

Hospital Discharge Network

Recovery Results briefing

In 2013 the Government invested £10 million in the Homeless Hospital Discharge Fund to improve services for people who are homeless and leaving hospital. Fifty two pilot projects were launched, including four by St Mungo's. An evaluation of the Fund has been published by Homeless Link.¹

Our Hospital Discharge Network (HDN) offers safe temporary accommodation for people who are homeless with support to recover from their stay in hospital, engage with health and social care services and find a suitable place to live. Too many people are still being discharged from hospital to the streets or into unsafe accommodation.

This briefing presents evidence and lessons from our services.

Summary of findings

The HDN was launched in June 2014 and has supported 63 clients to date². A team including a nurse, sessional GP and support workers help clients to improve and manage their health and move on to safe long-term accommodation.

Clients admitted to the HDN are frequent users of emergency health services, and have a wide range of complex physical and mental health needs. Initial evidence from the HDN indicates positive progress. Clients using the service have fewer A&E attendances and emergency hospital admissions during their stay, and are more engaged with planned healthcare through outpatient appointments and community health and social care services.



¹ Homeless Link (2015) Evaluation of the Homeless Hospital Discharge Fund <http://www.homeless.org.uk/sites/default/files/site-attachments/Evaluation%20of%20the%20Homeless%20Hospital%20Discharge%20Fund%20FINAL.pdf>

² All data is for the period from June 2014 to end Q2 2015-16 (Sept 2015) unless otherwise specified

About homelessness and hospital discharge

People who are homeless have worse health than most, and face barriers to accessing healthcare when they need it. Unplanned use of hospital services is common.

2010 Department of Health (DH) research found that people who are homeless attend A&E five times more often than the local average, and their hospital treatment costs are four times higher³. Recent data from Homeless Link shows:

- A quarter of people who are homeless have used an ambulance in the last six months
- 38% have been to A&E at least once in the last six months
- 26% have been admitted into hospital in the last six months⁴

On leaving hospital, a safe place to stay and active support for recovery is crucial to allow people who are homeless to recover from illness and treatment, maintain their health and prevent readmission.

A 2012 study found that only a third of people interviewed had received support for their homelessness when they left hospital. Unsafe discharge from hospital is costly for the NHS, with many people who are homeless entering a cycle of hospital readmissions.⁵

Our Hospital Discharge Network

The St Mungo's Hospital Discharge Network (HDN) provides places in our hostels for people who are homeless or at risk of homelessness and need additional support to manage their health when leaving hospital. The service consists of a hostel bed with support and clinical care from a team of health and homelessness professionals, providing:

- Nursing care
- In-house GP sessions⁶
- Support from health workers

Clients are referred from local hospitals. Some are also referred from hostels or rough sleeping if they require a 'step up' in medical support to prevent a vicious circle of emergency admissions.

The target is for clients to stay in the service for up to 12 weeks, though this can be extended if necessary. Clients are supported to move on to safe and appropriate accommodation. HDN services were planned by local forums bringing together managers, clinical staff, and representative from local authorities and hospitals. The forums were vital to ensure effective joint working.

The first hospital discharge services opened in June 2014 for a six month pilot. The network included beds in Camden, Westminster, Hackney and Lewisham. Following the pilot, our Camden and Hackney services have been recommissioned.

³ DH Office of the Chief Analyst (2010) Healthcare for single homeless people

⁴ Homeless Link (2015) Health Needs Audit <http://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data> (Accessed 12 October 15)

⁵ Homeless Link and St Mungo's (2012) Improving hospital admission and discharge for people who are homeless http://www.homeless.org.uk/sites/default/files/site-attachments/HOSPITAL_ADMISSION_AND_DISCHARGE_REPORTdoc.pdf

⁶ GP support for HDN clients is provided in partnership with the Greenhouse Practice and Camden Health Improvement Practice (CHIP)

Hackney and City

The Hackney and City HDN service provides eight health supported bed spaces in the St Mungo's Mare Street hostel. It opened in June 2014.

- 60 people have been referred to the service
- 29 have been admitted, staying for an average 13.2 weeks

Data collected from local hospitals shows frequent emergency health service use by clients prior to their HDN stay. In the three months before admission, the 29 clients had:

- 32 emergency hospital admissions
- 61 visits to A&E

Since the HDN opened, there have been six hospital readmissions and 27 visits to A&E (June 2014 – September 2015). On average, clients were 82% less likely to be admitted to hospital during their stay at the HDN than during the three months before their stay, and 56% less likely to visit A&E.⁷

22 clients have been supported to move on to appropriate accommodation, including sheltered accommodation, registered care and detox or rehab facilities.

