

Learning Briefing

The Croydon Hospital Discharge Project



Croydon Hospital Discharge Project – learning briefing

1. Overview

The Croydon Hospital Discharge Project (hereafter referred to as the CHDP) is run by Thames Reach and based at Croydon University Hospital. It was set up in January 2014 as a six-month pilot project funded by the Department of Health. The project has been further supported and commissioned by Croydon Council in recognition of its success in preventing the discharge of homeless people onto the street and ensuring their stay in hospital is no longer than necessary due to their homelessness. This briefing sets out the key areas of learning for Thames Reach from the early stages of this important initiative. The CHDP has played a critical role in addressing a gap in provision for vulnerable people. It is based on a model in which a link worker appointed by Thames Reach has developed strong ties with medical, social care, administrative and specialist housing staff both within the hospital and out in the community.

The CHDP has achieved the following successful outcomes:

- **204 people have been supported by the scheme since its inception**
- **A reduction in the number of discharges from Croydon University Hospital which result in people who are homeless returning to the streets**
- **The prevention of unnecessary hospital admissions: 66 people (32%) were only seen in the A&E department and were not admitted to hospital**
- **A reduction in length of stay and hospital readmissions within 28 days of discharge**

This was achieved by:

- **Setting up successful partnerships with health and housing**
- **Raising awareness of the service with health and housing teams**
- **Making improvements to discharge pathways and protocols coordinated by the Thames Reach link worker who acts as a single point of contact**
- **Identifying and contacting patients at the earliest opportunity and wherever possible preventing admission into hospital i.e. when met in A&E**
- **Identifying appropriate accommodation before discharge – through emergency, temporary or longer term housing and continued support for the patient after leaving hospital**



The uncoordinated discharge of homeless people from hospital can be very dangerous for those who end up sleeping rough.

2. Background

Living on the streets or without a stable home can make people susceptible to illness, poor mental health and drug and alcohol problems.

Homeless people often seek medical treatment at a later stage of illness, leading to poor health outcomes and costly stays in hospital that could have been avoided.

Many homeless people return to insecure accommodation or even rough sleeping after medical treatment, which reduces their potential for recovery. In some cases, accommodation may be lost during hospitalisation, leading to potentially serious housing problems for patients upon discharge. These circumstances clearly reflect the impact of homelessness and reduced access to appropriate healthcare and housing on a marginalised group.

The impetus to address these issues is driven by both the need to reduce inequality and to lessen the inflated costs delayed health care and poor housing inevitably lead to further down the line.

Costs to the NHS (1) (*numbers link to documents referenced on back cover.*) : The annual cost of unscheduled care for homeless patients is eight times that of the housed population and homeless patients are overrepresented amongst frequent attenders to A&E. Research by Professor Barry McCormick (2), former chief analyst at the Department of Health, has shown that homeless people attend A&E five times as often as the housed population, are admitted 3.2 times as often and stay three times as long. This results in secondary care costs that are eight times higher than average, largely consisting of unscheduled emergency admissions. Professor McCormick's analysis produces a conservative estimate of £85 million spent each year on secondary care for No Fixed Abode (NFA) patients, most resulting from emergency admissions. In fact, this is likely to be a considerable underestimate as many homeless people will give a hostel or 'care of' address which will disguise the fact they have no settled address. The Nuffield Trust (3) reported an overall increase of 11.8% in emergency admissions in England over the past five years at a cost of £330 million per year.

In January 2014, The CHDP was piloted to prevent the discharge of homeless patients onto the street and to ensure their stay in hospital was no longer than necessary as a result of their homelessness. Delivered by Thames Reach, the six-month pilot was initially funded by the Department of Health, as part of the £10million Homeless Hospital Discharge Fund announced in May 2013.

Homeless Link evaluation (4): In 2015, Homeless Link undertook an evaluation of the 52 pilot hospital discharge schemes established in the previous year. The key findings were:

- **69% of homeless people had suitable accommodation to go to when they were discharged; this rose to 93% in projects where NHS and housing staff collaborated**
- **72% of patients were not readmitted within 28 days of discharge**
- **71% of agencies reported improved data sharing across housing, the NHS and voluntary sector as a result of the hospital discharge schemes**
- **84% of voluntary sector agencies achieved 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**

It was recommended that hospital discharge pilot schemes should be commissioned through mainstream commissioning routes and funding should last longer than the six-month pilot schemes, reflecting the time needed to recruit and train staff, set up partnerships and embed practice.

Croydon Council identified funds to continue the pilot beyond the Department of Health funding, continuing the project to March 2016. The understanding of the needs of this group of patients was further improved over the period which helped in the development of a clear pathway for discharge planning and support involving hospital staff, community health services and housing departments. The CHDP has now been recommissioned for a further year and is funded up to April 2017.

