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Photographs courtesy of Shelter and Coastline Housing
1. Introduction

1.1 Executive Summary

The Homeless Patient Hospital Discharge Service had a very successful first year with almost 170 patients discharged with a support plan and 89% of patients discharged into suitable accommodation.

Over the past year the project has exceeded all the funding objectives as outlined below:

- 60 patients to be assessed who are homeless, or who may be homeless upon discharge, on admission to hospital.
- 50 patients offered advice and a planned discharge from hospital into suitable accommodation.
- To reduce the number of delayed discharges which result from patients being homeless or not having a suitable home to return to.
- Developed and implemented a county wide multi-agency protocol.

Wider Benefits include:

- Reduction in social exclusion.
- Improvements in health outcomes.
- Improvement in patient flow.
- Reduction in repeat admissions.
- Help to address frequent attenders.
- Pathway to accommodation support is clear and easier to navigate.

Cost Savings

The service has 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). The service has helped 170 patients, far in excess of the anticipated need. Wider whole system flow benefits also apply, demonstrating an additional £82,000 savings in relation to the management of the most complex care patients.

“\nThe 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

“\nDischarge planning can now begin at the point of admission as we clearly identify the housing needs at that point.”
Occupational Therapist
The challenges that this project worked to address

- Gaps in service expectation and ability to deliver: supporting patients with complex needs, particularly those with mental health issues. All too often this group are well-known to local support services and providers, and as a result have been excluded from services, or are considered too high risk.

There are a limited number of services who are able to provide support or accommodation, to those who are most excluded due to insufficient funding to ensure that support staff have sufficient time to spend with those service users. Often those entrenched rough sleepers who are treated at the acute hospital are discharged into inappropriate or unstable accommodation, which quickly breaks down.

The limitations on services due to the reduction of the supporting people budgets, lack of a dedicated service to provide support to those with personality disorders, the direct access night shelter currently having shared rooms only and short term funding streams, all compound the ongoing difficulties those with complex needs, entrenched rough sleepers or chaotic lifestyles face.

This is highlighted within the ministerial working group’s report ‘Addressing complex needs: Improving services for vulnerable homeless people’.

"As services tend to be structured around single ‘issues’, this group struggle to access the mainstream service offer...because none of their issues are singularly high enough to meet the access threshold. Yet their needs can sometimes be too high to be dealt with in the mainstream hostel system."

Other challenges encountered and resolved by the project are detailed in section 3.

Our success in meeting these challenges.

1. Supporting integration

The dedicated Homeless Patient Advisor is able to provide central coordination between a complex range of services to improve multi-agency working.

2. Improved link between the accommodation providers and health services

As part of the role the Homeless Patient Advisor has become a member of a number of working groups, such as the Cornwall Rough Sleeper Operational Group, Complex Needs Providers Forum, RCHT’s Alcohol Multi-Disciplinary Team and Domestic Abuse & Sexual Violence forum and the Working Project Group for the Integrated Personalised Commissioning. Within these groups the Homeless Patient Advisor is the key link between accommodation providers and health services.

3. Reducing the pressure on bed spaces and enabling people to go home

One of the unexpected outcomes is that a quarter of all referrals returned home, instead of securing alternative accommodation straight from a hospital bed. The Homeless Patient Advisor.

Often a patient would state that they couldn’t return home, and hospital staff have little time to question this or investigate further. The Homeless Patient Advisor had the available to discuss the concerns with the patient, advise them and refer them to the appropriate services. The patient would be willing to return home for a short while, with a plan in place to secure more suitable accommodation. This meant that the project was able to reduce the pressure on bed spaces both in the hospital and with accommodation providers, who may have otherwise had to provide emergency accommodation.

The learnings identified by Homeless Link’s recent review of the Hospital Discharge Fund reflects the successes and challenges of this project.

1 Addressing complex needs: Improving services for vulnerable homeless people, DCLG, March 2015, page 11
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.2

(Homeless Link: Review of Hospital Discharge Fund)

The project supports the continuation of 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’.3 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.4

1.2 Background

In 2013 the Minister for Public Health announced the Homeless Hospital Discharge Fund. This followed a report by Homeless Link and St Mungo’s published in May 20125 that showed 70 per cent 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. This can lead to a repeated cycle of inappropriate acute hospital readmissions, where the individual feels that admission to hospital is only safe place to go for assistance.

St Petroc’s Society, the lead contractor and its’ partners6 submitted a joint partnership bid for Cornwall in August 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 Homeless Patient Advisor, to work from the hospital sites and implement the protocol, at £39,261 per annum. 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.

The service launched in December 2013 and in October 2014 a further six months of funding was secured under the NHS Winter Pressures funding, this allowed the post for the Homeless Patient Advisor to continue until end of September 2015.

