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CCPS
COALITION OF CARE AND SUPPORT PROVIDERS IN SCOTLAND

Housing Support and Housing Advice in Hospitals

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Housing support and housing advice in hospitals

Evidence and evaluation of recent pilots

There is evidence suggesting that embedding housing support and housing advice in hospital settings can support hospital discharge and avoid hospital readmission. Currently in Scotland, there is not a national program supporting this type of partnership working, however there have been pilots in Scotland and England.

Scotland:

Fife HSCP and Shelter Partnership

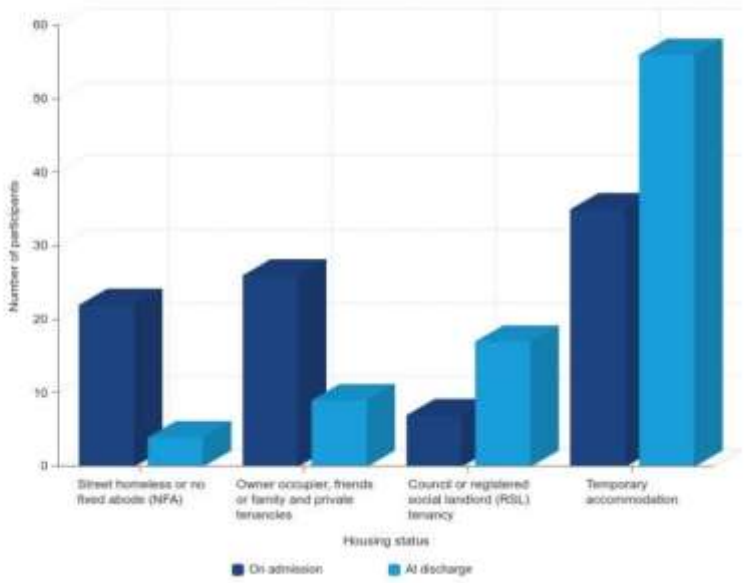
A partnership between Shelter Scotland and the Fife Health and Social Care Partnership (HSCP) included two full time members of staff employed by Shelter working in Victoria Hospital in Kirkcaldy. The intervention took place in the hospital's Discharge Hub between January 2018 and January 2019, and in A&E discharge between November 2019 and February 2020. Shelter members of staff provided a combination of clinical and housing expertise.

There were 91 participants, with 76 from the Discharge Hub and 15 from A&E.
Cost analysis was completed by Health Improvement Scotland (HIS) using net cost per bed day multiplied by length of stay. **There were savings of £378,360 in terms of reduced hospital activity.**

Table 1: Total Costs

	Pre-intervention	Post-intervention
Inpatient	£570,706	£189,467
Emergency	£74,155	£75,575
Outpatients/Daycases	£42,758	£44,217
Total	£687,619	£309,259

Figure 6: Self-reported housing status when admitted to hospital and at discharge



Cyrenians Hospital InReach Pilot

The Hospital InReach project was piloted in two hospitals in Edinburgh by Cyrenians. In the first 18 months, between February 2020 and September 2021, over 300 patients at risk of homelessness were supported to maintain or access accommodation after discharge. The project included:

1. Holistic approach to care at admission and a needs assessment in preparation for discharge.
2. Continuing community support after discharge until individual is at low risk of readmission.
3. Working with clinical staff to educate them on the increased needs of people experience homelessness and establish links with secondary care and community-based homeless services.
4. Development of specialised Hospital InReach Team dedicated to early intervention and focussed case management.
5. Stronger links into secure housing after discharge.

Evaluation of the programme after the first 18 months found that there was a reduction of 68.7% in readmissions compared to the 12 months prior to Hospital InReach referral. 86% of patients receiving targeted interventions completed inpatient treatment courses, 75% were linked with primary care providers, and 56% had appropriate accommodation sourced prior to discharge. Community homelessness/ housing services were able to contact the Hospital Inreach team during admissions to start earlier planning for discharge.

The evaluation of the project found consensus among staff that better health outcomes were achieved by delaying discharge until there was an appropriate housing solution, reducing hospital readmissions.

Table 2. Mean number of hospital admissions (of any kind) in the 12 months prior to Hospital In-reach referral, 6-12 month post-implementation and 12 -18 months post implementation.

Intervention (number of patients)	Baseline (Mean no of Admissions 12 months prior to Hospital In-reach programme referral)	Mean no of readmissions from baseline to 6 months	Mean no of readmissions from 6 months to 12 months	Mean no of readmissions from baseline to 12 months	% change from baseline to 12 months
All interventions (n= 66)	3.2	0.5	0.6	1	-68.7%**
Casework (n= 18)	3.2	0.5	0.6	1.2	-62.5%*
Light touch (n= 22)	4.4	0.7	0.6	1.6	-63.6%**
One touch (n= 26)	2.2	0.3	0.1	0.4	-81.8%**

* = P<0.05; ** = P<0.01.