Camden

Camden HDN provides six health supported bed spaces in St Mungo's Endsleigh Gardens hostel. It opened in June 2014.

- 34 people have been referred to the service
- 19 people have been admitted, staying for an average of 17.2 weeks

As in Hackney, data was collected from local hospitals about client health service use. In the three months before their admission, the 19 clients had:

- 16 emergency hospital admissions
- 17 visits to A&E

Since the HDN opened, there have been six hospital readmissions and 11 visits to A&E (June 2014 – September 2015). On average, clients were 63% less likely to be admitted to hospital during their stay at the HDN than in the three months before their stay, and 48% less likely to visit A&E.⁸

12 clients have been supported to move on from the service to appropriate accommodation.

⁷ Hackney and City:

- Average rate of hospital admission in 13 weeks prior to HDN stay: 0.084 admissions per client per week. Average during HDN stay: 0.016 admissions per client per week.
- Average rate of A&E use in 13 weeks prior to HDN stay: 0.168 visits per client per week. Average during HDN stay: 0.071 visits per client per week.

⁸ Camden:

- Average rate of hospital admissions in 13 weeks prior to HDN stay: 0.049 admissions per client per week. Average during HDN stay: 0.018 admissions per client per week.
- Average rate of A&E use in 13 weeks prior to HDN stay: 0.065 visits per client per week. Average during HDN stay: 0.034 visits per client per week.

StreetMed

St Mungo's StreetMed project provides nurse led outreach and case management for people who are rough sleeping or living in hostels or supported accommodation, working closely with A&E departments and outreach teams.

StreetMed nurses offer health assessments, secure care packages and help clients to engage with mainstream health services. The service is co-commissioned with the HDN in Hackney and Camden.

HDN and StreetMed share a common aim: to tackle health inequalities by improving the physical and mental health of people who are homeless or at risk. Both services work to overcome barriers to accessing NHS services for our clients.

StreetMed was previously a pan-London service. Evaluation of the service showed a reduction in hospital admissions and A&E use while clients were engaging with the service. For further details, visit www.mungos.org/documents/6308/6308.pdf

Other Hospital Discharge Network services

Two projects ended after the DH pilot period, but achieved positive health and housing results for clients during the pilot.

Lewisham

The Lewisham service provided 10 health supported bed spaces in St Mungo's Lewisham Assessment and Recovery Centre (LARC) between June and November 2014.

- 13 people were referred to the service
 - Six people were admitted, staying an average of 10 weeks
 - No clients were readmitted to hospital within 30 days after leaving hospital. One client had an emergency hospital admission more than 30 days after discharge which led to successful detox
 - Two clients attended A&E during their stay
 - Five clients are known to have had positive accommodation outcomes, moving into St Mungo's or local authority supported accommodation
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Westminster

The Westminster service provided 10 health supported bed spaces in the St Mungo's Harrow Road hostel between November 2014 and March 2015.

- 14 people were referred to the service
- Nine people were admitted, staying in the service an average of eight weeks

Clients were frequent health service users prior to their stay at the HDN. In the three months before the admission that led to their HDN referral, data on seven clients shows they had seven additional hospital admissions and 12 A&E visits.

Another client had 99 A&E attendances and 23 admissions at St Thomas Hospital alone in the past three years.

During their stay at the HDN, clients were supported to access 54 primary care and outpatient appointments, with only five appointments missed. Three clients were re-admitted to hospital during their stay, and three attended A&E.

Since the pilot project, an alternative model has been developed in Westminster providing intensive health support to discharged clients across a range of hostels.

Client E's story

Client E visited A&E 29 times and had three emergency hospital inpatient admissions during the three months before he was admitted to the Hackney HDN service.

- **Cost of A&E visits:** £3,393 (average £117 per visit)⁹
- **Cost of non elective admissions:** £4,770 (average £1,590 per visit)
- **Total cost of emergency healthcare:** £627.92 per week

During Client E's 23 week stay at the HDN¹⁰, he has only visited A&E once, shortly after his admission. He has not been readmitted to hospital during his stay.

- **Cost of A&E visits:** £117
- **Cost of non-elective admissions:** £0
- **Total cost of emergency healthcare:** £5.09 per week

The HDN successfully reduced Client E's immediate use of emergency healthcare, breaking a cycle of expensive readmissions and A&E use. The service is designed to generate long-term savings by improving Client E's ability to manage his own health.