The Homeless Patient Hospital Discharge service has three 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 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.

3. 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 not an appropriate environment for their recovery or treatment plans.

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2 Homeless Link: Review of Hospital Discharge Fund 2015, page 1
4 Homeless Link: Review of Hospital Discharge Fund 2015, page 1
6The 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.
1.3 Project objectives

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

1.4 Service KPIs

<table>
<thead>
<tr>
<th>Targets: Revenue Funding Stream</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 patients with a housing need to be assessed on admission</td>
<td>Shelter</td>
</tr>
<tr>
<td>For the Winter Pressures funding the requirement was the same but over a six month period.</td>
<td>Shelter</td>
</tr>
<tr>
<td>50 patients discharged with a support plan</td>
<td>Shelter</td>
</tr>
<tr>
<td>For the Winter Pressures funding the requirement was the same but over a six month period.</td>
<td>Shelter</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targets: Capital Funding Stream</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation available up to 2 years</td>
<td>St Petroc’s Society</td>
</tr>
</tbody>
</table>

1.5 Client Group

The Cornwall Homeless Patient Hospital Discharge Protocol covers patients over the age of 16, who have settled accommodation prior to admission but will be unable to return to it for medical reasons and patients who were homeless or living in temporary accommodation prior to admission.

1.6 Guidance and training for staff within health, housing or support services

The protocol was developed by March 2015; building on existing guidance and good practice established elsewhere, but primarily drawing on local stakeholder and service user input to reflect the unique geographical factors of service delivery in a largely rural area.

Partnership working is a critical element of this project. Key members of operational staff and decision-makers, in hospitals, mental health facilities and partner agencies, are 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) were provided to help staff understand the services available and the pathways for patients prior to discharge.
2. Project Performance

2.1 Project Highlights (2014 figures only)

167

Patients assessed on admission in the first year, 107 over the project target.

In the first quarter of 2015 a further 47 assessed on admission, 13 off target with a further six months to go.

81%

Patients were discharged with a support plan.

89%

of homeless patients had suitable accommodation to go to when they were discharged

44

Rough Sleepers who accessed the service. Based on the 2013 rough sleeping count (50), a significant proportion of that group became known to the project.

45%

Reduction in the number of hospital stays post intervention from the previous year.

£169,500

Cost saving in the number of bed days reduced as a result of the Homeless Patient Hospital Discharge Service.
2.2 Case Studies

Below are three case studies to demonstrate complexities faced by our clients and the positive impact the project has had on their lives.

Case Study 1: Entrenched rough sleeper

<table>
<thead>
<tr>
<th>Number of admissions/attendances prior to referral</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of bed days prior to admission</td>
<td>0</td>
</tr>
<tr>
<td>Bed days</td>
<td>54 (36 in acute bed &amp; 18 in community bed) = £31,500</td>
</tr>
<tr>
<td>Number of admissions since</td>
<td>0</td>
</tr>
<tr>
<td>Number of bed days</td>
<td>0</td>
</tr>
<tr>
<td>Admissions within 30 days</td>
<td>0</td>
</tr>
<tr>
<td>Referral made</td>
<td>June 2014</td>
</tr>
</tbody>
</table>

**Background**

Patient was admitted to hospital in May 2014 after collapsing at the local breakfast club, they suffered with COPD but due to months of self-neglect their general health was very poor.

They had been a long term rough sleeper and was well known in the local area, having spent many years living in the local park.

They had been in contact with outreach services and the housing department but the relationship had broken down and they would sit with their eyes closed, ignoring them when any of the support workers would visit them.

They did not respond to the nurses, they would close their eyes when they came to the bedside, an assessment under the Mental Capacity Act was undertaken and considered that they would not have been allowed to leave hospital if they should try to against medical advice.

**How we assisted**

- They were referred to the project by the homeless link worker for Cornwall Housing, however the nursing staff felt that they would not be able to live independently and was likely to be placed in residential care.
- After several weeks they became more active, getting up, talking to other patients and nurses, until eventually they were well enough to be discharged. They were in hospital for over two months.
- They were referred again when they were moved into a local community hospital for rehab treatment.
- They were placed into the hospital discharge accommodation.
- We arranged for them to be collected from the hospital and driven to the accommodation, which was fully furnished and a food parcel was provided whilst they waited for their benefit payments.
- They were visited at least twice weekly by support workers and assistance was provided to complete benefits claim, register with a GP and access required services.
- They were referred to long term supported accommodation for people with complex needs.