3. The Service

The CHDP offers a person-centred approach to service users which focuses on enabling and supporting individuals with their support needs, specifically related to housing and welfare benefits, upon presentation and/or admission to Croydon University Hospital. A link worker employed by Thames Reach is based within the hospital and works with medical, social care and administrative staff both on wards and in the A&E department, and out in the community.

Service users are rough sleepers and those with multiple and complex needs. Staff work with both new and entrenched rough sleepers, people at risk of becoming homeless, and Central and Eastern European people who are usually not entitled to claim housing and welfare benefits. The CHDP works mostly with people who have a connection with the London Borough of Croydon but can also support those without a local connection. Often the housing problem is complex and requires considerable liaison with departments and services outside of the hospital. The primary role of the Thames Reach link worker is to negotiate with the local authority housing team, including the specialist Support Needs Assessment & Placement (SNAP) team in Croydon, to secure suitable accommodation for individuals and to expedite and support recovery on discharge. Just as importantly, this has included working with housing teams in other London boroughs or neighbouring counties, in the event of out-of-borough admissions.

The discharge plan includes continued contact on discharge. In many cases, the continuity of support helps to settle the person into accommodation. This in turn improves a patient's wellbeing and the chance of a full recovery from their physical illness, decreasing the chance of further hospital admission and breakdown of the accommodation. This has often required referral and involvement of other community based services, including GP practices, adult social care and voluntary provider agencies. The link worker is both a bridge and broker between the patient and health/social care services.

Key components of the service are:

- **A specialist link worker based within the hospital and also operating out in the community**
- **Intervention to avoid hospital admission**
- **Coordination of timely discharge plans for patients leaving hospital**
- **Closer working with Croydon's housing department**
- **Practical support to ensure benefits and suitable accommodation are in place**
- **Continued support to sustain the discharge plan**
- **Enhanced support to promote health and wellbeing by developing stronger links with community services**



Karen, pictured by her new front door, after the hospital link worker found her accommodation.

4. Outcomes

From January 2014 to February 2016 the CHDP met with 204 people at the hospital, referred to the link worker due to their homelessness. The following outcomes were achieved:

Preventing hospital admissions: 66 people (32%) were only seen in the A&E department and were not admitted to hospital, instead being helped to settle in accommodation. The advice and ongoing support of the link worker was considered as an important factor in preventing admission.

Assisting reconnection from the borough on discharge: 81 people (40%) did not have a local borough connection when presenting at Croydon University Hospital, and of these, 32 people (39%) were admitted. The link worker was viewed as a vital resource in ensuring people were reconnected to boroughs and counties, facilitating appropriate links with services, support and accommodation, and timely discharge.

Minimising length of admission and occupied bed nights: Only four inpatient stays were deemed to be longer than necessary due to complications of discharge planning; all other discharges had occurred at the point of the individual being confirmed as medically fit for discharge. The average length of stay in hospital for those admitted is now 13 days. 50% of admissions are for less than seven days, with 21% being for a period of greater than 21 days.

Reducing readmission: The link worker continued contact both within the local community to limit readmission and in the event of repeat presentation at the hospital. There were 32 episodes of readmission to the hospital within 28 days (one third of these being attributable to two individuals). In summary, the project has achieved:

- **Recovery focused and person-centred interventions improving the patients' experience**
- **Systems and protocols to ensure effective management of the service, eg. liaison between the link worker and the hospital discharge coordinator and ward staff**
- **Capacity within the hospital to be responsive, ensuring that the required service quality and standards are attained and that adequate staff support is available. This includes attendance at hospital staff team meetings and ward rounds**
- **Work across the health and social care interface**
- **A stronger relationship with the borough housing teams (SNAP and Housing Options – local authority teams advising people about housing) with the link worker supporting the referral and placement of individuals to suitable temporary and appropriate longer term accommodation to promote recovery and wellbeing**
- **A reduction in delayed hospital discharges by providing emergency bed and breakfast accommodation where appropriate**
- **A reduction in readmissions to hospital and further relapse of an individual's physical and mental health as a result of the continued support upon discharge**

5. Key Challenges

The first two years of implementing the CHDP has been challenging and informative. The team has achieved its key objectives, taking on further roles such as working collaboratively with services that can help people return home safely or provide longer term community support.

Housing: Significant changes to the housing benefit system including the Local Housing Allowance cap which restricts the amount of benefit that tenants living in the private rented sector can claim to cover rent has had a significant impact on housing provision within all the London boroughs including Croydon. Limited access to housing, the welfare reforms introduced over the last few years, and an increase in homelessness, has put additional pressure on the hospital discharge teams to ensure people are discharged to appropriate accommodation whilst meeting targets for 'bed management'.

Project set up and promotion: One of the key tasks was to strengthen partnerships between the CHDP and health and housing services. This included the need to strengthen links between the hospital and our local outreach service to ensure early identification of homeless people. Developing these partnerships presented a challenge due to the size, number of departments and number of staff within Croydon University Hospital. The link worker focused on building relationships with health and housing staff, targeting key individuals and departments, to raise awareness of how to refer to the service.

