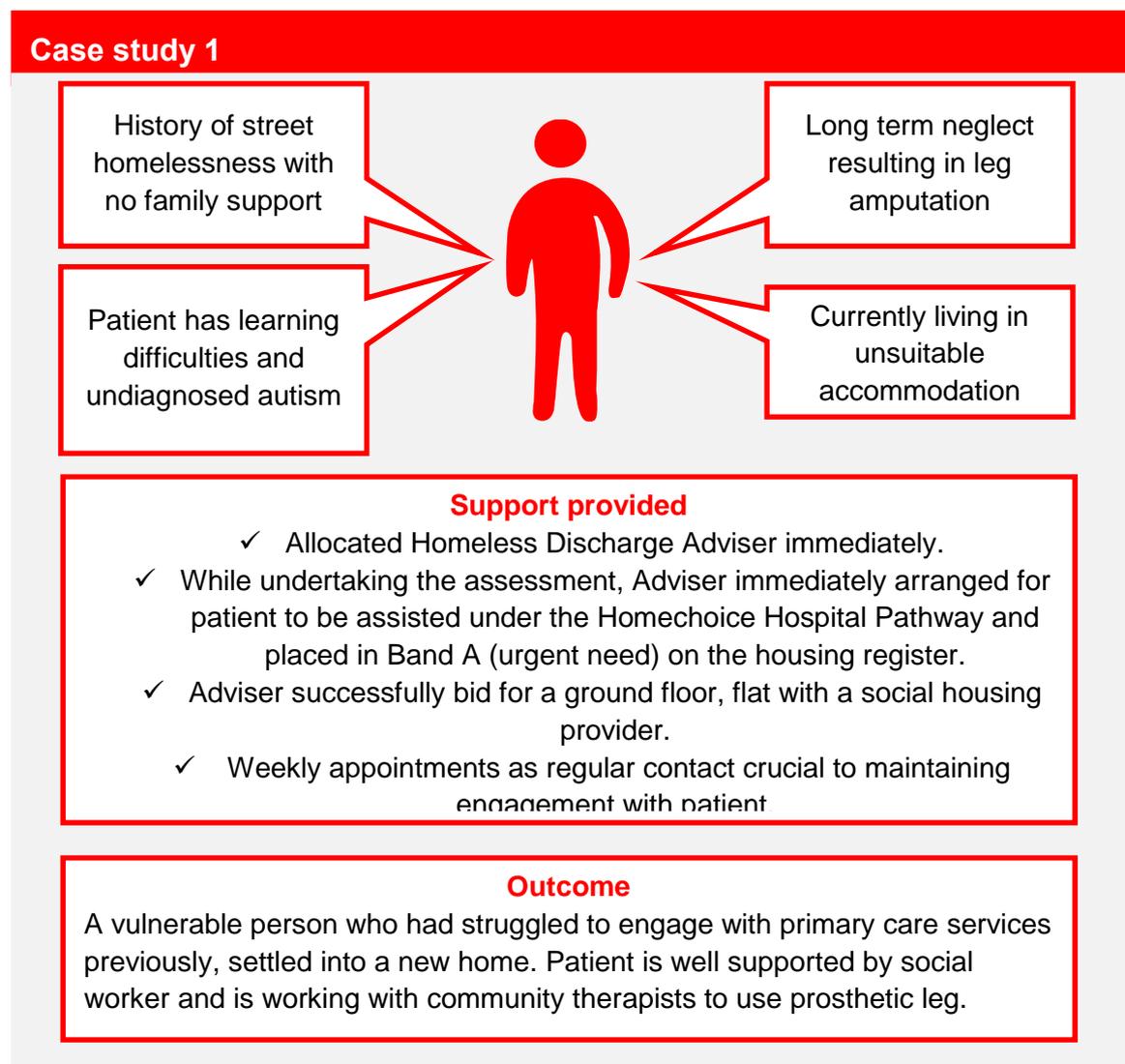
### Work, leisure, social, education and training

- Helping clients to identify and plan how they can work towards their aspirations with help from local community agencies.



## Case Studies

The three case studies below demonstrate the positive impact the project has had on the patients accessing the service and the complexity of problems facing this vulnerable client group. As outlined in case study 3 the complexity of issues often leads to repeat admissions. For clients who return to sleeping rough, or find their accommodation unsuitable, the service continues to play a key role in the recovery process.