**Outcome**

- Offered a place with the supported housing and has settled in well.
- They visits the support office every evening when the day shift ends and night one starts and has a coffee and catch up with the staff.
- Participates with the Sunday lunch club and socialises much more.
- Hopes to secure a social housing tenancy through the housing register, and are being assisted by the support workers to complete the application.
- No further admissions to hospital and general health has much improved.
Case Study 2: Suicide Attempt

| Number of admissions/attendances prior to referral | 0 |
| Bed days | 36 days in acute bed & 46 days in MH bed = £54,400 |
| Number of admissions/attendances since | 0 |
| Number of bed days | 0 |
| Referral made | June 2014 |

Background

Patient was living with grandparents and providing care for both of them, they found this increasingly stressful and was unable to cope.

In early May they made a serious attempt on their life and caused significant injuries. Once they were considered physically fit for discharge from the general hospital, they were transferred to a mental health bed.

How we assisted

- Referred to Coastline Housing for a space in the long term supported housing rather than crisis accommodation.
- Planned discharge with the ward and arranged for transport to take them to the accommodation.

Outcome

- Maintained tenancy with supported accommodation provider
- Enrolled in college and is managing well.
- No further thoughts of suicide or threats to harm themselves
- In full time education at local college.
Case Study 3: Migrant worker

| Number of admissions/attendances prior to referral | 5 |
| Admissions/attendance within 30 days | 5 |
| Bed days | 11 in acute bed = £11,000 |
| Number of admissions/attendances since | 0 |
| Number of bed days | 0 |
| Referral made | October 2014 |

**Background**

Patient’s admissions /attendances had been over a 7 day period; had become street homeless and so was persistently taking overdoses when heavily intoxicated.

Recently moved to the UK, they could not speak English very well, and felt overwhelmed and started drinking. As a result of issues fell behind with their bills; sleeping in a car that their employer had loaned them, drinking heavily and trying to continue to work.

Arrested by the police for drunk driving and driving without insurance. Subsequently patient did not know how to cope and so would drink excessively and then overdose using medication they bought over the counter.

Did not want to be reconnected to home county as they were too ashamed of what had been happening and did not want to tell their parents.

The patient was not referred to the project until their sixth attendance to the emergency department, and by this time their health was so poor they were admitted for six nights.

**How we assisted**

- Provided accommodation through hospital discharge project
- Support staff assisted them with legal issues.

**Outcome**

- Served a short term prison sentence for the driving offences and when released was offered accommodation with St Petroc’s in a different project, as they had managed so well prior to imprisonment.
- Attended a number of training courses, computer literacy etc.
- Started working in paid employment but prior to this was undertaking some voluntary work.
2.3 Outputs, inputs and impact

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed Outputs</td>
<td>Eviction</td>
<td>$Financial savings for Local Authority and NHS Trusts</td>
</tr>
<tr>
<td>Referrals Discharged</td>
<td>helped to return home</td>
<td>$Sustainable housing for clients</td>
</tr>
<tr>
<td>Month</td>
<td>with support plan</td>
<td>Suitable accommodation secured</td>
</tr>
<tr>
<td>Referrals Assessed</td>
<td>Eviction prevented</td>
<td>Timely access $</td>
</tr>
<tr>
<td>Discharged w/ plan</td>
<td>return home</td>
<td>to preventative services</td>
</tr>
<tr>
<td>Quarter</td>
<td></td>
<td>Increase in the number of hospital beds available</td>
</tr>
<tr>
<td>ly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Quarterly Assessed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly Discharged w/ plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>February</td>
<td>8</td>
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<td>March</td>
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<td>11</td>
</tr>
<tr>
<td>December</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Sub-total</td>
<td>167</td>
<td>156</td>
</tr>
<tr>
<td>January</td>
<td>20</td>
<td>19</td>
</tr>
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<td>February</td>
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<td>15</td>
</tr>
<tr>
<td>March</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>216</td>
<td>203</td>
</tr>
</tbody>
</table>

$Figures correct as of April 2015
2.4 Patient outcomes analysis

Assistance Provided Jan ’14 - Dec ’14

With the assistance of the dedicated project Homeless Patient Advisor:

- **25%** of patients were assisted to return home
- **16%** of patients were placed in the dedicated Hospital Discharge Accommodation
- **38%** of patients were placed in supported accommodation
- **7%** of patients were discharged as no fixed abode
2.5 Re-admission analysis

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,

69% of the readmissions were 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.

For further referral analysis see Appendix 1
2.6 Cost Savings

For RCHT

The service has 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). The service has helped 170 patients, far in excess of the anticipated need. Wider whole system flow benefits also apply, demonstrating an additional £82,000 savings in relation to the management of the most complex care patients.

Economic Benefit

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 43 patients fall under the complex needs umbrella, requiring support with at least two other problems as well as hospital admissions. Of those 43 patients, 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

2.7 Cost overview

For Cornwall Housing

From April 2013 to March, 56 households requested advice and assistance direct from hospital, from April 2014 up to March 2015, 49 households direct from hospital. However of those 49 contacts, only 13 required emergency accommodation.