Adapting for Change: learning points

The Adapting for Change initiative (AfC) supported by the Scottish Government and iHub included five pilots to test ways of improving the housing adaptations process from 2014 to 2017. The pilots were:

Aberdeen: Bringing representatives from range of organisations involved in adaptations and housing together to agree a cross-tenure Single Major Adaptation Pathway.

Falkirk: Developing a new outcome focused service model for adaptations including developing training packages and performance management tools.

Fife: Understanding local challenges to develop a single adaptations pathway through 'tests of change'.

Lochaber: Developing a tenure-neutral one-stop-shop to provide people with solutions including aids and equipment, handyperson services, adaptations and housing options advice.

Scottish Borders: Developing a self-referral one-stop-shop approach for adaptations.

One key learning point was the effectiveness of designing joint approaches to complex cases. **The experience of AfC initiatives suggested that embedding adaptation-related pathways to support hospital discharge encouraged a successful redesign of**

services. A further key learning point was around making the best use of Occupational Therapy Services, including specialist housing expertise.

England:

Evaluation of housing association support service in facilitating hospital discharge in Yorkshire

Between 2018 and 2021, social housing provider, Wakefield and District Housing, provided Housing Support Coordinators across two hospitals. The pilot service aimed to provide support to people leaving hospital and ensure that housing needs were met. One of the hospitals was an acute hospital while the other was a mental health hospital. Support was necessary for a variety of reasons including, unsuitability of previous housing, requirements for home adaptations, or service users wanting to move to be closer to family.

488 people were referred to the service across both hospitals. **The service was reviewed by researchers at the University of Sheffield who found that the service supported the reduction of delayed discharge.** Through alleviating problems associated with housing need, more time was able to be spent by frontline staff on clinical work. Additionally, the Housing Support Coordinator Service has potential for cost savings; if the service reduced delayed discharge by 2-3 days in 1-2 patients ever week, then the service would pay for itself.

Delivery challenges of the service included a lack of appropriate housing, organisational differences affecting the Housing Support Coordinator's ways of working, and managing service-user's expectations of the housing available.

Key recommendations from the evaluation include:

1. Allowing Housing Support Coordinators to access appropriate IT systems and be placed within a health and care discharge setting.
2. Ensuring appropriate support from healthcare managers to understand the role of Housing Support Coordinators.
3. Placing Housing Support Coordinators within an organisation that provides services for onward referral.

The full report can be viewed on the NIHR School for Public Health Research website.

Home Group Hospital Discharge Service

Home Group have a Hospital Discharge Service model that offers housing advice and support within hospital wards and after-discharge in the community. The service has been a part of Home Group's wider community services and the support offered includes finding alternative accommodation, maintaining safety and security of the home, and support to access other appropriate services. The service also aims to reduce the pressure on hospital

staff to resolve housing issues before discharge, freeing up more clinical time, and removing barriers to discharge.

The service began in partnership with Durham County Council but has now also been implemented in Darlington and Tees Valley through a partnership with Tees Esk and Wear Valley NHS Trust, and across the North East in partnership with Cumbria, Northumberland, Tyne and Wear NHS Trust.

'In a 12 month study of the Durham and Teesside hospital discharge services, the average reduction in duration of inpatient stay for individuals presenting with a housing need was over 100 days. **This amounted to a cost saving for the trust of over £35,000 per person**.'

Housing- Getting People Home from Hospital, Interactive map developed by Foundations and the Housing LIN

This interactive map gives details of projects across England delivered by providers of housing support and local housing authorities that aim to address delayed discharges caused by housing issues. It also shows the number of delayed discharges of care from hospital arising from housing issues reported by NHS England between January and December 2017.

Conclusions

The recent pilots demonstrate that embedding housing support and housing advice in hospitals can not only improve outcomes for people after discharge, but also deliver cost savings in terms of reduced readmission, and reducing delays. The evidence of recent pilots suggests that these positive outcomes are encouraged by coordinated working, support and understanding of housing support across all levels of staff.

If you would like to discuss further, please contact Emma Mathews at emma.mathews@ccpscotland.org.

CCPS
COALITION OF CARE
AND SUPPORT PROVIDERS
IN SCOTLAND

CCPS, Norton Park, 57 Albion Road, Edinburgh EH7 5QY
t: 0131 475 2676 **e:** info@ccpscotland **www.ccpscotland.org**

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