Number of bed days in last year	27 acute bed days 118 community bed days
Cost of Bed Days	£56,500
Number of admissions since support	0
Number of Bed Days	0
Admissions within 30 days	0
Referral made	May 2015

## Case study 2

Patient lost home, job and partner as a result of heavy drinking

Patient prior to admission had been living in a car for almost a year



Deterioration in health related to liver problems

Frequent hospital admissions

### Support provided

- ✓ Allocated Homeless Discharge Adviser
- ✓ Linked patient in with Addaction hospital in-reach workers, who started to build up therapeutic relationship with patient.
- ✓ Referral was made to Coastline Homeless Service and they were accepted to the discharge beds.

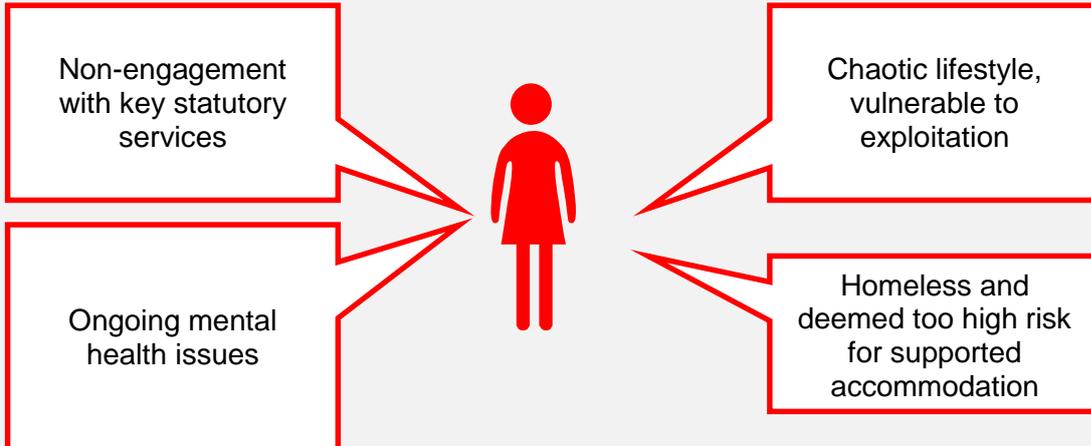
### Outcome

Patient engaged well with support both from Coastline and the Community Addaction worker, and had maintained abstinence during time in discharge beds. Has now moved into long term supported housing, his health has improved, he has put on weight because he had been struggling to eat and taken up cycling. He has had the odd relapse but continues to engage well with support. No further hospital presentations or admissions.

### Calc

Number of admissions prior to referral	4
Number of bed days in last year	8
Cost of Bed Days	£8,000
Number of admissions since support	0
Number of Bed Days	0
Referral made	June 2017

### Case study 3



#### Support provided

- ✓ Allocated Homeless Discharge Adviser immediately
  - ✓ Referred to the Rough Sleeper Operational Group
  - ✓ Supporting key agencies/workers to look for solutions
  - ✓ Referrals to complex needs accommodation providers

#### Outcome

A vulnerable person who has struggled to break the cycle and is currently in hospital again after being transferred from prison. We are continuing to work with the patient.

Number of previous admissions	3
Number of days in the previous year	27 (acute ward) & 88 (out of county acute ward)
Cost of Bed Days	£10,800 and £55,000 = £65,800
Referral made	December 2015
Current admission since	September 2016
Treatment options	Locked rehab

## Cost Savings

### For RCHT<sup>15</sup>

Cost savings to NHS <sup>16</sup>	
Project year	Update <sup>17</sup>
2014	<p>The service has continued to improved patient flow, reducing bed days from 5.77 to 4.72 for patients identified as homeless, saving £56,000. The service has also reduced the amount of bed-days used for homeless patients down from 976 (pre-service) to 638 (once service in place), saving 338 bed days or £169,000 (* £500 per acute hospital admission).</p> <p>Wider whole system flow benefits also apply, demonstrating an additional £82,000 savings in relation to the management of the most complex care patients.</p>
2015	<p>The service has continued to improved patient flow, reducing bed days from 4.62 to 2.75 for patients identified as homeless, saving £56,000. The service has also reduced the amount of bed-days used for homeless patients down from 638 to 415, saving 223 bed days or £111,500 (* £500 per acute hospital admission).</p> <p>Wider whole system flow benefits also apply, demonstrating an additional £77,234 savings in relation to the management of the most complex care patients.</p>
2016	<p>In previous years we have seen a reduction in bed days spent in the hospital by homeless patient, this has not been the case this year as there has been an increase in referrals of complex needs clients, but also long term rough sleepers being admitted to hospital with significant health problems. There has also be an improvement to RCHT referring cases to the service as a result of being based in the safeguarding team.</p> <p>The service still has an impact on patient flow, reducing length of stay for patients, with those with repeat admissions staying an average of 6.26 stays prior to involvement, and with any further admission being an average of 5.85.</p> <p>The average length of admission was 14.79 days for 141 patients spending a total of 2086 days.</p>