This shows the possible costs savings to the temporary accommodation budget by reducing the need for bed and breakfast use.

For Cornwall Partnership Foundation Trust

- 15 patients who were in hospital in an out of county acute ward placement were referred to the project. Patients spent a total of 776 nights at a potential cost of £485,000.
- Of these, 10 were secured accommodation by the project worker, with 7 placed in the discharge accommodation.
- Of 32 patients referred, 4 required specialised treatment or residential care. The remaining 28 spent a total of 2185 days in hospital at a cost of £874,000.
- Of these 3 were placed in the discharge accommodation, 2 within the No Second Night Out service and 6 were referred directly in supported accommodation and 7 were able to return home with advice and support.

For Peninsula Community Health

- Of the 8 referrals direct from PCH services, 4 were assisted to secure accommodation.
- Many of the longer term admissions from RCHT were moved into community beds and so whilst the initial referral was made when the patient was admitted to an acute ward, they were discharged from a community bed.

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8 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

9 This figure is a proxy as the admissions data is based on patients that are registered with Health for Homeless Practice and therefore does not give the full picture of Hospital Admissions.

10 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 are £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
2.8 Benefits: NHS Stakeholder feedback

The project has had positive feedback from a range of internal stakeholders working with a cross-section of patients. Prior to this project none of the departments interviewed had a clear discharge process in place, often sign posting on to the local authority or local housing providers, for patients identified as homeless/NFA. This is supported by Homeless Link’s recent review of the fund where ‘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.’

Impact

Dedicated worker with a housing expertise has resulted in:

- Clear pathway in place allowing for discharge to begin at the point of admission
- Much more help and clarity around the process who are admitted with no fixed abode
- Safe and effective discharge plans
- Enabled staff to dedicate more time to other aspects of patients care
- Greater awareness of and understanding of timescales and options available to our Homeless patients
- Changes made have allowed for earlier interventions.

The project has resulted in a formal referral pathway to the Homeless Patient Advisor who has brought homeless/housing expertise to the care of a very vulnerable group of patients who often are at high risk of serious self harm/suicide and on occasions a risk to others if not provided urgent assistance with housing. The service is always prompt and effective.

I have no hesitation in stating I am sure the project had saved lives . . . . we have already identified this service as an important part of the future suicide prevention strategy that should be developed further and adopted in other health services of the South West.

Adult Liaison Psychiatry Service, Royal Cornwall Hospital

They have excellent knowledge of process and procedures in regards to Cornwall Council and other accommodation providers and have a good understanding of particular issues which can impact further on those with mental health difficulties.

It is a fantastic resource and our patients have and continue to benefits greatly from the service. Long may it continue.

Social Worker, Bowman Ward (Low Secure Unit), Bodmin Hospital

Stakeholder recommendations

Feedback from the questionnaires highlight the clear benefits of having a Homeless Patient Advisor based at RCHT and the feedback outlined above would like the support to continue with a recommendation for the Homeless Patient Advisor post to be extended in terms of days / hours.

It 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 Therapist, Acute Mental Health Ward, Bodmin Hospital, Cornwall Partnership NHS Foundation Trust
3. Key sector challenges and recommendations

Proving intensive short term support

**Challenge:**

**Accessing clients on admission or attendance:** The service currently operates Monday to Friday, 9am to 5pm, and therefore it isn’t possible to engage with clients at the point of admission or attendance outside of these hours. This is particularly pertinent when considering attendances to ED over the weekend or evenings, the opportunity is missed to start supporting those clients who tend to avoid contact with support staff and are admitted outside of the current opening hours.

Whilst they are in a hospital bed or bay, it is possible to meet with them, discuss their current situation, what support may be available and build up a rapport. Often cold calling patients on a Monday morning, means that the phonecall is either not answered, or patients being suspicious or dismissive of the support offered.

**Recommendation:**

**Extend service to available 7 days a week:** by extending the operating hours the Homeless Patient Advisor will be able to access and start working with patients from the hospital bed, providing ongoing, personalised support, which may prevent further admissions and address the housing issues, which in turn should improve the health and well-being of that patient. Intensive short term support would be particularly important for those patients staying in the hospital discharge accommodation.

Access to appropriate accommodation

**Mixed support levels:** The bed spaces acquired so far have been within other projects, sharing with clients who are in the final stage of supported housing, and considered to require very low support and are very settled.

**Staff expertise:** The staff providing support are not dedicated to the hospital discharge spaces only and so are not able to offer the high level of support many of the patients require.

**Helston accommodation example**

The accommodation acquired in Helston are two rooms within a five bedroomed house, the other three residents are in the final stage of support, and so are able to live in the property for up to two years.