Protocols and data sharing: Initially staff reported data sharing problems as CHDP does not have direct access to hospital databases. Although having successfully adapted Thames Reach's

systems to meet the CHDP's needs, we are working with health colleagues to ensure that CHDP has access to all relevant data. Information about patients is kept on many different systems, across organisations, making it difficult to find out what support is already in place or has been put in place in the past. The hope is that in future the CHDP will be given better access to the hospital data and this can be achieved through the use of an 'honorary contract', which will allow the Thames Reach link worker to access information held by the NHS to build up a fuller picture of a patient's needs.

Identifying and accessing patients: Initially, there were challenges with building relationships with hospital staff and getting access to patients on the wards. There was some reluctance to engage with another new project in the hospital or staff lacked awareness that the service existed. The link worker was persistent in visiting the wards and raising the profile of their work and they were assisted by some enthusiastic and cooperative ward staff who were able to influence colleagues.

6. Key Successes

Increase in early identification of homeless people: Once the CHDP became embedded within hospital discharge planning, the team achieved consistent levels of referrals, by extending the referral pathways to all departments across Croydon University Hospital. Whilst working with rough sleepers and those with complex needs, they also accepted referrals of people at risk of becoming homeless when entering hospital.

Access to emergency accommodation: Immediate access to funds for urgent accommodation enables the link worker to prevent individuals from being discharged back to the street following treatment and whilst waiting for temporary or longer term accommodation.

Joint working with SNAP and LA Housing Options: Over the last two years the CHDP has worked closely with the local authority and has developed a good relationship and contacts within the council teams, ensuring good practice in joint working and information sharing.

Reconnection to other boroughs: The link worker is a dedicated resource who can set up appropriate discharge plans for people returning to a different geographical area. This is of benefit to the patient and reduces costs for Croydon Council.

Planned discharge and readmission: Previously patients often had a negative experience of discharge, e.g. either not knowing when or where they were going to or the staff not knowing until the last minute, causing distress for the patient. The CHDP supports the discharge process, allowing for sufficient notice to be given concerning discharge dates and where the patient is going to be discharged to. Having a clear housing outcome is key in reassuring the client about their discharge process, supporting their recovery and decreasing the chance of readmission to hospital.

Developing key relationships with Croydon University Hospital and other agencies within the hospital: Having the link worker based in the A&E department, with an identified workspace, and access to the wards, has improved awareness of the service and enabled the worker to attend hospital team meetings and ward rounds prior to discharge.

The link worker has developed strong ties with Turning Point's substance misuse worker, also based in the hospital, which has been useful when identifying and supporting people who have been admitted to hospital for health reasons linked to drug and alcohol problems.

Cost and savings: The CHDP's access to emergency accommodation as well as close links to the local authority housing services, has helped reduce the pressure on hospital bed spaces. It ensures unplanned and inappropriate discharges are avoided which would otherwise lead to people returning to the street, increasing their chance of readmission and a further protracted period of treatment.

The daily cost of a bedspace at Croydon University Hospital is approximately £330, while the average cost of emergency bed & breakfast accommodation is £40 per day, so by avoiding delayed discharge from hospital or readmission, the savings to the NHS are substantial.

Cost for the provision of the CHDP is currently £68,000 per annum; this provides considerable savings for the hospital and the local borough. It has delivered improved systems and a better response to the problems faced by homeless people.

It is estimated that through early identification of homeless individuals presenting at Croydon University Hospital, and specialist intervention and improved hospital discharge, that savings of a minimum of two occupied bed nights per individual are achieved. This represents a potential cost saving of £134,670 per annum.



Karen (pictured right) was admitted to Croydon University Hospital following a fall and a resulting fractured thigh bone.

Staff were very concerned about her vulnerability, wellbeing and the risk of being discharged onto the streets when the time came for her to leave – she had lost her accommodation and could have ended up sleeping rough.

Teena, (pictured left) the Thames Reach link worker, was involved by the ward staff in discharge planning. This ensured clear plans were in place and Karen was safe.

Teena liaised with Croydon's Housing Options Team and ensured that Karen was found a room in temporary accommodation locally.

The support didn't stop there though – Karen was helped to get support around her alcohol problem and she was supported to reapply for benefits.

Karen now wants to give something back herself and is about to volunteer as a peer mentor with Thames Reach, providing support to people who have had similarly troubled times and want to get their lives back on track.

If you would like more information please contact Thames Reach area director Katy Porter who has been involved in the project since the outset: katy.porter@thamesreach.org.uk

7. References

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(2) Office of the Chief Analyst. Department of Health. 2010. Healthcare for single homeless people.

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<http://www.nuffieldtrust.org.uk/publications/trends-emergency-admissions-england-2004-2009>

(4) Homeless Link. 2015. Evaluation of the homeless hospital discharge fund.

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