<sup>15</sup>**Methodology:** Average Number of Hospital Stays Prior to Project - Average Number of Hospital Stays Since Project = Average reduction in bed stays x number of homeless hospital admissions/re-admissions = potential reduction in bed stays x daily cost in an acute trust = Cost Saving

<sup>16</sup> **2017 data:** currently unavailable

<sup>17</sup> **Methodology:** For the purposes of calculating Homeless Bed Stays, calculations have been based on the following definitions: crisis accommodation, emergency accommodation, rough sleeping, sofa surfing, staying in a holiday lets/hotel, staying in a van/tent/ car, traveller site (modern slavery)

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## For the economy

The total national cost of an individual with the most complex needs is £21,180, with their physical health problem costing £1,600 and costs to psychiatric hospitals being £3,094. In relation to the HPHD service between January 2014 to September 201, 184 patients fall under the complex needs umbrella, requiring support with at least two other problems as well as hospital admissions.

In 2014, 43 patients referred to the service would be considered to have multiple and complex needs, 9 were referred to the project whilst an inpatient on a mental health ward and the remaining 34 were seen in the general hospitals. The potential cost saving is £82,246.<sup>18</sup>

In 2015, 38 patients referred to the service would be considered to have multiple and complex needs, 38% of which have attended hospital 4 times or more in the last year. 11 were referred as a patient on a mental health ward and the remaining 27 were seen in the general hospitals. The potential cost saving is £77,234.<sup>19</sup>

Comparing the two years it could be argued that the service has had an impact on the number of patients with complex needs requiring acute hospital care, with a reduction of 5 presenting in 2015 in comparison to 2014.

In 2016, 51 patients referred to the service would be considered to have multiple and complex needs. This shows a likely correlation between the suspected increase in rough sleeper numbers and those presenting with complex needs to acute services. 16 were referred as a patient on a mental health ward and the remaining 35 were seen in the general hospitals. The potential cost saving is £90,484.<sup>20</sup>

In 2017 so far, 48 patients referred to the service would be considered to have multiple and complex needs. 10 were referred as a patient on a mental health ward and the remaining 38 were seen in the general hospitals. The potential cost saving is £92,866.<sup>21</sup>

When comparing the years there seems to be an increase of patients with complex needs using the acute hospital services.

## For Cornwall Housing

2015

- Of the 22 that were referred to Homechoice; 13 patients were rehoused directly into a social housing tenancy from hospital, with only 2 requiring a residential placement through adult social services.
- Of the 36 that were referred to the Advice & Options team, only 16 were placed in emergency interim accommodation. 9 patients were able to return home but continued to seek advice and assistance in a

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<sup>18</sup> **Cost based on:** Health service (hospital and A&E/ambulance) costs in respect of physical health problems, based on national average episodes per head by age group, weighted by whether subject reports serious physical health problems or not (based on three general and 12 specific indicators). These costs are assumed to apply over the whole SMD career duration from first serious experience to date. The weightings are half the national average for those not reporting serious physical health problems and three times for those who do report these. The composite unit cost is £360 for A&E attendance including ambulance and £1779 [UCD] for inpatient episodes. The London mark-up of 20% is applied if applicable. Appendix H of the 'Hard Edges' report, Lankelly Chase, page 38

<sup>19</sup> A&E attendances, inpatient episodes, 11 psychiatric inpatient stays

<sup>20</sup> 15 A&E attendances, 20 inpatient episodes, 16 psychiatric inpatient stays

<sup>21</sup> 4 A&E attendances, 34 inpatient episodes, 10 psychiatric inpatient stays

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timely and planned way. 3 secured a private tenancy and 2 went into supported housing placements. 1 was placed by adult services and 5 went to stay with family or friends.

#### 2016

- Of the 14 that were referred to Homechoice, 7 patients were rehoused directly into a social housing tenancy from hospital, with only 3 requiring a residential placement through adult social services.
- Of the 35 that were referred to the Advice & Options team, only 10 were placed in emergency interim accommodation. 6 were able to return home, 9 were able to stay with family or friends and 1 was granted a social housing tenancy.