Although there have been some benefits with the patients living in shared accommodation, such as the other residents offering support to those struggling due to mental or physical health issues, it is felt that:

- It is not appropriate for the residents to feel like they have to offer support
- The anti-social behaviour of some of the patients has made it unsettling for the other residents
- Some of the restrictions such as no drinking, means that the most excluded and hard to engage with people, are not able to be accommodated, or are evicted
- The lack of dedicated support, means that many of the patients end up presenting as homeless to the local authority or moving to the night shelter
- In some more chaotic or complex cases, the limit of six weeks maximum stay means the intervention of the project is not as meaningful or has the impact that it should.

**Pool accommodation example**

The accommodation acquired in Pool are two rooms within a nineteen room property. One of the rooms is used for the No Second Night Out service and the remaining sixteen rooms
are part of St Petroc’s Society’s supported accommodation for those requiring medium to low support.

**Accommodation based Support Workers:**
The patients who have been placed in these bed spaces have achieved more successful outcomes. This would suggest that this is a result of the support workers being based at the accommodation, work from an office within the building. There is also security staff there overnight from 7pm to 7am, who can deal with any problematic behaviour immediately, additionally the rooms all have an ensuite bathroom, which means the residents only have to share kitchen facilities. Although there have been some patients whose behaviour has caused issues for the other residents, these have been able to be managed better, and have not led to the immediate eviction of the patients.

**Recommendation:**
Reducing the transition from hospital to hospital discharge accommodation and then settled accommodation

The initial plan of three 2 bedroomed properties in different locations, is not practical when considering the support that many of the patient require. In terms of the financial implications of providing support staff during the day and security staff overnight, it is much more affordable to do this in one location.

This evaluation recommends that the ongoing support to the patients should be provided by the project as an extension to the remit of the Homeless Patient Advisor. This would make the transition from hospital to hospital discharge accommodation and then settled accommodation less challenging.

**Benefits of this approach**
This approach will help facilitate planned admissions for those entrenched rough sleepers, which until now has not happened. If the accommodation was able to facilitate a clinic for the Health for Homeless GP service, they may have patients that they see at their other clinics, who would need hospital treatment but have been unable to follow this up due to lack of access to services or lack of accommodation to allow recovery. The benefits of this approach will mean patients are admitted, receives hospital treatment, accommodation by the project whilst recovering and then returns to rough sleeping, but with their underlying health problem being treated.

**I.T**

**Lack of centralised IT system and encryption**
The Homeless Patient Advisor actively uses three email accounts, which can make keeping track of referrals challenging and is the biggest barrier to working efficiently. For example the acute hospital uses as different system to the mental health hospitals, but NHS staff are unable to send patient information to an email address for an outside organisation without encrypting it. As the worker is employed by Shelter and works remotely within the hospital, using Shelter equipment and IT resources, it is not always possible to open an encrypted email, due to the encryption software on the laptop.

However they need to work on the hospital site so they can easily see the patients when they are referred. Hence the need to have separate email accounts to allow the NHS staff to refer a patient easily.

**Inefficient discharge due to IT encryption**
Much of the information shared between the adviser and the community agencies is via email, and having emails blocked by the other organisation’s IT department, due to it being encrypted does not allow for efficient discharge planning. Therefore many of the emails referring a patient to an accommodation provider are sent using the Shelter account, as this doesn’t restrict information sharing.

**Recommendation:**
The Living Well project is currently reviewing information sharing and devising IT solutions to try and overcome the obstacles. It is also expected that RCHT will move over from the Groupwise email system to nhs.net, which is an Outlook based system.
Once this change takes place there will be only two email accounts instead of three, but also both the Shelter and nhs.net are Outlook systems, and so will hopefully be able to merge. Once the move to another system within RCHT has taken place, it will be possible to liaise with both IT departments to find a solution.

Partnership working:

Information sharing between agencies

As highlighted in Homeless Link’s recent evaluation report ‘developing or implementing pathways successfully can depend on staff and departments having the flexibility to adapt their practice and culture to new ways of working. Although in many cases, hospital staff were willing to engage, there were reports of resistance to this… there needs to be agreed practice about how homeless patients will be identified and recorded from the earliest point of contact in hospital so that support can be coordinated throughout the different stages of the discharge pathway.’

This reflects the experience of the Cornwall service; in terms of partnership working most agencies want better working practices, however differences in working practices and culture can lead to a breakdown in the flow of information between agencies. If the project worker is aware of the patient before the day of discharge, it is possible to ensure that there is a planned move into accommodation, without the patient having to sit for hours in a council office for instance, because they are presenting as an emergency homeless case. assessment.

What is clear is that although many agencies want to work in partnership, the front line staff have so many pressures, this becomes very difficult.