- Client E was supported to attend planned healthcare appointments: four GP visits, one memory clinic appointment, one optician's appointment and two visits to the dental van
- Staying at the HDN gave Client E the opportunity for a social care assessment, securing help with personal hygiene and meals. He is planning to move into accommodation with the 24 hour support he needs to manage his health and personal care sustainably

Learning

Providing hospital discharge services has given us an important insight into the experiences of people who are homeless and leaving hospital. Above all, our services confirm that there is a cohort of people who are homeless and in very poor health who need a safe environment and active support to recover after a hospital stay.

- **People who are homeless have a wide range of complex health issues**

The HDN supports clients with complex health issues that other services struggle to address. According to data from Westminster and Lewisham, 80% of clients accessing the HDN had tri-morbidity – a combination of physical and mental health issues and substance use. Many health problems are caused or compounded by homelessness and require intensive support.

⁹ Health service costs from the New Economy Unit Costs Database, funded by the Department for Communities and Local Government (DCLG) http://neweconomymanchester.com/stories/832-unit_cost_database

¹⁰ Client E had been staying at the HDN for 23 weeks by the end of Q2 2015-16

- **Early evidence from our Hospital Discharge Network is positive**

Data from our HDN suggests a positive impact, reducing hospital admissions and A&E use for a cohort of people in very poor health, and supporting clients to better engage with health and social care services.

- **Addressing multiple needs is challenging but pays dividends**

The HDN addresses multiple needs in a single service, requiring a comprehensive set of partnerships across health and housing. We found that this holistic approach to multiple needs is effective but requires a lot of work to build and maintain partnerships across agencies.

Our services in Hackney and Camden are working closely with hospitals, outreach workers, GP practices, community nurses, drug and alcohol services, mental health services, social care, and housing services to identify suitable clients for referral and create effective support systems for clients. Our processes have been streamlined by building links with local authorities and agreeing sharing formats for paperwork.

We believe that every hospital visit is an opportunity for people who are homeless to engage with services. It is vital that people receive the support they need to recover and manage their health, preventing repeated emergency hospital and A&E use and escalating costs to the NHS.

Only 17 of the 51 national DH pilot projects received continuation funding¹¹. Services need longer term funding of more than six months to allow effective promotion and workforce training.

In a challenging funding environment, creative commissioning can offer opportunities to build services that bring health, housing and social care agencies together and work to prevent future need for costly health and social care provision.

Hospital to Home

St Mungo's offers alternative support to people who are homeless or at risk on discharge from hospital through the Hospital to Home (H2H) service. H2H workers based at Charing Cross and Hammersmith Hospitals support patients to resolve their housing issues while they are in hospital. Workers also search for accommodation for clients and arrange reconnections so clients can access support in their home area. H2H provides training within the hospitals to raise awareness about homelessness.

The Hospital to Home pilot was funded through the DH Homeless Hospital Discharge Fund between November 2013 and June 2014. The pilot worked with 71 people, 30 of whom were sleeping rough when they came to hospital. The project prevented 27 people returning to the streets. The project relaunched with new funding in May 2015.

An independent evaluation of the pilot is available at www.mungsbroadway.org.uk/documents/6345/6345.pdf

¹¹ Homeless Link (2015) Evaluation of the Homeless Hospital Discharge Fund

About St Mungo's

St Mungo's vision is that everyone has a place to call home and can fulfil their hopes and ambitions.

As a homelessness charity and housing association our clients are at the heart of what we do. We provide a bed and support to more than 2,500 people a night who are either homeless or at risk, and work to prevent homelessness.

We support men and women through more than 250 projects including emergency, hostel and supportive housing projects, advice services and specialist physical health, mental health, skills and work services.

We work across London and the south of England, as well as managing major homelessness sector partnership projects such as StreetLink and the Combined Homelessness and Information Network (CHAIN).

We influence and campaign nationally to help people to rebuild their lives.

St Mungo's began helping people sleeping rough off the streets in 1969. It then developed many ground breaking services including; the first specialist project solely for mentally ill rough sleepers, funded by the Government; the first specialist project solely for rough sleepers who drink heavily; the only specialist project solely for elderly rough sleepers and, more recently, the first Recovery College in the homelessness sector. In April 2014, St Mungo's merged with Broadway, founded in 2002, to form one of the UK's leading agencies working with people who are homeless, or at risk of becoming homeless.

St Mungo's vision is that everyone has a place to call home and can fulfil their hopes and ambitions.
We provide a bed and support to more than 2,500 people a night who are either homeless or at risk.
We work to end homelessness and rebuild lives.

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St Mungo Community Housing Association is a registered charity and a limited company registered in England and Wales
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St Mungo's
Ending homelessness
Rebuilding lives