#### 2017 – so far

- Of the 7 that were referred to Homechoice, 4 patients were rehoused directly into a social housing tenancy from hospital, with only 2 requiring a residential placement through adult social services.
- Of the 29 that were referred to the Advice & Options team, only 18 were placed in emergency interim accommodation. 1 was able to return home, 1 were able to stay with family or friends and 1 secured a private rented tenancy.
- 5 were referred to Nos Da, with 1 accessing their temporary bed spaces and the rest returning home or staying with friends.

### **For Cornwall Partnership Foundation Trust**

#### 2015

- CPFT staff referred 83 of the patients to the service, with 19 coming from the psychiatric liaison team based at RCH. 9 referrals came from CMHT staff or from within the housing support team.
- Of 53 patients admitted onto the acute wards, the service was able to ensure that 30 of these patients did not have their discharge delayed because of a lack of accommodation.
- 53% of the referrals from CPFT staff were secured alternative accommodation by the project worker directly from hospital, with 8 placed in the discharge accommodation.

#### 2016

- CPFT staff referred 68 of the patients to the service, with 18 coming from the psychiatric liaison team based at RCH. 2 referrals came from CMHT staff.
- Of 42 patients admitted onto the acute wards, the service was able to ensure that 25 of these patients did not have their discharge delayed because of a lack of accommodation.
- 38% of the referrals from CPFT staff were secured alternative accommodation by the project worker directly from hospital, with 11 placed in the discharge accommodation. 25% were able to return home with advice and support in place.

#### 2017

- CPFT staff referred 65 of the patients to the service, with 6 coming from the psychiatric liaison team based at RCH. 2 referrals came from Home Treatment Team and 2 from the bed managers. All the rest from the weekly screenings held for the wards.

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- Of 50 patients admitted onto the acute wards, the service was able to ensure that only 8 have had their discharge delayed because of a lack of accommodation.
  - 42% of the referrals from CPFT staff were secured alternative accommodation by the project worker directly from hospital, with 10 placed in the discharge accommodation. 18 were able to return home with advice and support in place.

## **For Community Hospitals**

### **2015**

- Of the 16 referrals direct from the community hospitals, 7 were assisted to secure accommodation, 4 were allocated step down placements, 3 returned home, 1 went to stay with family and 1 died in hospital.
- Many of the longer term admissions from RCHT, were moved into community beds and so whilst the initial referral was made whilst admitted to an acute ward, they were discharged from a community bed.

### **2016**

- Of the 10 referrals direct from the community hospitals, 5 were assisted to secure accommodation, 3 were allocated step down placements, 1 returned home and 1 refused the offer of accommodation.

### **2017**

- Of the 16 referrals direct from the community hospitals, 10 were assisted to secure accommodation, 2 was allocated step down placements, 3 returned home and 1 person went to stay with family.

## Benefits: NHS Stakeholder Feedback

We have been in consultation with a range of key service stakeholders over the past 6 months, the overwhelming feedback has been that the removal of the service would be a huge loss to a range of departments across RCHT. Prior to the project none of the departments interviewed had a clear discharge process in place, often signposting on to the local authority or local housing providers, for patients identified as homeless/NFA.

### Positive Impact

Dedicated adviser with a housing expertise has resulted in:

- Costs savings as a result of reduction in A&E and the Mental Health departments
- Clear pathway in place allowing for discharge to begin at the point of admission
- Much more help and clarity around the process to assist those admitted with no fixed abode
- Safe and effective discharge plans
- Improved patient well-being
- Staff enabled to dedicate more time to other aspects of patient care
- Greater awareness of and understanding of timescales and options available to our Homeless patients
- Changes made have allowed for earlier interventions.

### Recommendations

- Continue to fund the current post.
- Extend service provision to cover evenings and weekends. The extension of the service will enable the adviser to help patients who often present outside of service hours. The suggestion for service improvement from all of the NHS stakeholders who provided feedback was an increase to the availability of the worker.
- Increase service provision through the recruitment of additional staff to meet increasing need – *“the worker is often at Bodmin or Longreach and there is work for more people in this role”* - Consultant Liaison Psychiatrist
- Preventative interventions: monthly case conferences to identify the support needs of regular users of the Emergency Department as a way to reduce emergency service use and increase primary care use.