Providing a dedicated service, which offers advice, support and a clear pathway to those patients, who otherwise might remain in hospital, or be discharged as homeless or into unsuitable housing, frees up hospital beds, staff time and helps the services genuinely work together.

Recommendation:

The continued funding of the dedicated Homeless Patient Advisor, to ensure the safe and timely discharge of those patients with housing problems.

Flexible Enabling Fund

The funding available is underspent but remains in place and continues to be available. 33 individuals have been assisted; with total spend of £593, ranging from £2 to £80. This generally, covered transport costs and multitude of smaller issues (many less than £20) that has released hospital bed and enabled a safe discharge. For one client the fund replaced their mattress and arranged for the old one to be taken away, as they had been seriously ill prior to admission and had soiled the mattress, which was not cleaned for the three week period they had been in hospital. The property was in a poor state and required intense cleaning.

Initially it was considered that the money would be used for larger expenses, rent in advance or deposit, and so the application process meant a four page form was to be completed by the project worker, and that the chair of the steering group and Inclusion Cornwall would agree to application. However when in the hospital trying to get a patient to emergency accommodation and having to give them £2 for the bus fare, this was not always practical.

The process was modified to allow the project worker more discretion in giving out smaller sums of money.

Recommendation:

Continue with the process: The funding has been invaluable in enabling patients to be discharged, the fund has been used for a range of needs including travel and food.

Ensure that it is included in a future funding applications: the fund is invaluable resource to increase patients’ ability to plan and return back home or into suitable accommodation.

12 Evaluation of The Homeless Hospital Discharge Fund, January 2015, Homeless Link, page 6 & 21
4. Conclusion

Joint Commissioning

Future investment of hospital discharge projects 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.

Extending the role

The Homeless Patient Advisor is in a unique position bridging a gap between services that want to work together but find it challenging to do so. I.e. they bring an understanding of the restrictions of each provider and knowledge of the appropriate level of involvement from stakeholders to improve multi-agency working. As a member of the following groups this project is in a unique position to expand and improve this coordination role as a key link between accommodation providers and health services. Groups include:

- Cornwall Rough Sleeper Operational Group
- Complex Needs Providers Forum
- RCHT’s Alcohol Multi-Disciplinary Team
- Domestic Abuse & Sexual Violence Forum

Final Statement

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, improve ROI and utilise volunteer resources to add further value to the impact of the service.
Appendix 1: Referral Analysis

Housing Status on admission Jan ‘14 = Dec ‘14

- 25% of patients admitted are rough sleeping.
- 19% of patients admitted are living in the private rented sector.
- 14% of patients admitted are living with family.

Reason for Admission Jan ‘14 - Dec ‘14

- 19% of patients were admitted into hospital because of psychosis.
- 11% of patients were admitted into hospital because of overdose and self-harm problems.
- 10% of patients were admitted into hospital because of trauma.
Medical Wards

- 19% of patients are from the Mental Health ward.
- 16% of patients are from the Emergency ward.
- Overall 28% of all patients have mental health problems.

Assistance provided Jan '14 - Dec '14

- 48% of patients were referred to other providers, of which 23% were referred to St Petroc's dedicated Hospital Discharge Accommodation.
- 30% of patients received Housing Options advice from the Hospital Discharge Adviser.
- Only 4% of patients accessed the Enabling Fund.
Appendix 2: Cornwall Homeless Patient Hospital Discharge Protocol

Foreword

Both the Department of Health and the Department for Communities and Local Government have issued explicit guidance on the role of Hospital Trusts and district/borough councils to ensure that homelessness is prevented for patients leaving hospital. The guidance states that:

All acute hospitals should have formal policies which will ensure that homeless people are identified on admission and their pending discharge notified to relevant primary care services and to homeless services providers. (CLG 2006 Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation)

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

In Cornwall, between 2012 and 2013 ¹ the number of people counted as sleeping rough rose by 54% from 50 to 77 people.

In 2012 ², 41 people were admitted to hospital as having no fixed abode. Between April 2011 and March 2013, 187 no fixed abode patients presented to hospital and 63% presented more than once during this period.

The homeless patient hospital discharge service has to overarching aims:

4. to will 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.

5. 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

¹ Department for Communities and Local Government – Rough Sleeping in England Autumn 2012 & 2013
² Based on APC (Inpatient) SUS Data, based on patients registered with Health for the Homeless so may not give a complete picture of homeless people using hospital services - Period: 01/04/2011 and 31/03/2013
Scope
The protocol covers:

1. Adult patients who have settled accommodation prior to admission but will be unable to return to it for medical reasons.

2. Adult patients who were homeless or living in temporary accommodation prior to admission.

Aims
The protocol aims to:

- Reduce the number of delayed discharges due to housing need.
- Reduce the number of patients discharged to no fixed address or inappropriate housing.
- Reduce the number of readmissions and emergency presentations.
- Improve the health and reduce inequality for the homeless and move to long term outcomes e.g. settled accommodation, support services and work (either training, volunteering or paid work).