*“The changes made have allowed for earlier interventions to be made alongside discharge planning. The project has enabled the Shelter worker to use their expertise sooner and quicker than what is possible for a busy ward.”*

Patient Flow Co-ordinator

*“Discharge planning can now begin at the point of admission as we clearly identify the housing needs at that point.”*

Occupational Therapist

*“Without the safeguards afforded by (the) role, our ED would have a higher re-attendance rate for homeless patients, would suffer more delayed discharges from CDU / ED, would be less able to keep resources up-to-date and train staff, and would see more homeless patients with deteriorating conditions due to inadequate follow-up and ignorance of their other needs.”*

Consultant Emergency Physician

## Challenges and Recommendations: An Update

As the service capacity has remained the same the challenges outlined in the previous evaluation report are broadly the same. Shelter and our partners have taken actions to address some of the challenges during phase 2. The challenges are broadly a result of:

- An increase in demand in Cornwall
- Partnership Working
- Operational barriers.

Each of the points outlined in the table below further illustrates the need for a dedicated hospital discharge service, where an adviser can provide a safe and secure discharge of patients and bridge the gap between departments across RCHT.

No:	Challenges	Recommendations
1	<p><b>High admission rates outside of service provision hours</b></p>	<p><b>Increase the availability to 7 days a week</b></p> <p>By tailoring the service to improve access, the Patient Liaison Adviser will be better placed to engage patients at the earliest opportunity to address their immediate housing issues. Safe discharge into suitable accommodation will improve patient flow and repeat admissions.</p> <p>Key staff stakeholders continue to recommend for an increase in provision.</p>
2	<p><b>High re-admission rates</b></p> <p>The re-admission rates remain high. The complexity of issues facing many of our clients means that they often have to be re-admitted to resolve on-going health and housing issues.</p>	<p><b>Extend the remit of the Patient Liaison Adviser</b></p> <p>We recommend extending the remit of the Patient Liaison Advisor so they can offer ongoing transitional support. This would be particularly important for those patients staying in the hospital discharge accommodation.</p> <p><b>Benefits include:</b></p> <ul style="list-style-type: none"> <li>▪ Making the transition from hospital to hospital discharge accommodation and then settled accommodation less challenging.</li> <li>▪ Making it easier for the project to facilitate planned admissions for those entrenched rough sleepers, which until now has not happened.</li> <li>▪ Extending the offer to GP Practices to enable early interventions to avoid hospital admissions by improving the health of the patients referred to the service.</li> </ul>

No:	Challenges	Recommendations
3	<p><b>Limited resources to address an increase in demand</b> As statutory funding continues to reduce for support within the community, more people are presenting to the acute services.</p>	<p><b>Increase service capacity</b> The service has become more established and embedded within RCHT resulting in an increase in referrals. Since the start of the Cornwall service in December 2014 there has been a 32% increase in referrals.<sup>22</sup></p>
4	<p><b>Inappropriate supported accommodation for patients with multiple complex needs</b>  (See page 8 for details)</p>	<p><b>Access funding for 2 further bed spaces</b> We recommend funding to be made available for a further two bed spaces to offer accommodation to the most entrenched and chaotic clients. Accommodation providers must be willing to accommodate those usually excluded from services or difficult to place, providing extensive support, as Coastline Homeless Service have been able to do.</p> <p>It would be preferential if the accommodation could be provided further east of county.</p>
5	<p><b>I.T. Systems and barriers to information sharing</b></p> <p><b>Phase 1: January 2014 – September 2015</b> The acute hospital uses a different I.T. system to the mental health hospitals. As a result, NHS staff are unable to send patient information to an external email address without encrypting it. As the adviser is employed by Shelter and works remotely within the hospital, using Shelter equipment and IT resources, it has not always been possible to open an encrypted email.</p> <p><b>Resolution:</b> To resolve this the adviser used three email accounts to ensure the flow of information/referrals between the adviser, hospital staff and community agencies.</p>	<p>Adapting Shelter’s case management system to look at ways of recording and monitoring in line with the other systems to avoid duplication and ensure access to files and figures. As this is a cloud-based system staff are able to access this through the Office365 portal, which would mean that files can be accessed anywhere.</p> <p>A discussion would need to take place regarding the use of Inform by the service, it is useful to have access to these records for the service, but also for the other providers to confirm if a client has recently visited the hospital.</p>

<sup>22</sup> December 2014 – 15<sup>th</sup> December 2016

No:	Challenges	Recommendations
	<p><b>Phase 2: September 2015 – September 2016</b></p> <p>All NHS staff within Cornwall now use nhs.net as the email provider and so the adviser only has two email accounts. This can make it difficult at times to keep track of cases but it does mean that sending attachments to external agencies and receiving encrypted emails is easier.</p> <p>The case management system operated by Shelter is not set up for the hospital discharge service and so recording casework is done in a fairly rudimentary way, relying on an excel spreadsheet and case notes saved into individual network folders.</p> <p>It remains unsuitable for all cases to be recorded onto the Inform system shared by Coastline and St Petroc's, as many of the referrals are not from those who have a history of homelessness, and/or use street services and so it is not appropriate for their information to be recorded onto a system that should be used for that demographic.</p>	
6	<p><b>HDHP Multi Agency Protocol and barriers to effective partnership working</b></p> <p>Many agencies want to work in partnership, but the differences in working culture, flow of information, work practices and pressures can inhibit the safe discharge of patients.</p> <p><b>Example:</b> Upon medical approval nursing staff tend to make arrangements for a patient's discharge by late afternoon. Most supported housing providers that are open close by 5pm and it is too late to secure interim accommodation. If the adviser is aware of the patient before the day of discharge, it is possible to ensure</p>	<p>The continued funding of the dedicated Patient Liaison Adviser, to ensure that the protocol still operates and to partake in the discharge planning of the more complex cases.</p>

No:	Challenges	Recommendations
	<p>that there is a planned move into accommodation.</p>	
7	<p><b>Flexible Enabling Fund</b></p> <p>The revenue stream also allowed a flexible enabling fund of £7,500. The fund is administered by Inclusion Cornwall and allows the project worker to provide financial assistance to a patient, to ensure that their discharge is not delayed.</p> <p>From the outset it was agreed by the partners that the fund would be used for larger expenses such as rent in advance or deposit. However, once the service started it was evident many patients were in need of smaller amounts i.e. £2 bus fare to emergency accommodation and the process was too cumbersome. As a result, the process was modified to allow the adviser to use their discretion in distributing smaller sums of money.</p> <p>In phase 1 the fund remained in place, and continued to be available to patients.</p> <p>The fund has still not been completely spent, <b>118 individuals assisted, total spend of £1,495, ranging from £2 to £136.</b></p> <p>Support staff for the discharge beds are now making applications to it, which will assist those in the discharge beds to move on. That is if barriers to securing accommodation are as a result of rent arrears for example.</p>	<p>Continue to have a funding pot in place, the fund has been invaluable for the adviser to be able to give money to a patient to cover travel and some food costs until they are able to get wages or apply for welfare benefits.</p> <p>Commissioners should ensure that it is included in any future funding applications.</p>

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## Funding Request

The project recommends continued long term sustainable funding for the service which ties into the NHS 5 year plans on the need for a 'radical upgrade in prevention and public health' and the need for 'stronger partnerships with charitable and voluntary sector organisations'.<sup>23</sup>

As clearly demonstrated in the report the service has and can continue to help Cornwall Council's Homelessness strategic aims to: <sup>24</sup>

- Tackle poverty and deprivation
- Reduce crime and the fear of crime
- Reduce substance misuse and anti-social behaviour
- Improve health and wellbeing.

The Cornwall Patient Hospital Discharge service is unique in offering this holistic approach that looks to treat health and housing needs simultaneously. Shelter wants to build upon our innovative partnership with local authorities, housing associations and key health commissioners.

### Shelter financial summary

	2018/19 <sup>25</sup>	2019/20	2020/2021	TOTAL
1 x FTE Patient Liaison Adviser	£42,332	£43,159	£44,001	£129,492

The cost to fund 1 full time Adviser in Financial Year 2018/19 is £42,332.<sup>26</sup>

### Long term funding for the existing post

The Patient Liaison Adviser is in a unique position bridging a gap between services that want to work together. I.e. the adviser brings an understanding of the challenges of each provider and knowledge of the appropriate level of involvement from stakeholders to improve multi agency working.

The service has successfully achieved:

- Costs savings
- Safe secure discharge
- Improved communication and integration between stakeholders in complex cases
- Improved patient flow
- Reduction in re-admission
- With continued funding the project can expand and improve on outcomes.

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<sup>23</sup> <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<sup>24</sup> It's never too early' Our Homelessness Strategy for Cornwall 2015 – 2020, page 4

<sup>25</sup> Service start date: April 2018.

<sup>26</sup> Final salary costs to be confirmed.

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## **Joint commissioning**

Future investment of hospital discharge service 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 promoted by all partners working in health, housing and adult social care. Commissioners can play a key role in tailoring and flexing the service to the needs of the population in Cornwall.

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## Ambitions and Aspirations

Shelter wants to jointly build on the innovative and unique relationship with key stakeholders across Cornwall, and following on from the challenges and successes of the service to date, we now set out our ambitions and aspirations for the future.