Procedure
The flowchart at Appendix 1 shows how the procedure should work.

Discharge from RCHT wards and/or Community Beds

On admission or transfer to other wards, staff will confirm if a patient can be safely discharged. Ward staff will seek to ascertain if, prior to admission, the patient was:

- Living in settled accommodation but will be unable to return to it for medical reasons.
- Staying in temporary accommodation such as:
  - a hostel or night shelter
  - bed-and-breakfast accommodation
  - a friend or relative’s home
  - Sleeping rough

If the patient is of no fixed abode, the postcode ZZ99 3VZ should be entered onto their records on the Patient Administration System and therefore easily identifiable as such.

Information Services will email the Homeless Patient Advisor when a patient is admitted with the no fixed abode postcode or uses the postcode for Coastline Homeless Services, St Petroc’s and Breadline, as these addresses are often used by homeless people as correspondence addresses.

When an email notification is received the Homeless Patient Advisor will contact the ward to verify if the patient requires assistance.

Where a housing issue is identified, ward staff should ask the patient if they would like to be referred, record the date and time of this discussion within the patient’s ‘Discharge/Transfer Plan’ or Patient’s Notes and contact the Homeless Patient Advisor via email or telephone at the earliest opportunity, providing the patient’s name and the ward they are located on and an estimated date of discharge.

Contact Details of the Homeless Patient Advisor (HPA)
Name – Colette Jolly
Email – colette.jolly@rcht.cornwall.nhs.uk
Mobile - 07969 801 807

If the patient agrees to discuss their housing problems with the worker, then the HPA will visit the patient and carry out an initial assessment.

The HPA will outline options available and agree the next steps with the patient, the HPA will then notify the nurse looking after the patient that day and update the nursing notes as necessary.

If the patient is to be referred to Cornwall Housing for advice and assistance, an options form will be completed by HPA whilst the patient is still in hospital. The completed options form will then be emailed to the Options manager (either West, Mid or East) relevant to the patient and the Homelessness Team manager.
If there is already a named options officer they will be sent notification of the admission and any details of the discharge plan if available.

In some cases the patient may be unable to return to their accommodation as following the admission it is no longer suitable. For example, the patient is unable to return as they have had their leg amputated and can no longer access their home as it is a first floor flat.

In such cases, Cornwall Homechoice may consider the patient for Band A status, so long as an environmental inspection has taken place and it is considered by an OT or physiotherapist to be unsuitable. If the patient is not on the Homechoice register, the HPA will complete the application online and provide the Homechoice manager with a copy of the environmental report.

If the patient is unable to bid for properties, as they are not able to access a computer and cannot go to the one stop shops, the HPA will check the adverts each week. If there is a suitable property, the HPA will contact the ward and ask if the patient is happy for a bid to be submitted. If this is agreed the HPA will submit the bid and confirm the patient’s status at the end of the bidding, with the patient and ward staff.

Patients attending emergency departments, urgent care centres and assessment units who are not admitted to hospital.

If a patient identifies them self as homeless, but will not be admitted to another ward, staff will contact the HPA for assistance, with the patient’s permission. Details of this discussion should be recorded in the patient’s nursing notes.

The HPA will visit the patient and discuss options with the patient.

If a patient presents and is discharged over the weekend or in the evening, ward staff should notify the HPA of this presentation, and provide contact details so the HPA can follow this up when they return to work.

Patients admitted to Longreach House or Bodmin Hospital.

The HPA and Housing Support Development Co-ordinator will attend weekly ward rounds at Bodmin, to discuss any patients, who will have a housing problem when they are discharged.

The ward staff should inform the Care Co-Ordinators that the patient will need assistance, who in turn should notify the Housing Related Support workers.

The HPA and Housing Related Support workers will liaise to ensure there is no duplication of work.

Patients taking responsibility for their discharge against medical advice

Ward staff should inform the Homeless Patient Advisor at the earliest opportunity when a patient self-discharges if there are concerns for their welfare.

Where a patient presents to a Cornwall Housing options service unannounced, stating they have been discharged directly from a hospital ward, the duty officer will contact the Homeless Patient Advisor to confirm the circumstances.

Accommodation

The accommodation provided will be six bed spaces across the county. These will be made up of two bedroom properties and will be self-contained. The purpose of the accommodation is to ensure that a patient’s discharge is not delayed or that a patient is not discharged back onto the streets.

Any patients requiring accommodation when they are discharged should be considered for the Hospital Discharge Accommodation Units. Referrals to this accommodation should be made via the HPA only.