### 1. More intensive and longer support (two full-time Patient Liaison Advisers)

**Overview:** Our current support is light touch due to only having one staff member to offer support to entrenched homeless people who in our experience need intensive long term support. Two full time posts, split Cornwall into East and West with one full time post based in Bodmin and one full time post in Truro would enable the service to offer more intensive support for a longer period. In Shelter's experience this is critical to sustaining long term outcomes and reducing re-admission figures. The service could be further enhanced through the recruitment of volunteers in a more structured capacity i.e. form a partnership with a local university.

#### Benefits and Outcomes

- Improves health and accommodation outcomes for the rough sleeping and street population.
- Reduces bed blocking and overstays in hospitals
- Reduces repeat use of hospitals
- Offers great savings and value for money
- Reduces / ends rough sleeping for individuals.

### 2. Older patients / community hospitals

**Overview:** Community Hospitals across Cornwall for Older people proposal, specifically Geriatric wards, where the mobility of patients may have an impact of them returning home. This is a key barrier for onward care teams. Helping with patient flow would help reduce costs.

#### GP drop-ins

**Overview:** We have had feedback from GP surgeries that having a housing adviser based in the premises for half a day would be really useful for preventative advice and ensuring problems do not escalate out of control. Shelter could offer advice e.g. patients with health problems as a result of disrepair/poor conditions. It may be useful to explore the GP networks.

### 3. Innovation: using an asset-based approach through Peer Mentoring

**Overview:** Peer mentors are former clients with lived-experience of homelessness and health issues. They work alongside a Support Worker or an Advice worker to engage with and build rapport with current clients, advise on coping mechanisms and strategies and running support groups. The peer mentor programme could be family-to-family and other client groups with lived experiences of different health conditions. We have found that using staff or volunteers with lived experience significantly boosts engagement of more vulnerable people with chaotic lifestyles, often referred to as 'hard-to-reach.'

Potential responsibilities could include:

- Provide administrative support on site

- 
- Provide practical onsite support to clients, such as help filling forms, collecting essential shopping prior to discharge
  - Provision of befriending and practical support in their accommodation post-discharge.

### **Benefits to the NHS**

Nesta (2013)<sup>27</sup> attributes the tangible benefits to peer support, mainly through reduced hospital admissions, emergency admissions in particular.<sup>28</sup> These indicators in turn, point to:

- Improved self-management by patients of their condition, resulting in fewer critical incidents requiring medical attention
- Lower costs to the NHS, resulting from reduced demand for services.

## **4. Rough Sleepers PRS Access Scheme**

**Overview:** The aim is to secure accommodation in the private rented sector for rough sleepers, working closely with landlords and agencies and to then support the tenants to sustain their accommodation for a minimum of six months. The position would not be office-based but peripatetic, operating out of partner agency offices around the county.

### **Benefits to the NHS**

- Reduce the flow of new rough sleepers to the street through more targeted prevention activity
- Ensure that people have a safe place to stay while services work with them to resolve the homelessness crisis
- Help new rough sleepers off the street and into independence, through more rapid crisis interventions and support to access and sustain move-on accommodation
- Interventions to help new rough sleepers, or people at imminent risk of sleeping rough, get the rapid support they need to recover and move-on.
- Reduce the number of 'social crisis' attendances to the emergency department, often those who suddenly find themselves homeless with nowhere to go will take an overdose or cause an injury to themselves, as they have nowhere to turn.

### **Benefits to wider community**

- Reduce the number of rough sleepers and work to ensure that accommodation found is sustainable.
- Work within a wider remit across the county, providing specialist role.

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<sup>27</sup> Nesta, 2013. *People Helping People: Peer Support that Changes Lives Support: What is it and does it work?* [pdf] Nesta Available from: <http://www.nesta.org.uk/publications/people-helping-people-future-public-services> [accessed 28 April 2016] p11

<sup>28</sup> De Silva, D. (2011) cited in Nesta, 2013. *People Helping People: Peer Support that Changes Lives Support: What is it and does it work?* [pdf] Nesta Available from: <http://www.nesta.org.uk/publications/people-helping-people-future-public-services> [accessed 28 April 2016] p11

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- Reduce the number of evictions or need to seek assistance from housing services, by providing a mediation service between tenants and landlords.
  - Encouraging private landlords to make their properties available, affordable and suitable. Reducing the levels of poor or sub-standard properties by providing incentives for landlords to meet certain standards, above the basic statutory requirements.

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## **Next Steps**

Please contact Vicki Sampson on 0344 515 2360 or [vicki\\_sampson@shelter.org.uk](mailto:vicki_sampson@shelter.org.uk) for further information.

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## **Appendix 1: Referral and Outcomes Service Data January 2014 – September 2017**



Appendix 1 Referral  
Analysis 2014 to Sep

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## Appendix 2: Background December 2013 – September 2015

In 2013 the Minister for Public Health announced that funding was to be made available to improve hospital discharge procedures for the homeless, called the Homeless Hospital Discharge Fund. This followed a report by Homeless Link and St Mungo's published in May 2012<sup>29</sup> that showed 70 % of homeless people had been discharged from hospital back onto the street, without their housing or underlying health problems being addressed. Many homeless people have nowhere to go when discharged from hospital and far too many are simply discharged back to the streets or end up in a hostel that is not an appropriate for their recovery.

St Petroc's Society, the lead contractor and its partners<sup>30</sup> submitted a joint partnership bid for Cornwall in December 2013. The bid was successful and Cornwall received funding of £65,780 from the revenue stream and £83,894 from the capital stream. As a delivery partner Shelter provides a dedicated advisor, to work from the hospital sites and implement the protocol, at a cost of £39,261 per annum. The revenue stream also allowed a flexible enabling fund of £7,500 to be allocated. The fund is administered by Inclusion Cornwall and allows the project worker to provide financial assistance to a patient, ensuring discharge is not delayed.

The service launched in December 2013.

The Homeless Patient Hospital Discharge service has two overarching aims:

1. to link acute health care and community-based support, to improve the health of anyone who is homeless or unsuitably housed at the point of admission by offering them appropriate advice, assistance and support with their accommodation needs
2. to provide appropriate facilities for those requiring ongoing medical support after hospital discharge to allow time for recovery. All too often, the homeless end up in a hostel that is an inappropriate environment for treatment plans and for their recovery.

### Project objectives

- To assess patients who are homeless, or who may be homeless upon discharge, on admission to hospital
- To provide advice and a planned discharge from hospital into suitable accommodation
- To reduce the number of delayed discharges (bed-blocking) which result from patients being homeless or not having a suitable home to return to.

### Service KPIs

Targets: Revenue Funding Stream	Responsibility
60 patients with a housing need to be assessed on admission	Shelter
50 patients discharged with a support plan	Shelter

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<sup>29</sup> <http://www.mungosbroadway.org.uk/documents/3432/3432.pdf>

<sup>30</sup> The partner agencies include Cornwall Council – Public Health, Kernow Clinical Commissioning Group, Royal Cornwall Hospitals Trust, Cornwall Foundation Partnership Trust, Drug & Alcohol Action Team, Inclusion Cornwall, Coastline Care, St Petroc's Society, Cornwall Housing, Peninsula Community Health, Cornwall Health for Homeless and Shelter.

<b>Targets: Revenue Funding Stream</b>	<b>Responsibility</b>
<b>Targets: Capital Funding Stream</b>	<b>Responsibility</b>
Accommodation available up to 2 years	St Petroc's Society

### **Client Group**

The protocol covers adult patients who have settled accommodation prior to admission but will be unable to return to it for medical reasons, and adult patients who were homeless or living in temporary accommodation prior to admission.

### **HDHP Multi Agency Protocol**

The project will develop and implement a county-wide multi-agency protocol, to ensure that no patient is discharged from hospital onto the streets or back to accommodation without their underlying housing and health problems being addressed.

### **Guidance and training for NHS staff**

The protocol will be developed within 3 months; building on existing protocols, guidance and good practice established elsewhere, but primarily drawing on local stakeholder and client input to reflect the unique geographical factors of service delivery in a large rural area.

Partnership working will be a critical element of this project. Key members of operational staff and decision-makers, in hospitals, mental health facilities and partner agencies, will be encouraged and supported to adopt the protocol so that the agreed care pathways for discharged patients are consistently followed. Training and awareness events (e.g. inductions, team meetings) will be provided to help staff better understand the services available and the pathways for patients prior to discharge.

**Cornwall Homeless Patient Hospital Discharge Service  
in partnership with**

**Shelter**



**One + all | we care**

**Royal Cornwall Hospitals**   
NHS Trust

   
**Kernow Clinical Commissioning Group** **Coastline**  
care

**Cornwall Partnership**   
NHS Foundation Trust

**Inclusion Cornwall** 

 **Peninsula  
Community  
Health**

  
*one and all* *onen hag all*  
**CORNWALL  
HOUSING**

Shelter helps millions of people every year struggling with bad housing or homelessness through our advice, support and legal services. And we campaign to make sure that, one day, no one will have to turn to us for help.

We're here so no one has to fight bad housing or homelessness on their own.

Please support us at [shelter.org.uk](https://shelter.org.uk)

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