Times when this procedure has not been followed has led to patients being made homeless at the end of a six week period, as the patients’ did not want to engage with the support offered.
The HPA will ensure that the patient’s details are entered onto the Inform system and a risk assessment is completed. Information relating to the housing history and background is also entered onto the Inform system. When applicable a discharge/care plan will be provided, however it is not a condition of the accommodation being offered to a patient, as this may cause the discharge to be delayed.

Residents will be visited at least twice a week by a support worker to ensure that they are coping and offer any support or assistance as necessary, however this may increase or reduce dependant on the needs of each person.

The support workers will ensure that the patients are registered with a local GP immediately to ensure that any ongoing healthcare needs are met.

Referrals to the accommodation must consider if the patient is already in receipt of Housing Benefit and the reasons why they are unable to return home. There are limited circumstances whereby a person can claim Housing Benefit assistance for two properties at the same time.

In cases when the patient’s income/capital is too high for them to receive any assistance from Housing Benefit, they will be expected to pay the full rent and eligible services charges.

Any patients having to pay the rent will be expected to pay in line with the current Local Housing Allowance.

The current figures are:- (correct on 15th July 14)

- For a room in a shared house - £66.43 per week
- Self contained one bedroom property - £103.85 per week

They will also be expected to pay the ineligible service charges, such as utilities etc, that should be paid by all residents.

Longer term well being outcomes – preventing inequality, improving lives

Any patient requiring a longer term outcome – progressing to work, training and or volunteering – refer to Cornwall Works Hub bwilson@cornwall.gov.uk (01872) 355015, to discuss accessing relevant programmes and support

Enabling Fund

Applications to the fund will be made by the HPA to Anthony Ball, Chair of the Steering Group and Bev Wilson, Inclusion Cornwall.

The HPA will complete an enabling fund application, and email a scanned version, ensuring that the original signed version is given to Bev Wilson.

The HPA will research the cost of the items required and provide this information.

When a small amount is required to cover travelling expenses or food, the HPA is able to agree to these amounts without submitting a formal application. If possible the HPA will get the patient to sign a hardship form confirming the amount they have received.

Monthly submissions will be made to Inclusion Cornwall by Shelter in relation to these payments.

Monitoring

The protocol will be monitored using the following indicators:

1. The number of bed days lost where the patient’s length of stay has been extended beyond their clinical need.
2. The number of people for whom timely intervention has resulted in homelessness being prevented.
3. The number of people who are identified as having delays in discharge due to lack of accommodation as reported.
4. The number of patients discharged from hospital for which the protocol has not been followed.
5. The number of repeat admissions for patients referred to the project.
6. The number of homeless applications immediately following hospital discharge.

7. The number of emergency presentations to Cornwall Housing Options from hospital, in comparison to the year before.

Responsibility for monitoring the first to the fifth indicator will rest with the Homeless Patient Advisor.

Responsibility for monitoring the fifth and sixth indicator will rest with the local authority homelessness team.

**Monitoring Procedure**

The protocol will be monitored at the Steering Group and Operational Panel meetings.

The purpose of which will be to develop and share good practice; and encourage continuous improvement by sharing lessons learned.

The Protocol is not a final document and will be amended and adapted to reflect the working methods of the project.

The Homeless Patient Advisor will complete a monitoring form for every hospital discharge that they have been involved with whether or not it led to a successful outcome.

Records of unsuccessful outcomes will be discussed at the Steering Group and Operational Panel meetings as part of the monitoring process.

**Inappropriate Referrals**

The project is established to facilitate the timely and safe discharge of patients, when a lack of suitable accommodation, would normally prevent this.

If there is a lack of suitable accommodation because of the level of care required by the patient then a referral should not be made to the HPA.

In such cases the HPA may be able to offer advice and guidance, and explain why the referral falls out of the remit of the project.

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**Roles and responsibilities of partner agencies**

**Shelter**

- Develop and implement a county wide multi-agency protocol
- Provide a dedicated full time worker for hospital staff and agencies to contact and engage with the service.

The worker will:
- Undertake a full assessment of the patient’s housing, community care and support needs.
- Provide specialist advice, support and advocacy.
- Client information will be stored using the INFORM database.
- Liaise with partner agencies and other providers.
- Collate and monitor information gathered for the purposes of evaluating the pilot.
- Report any concerns or difficulties encountered to the steering group.
- Provide training to hospital and support agency staff and partners to ensure that the protocol is implemented.
- Provide suitable staff to sit on both the steering and operational group.
- Provide statistical and monitoring information to facilitate a review of the project.
- Offer support and assistance to the HPA as required.
St Petrocs

- Manage the accommodation for the project.
- Provide support, advice and assistance as required to the residents.
- Provide assistance with move on from accommodation as necessary.
- Offer support and assistance to the HPA as required
- Collate and monitor information gathered for the purposes of evaluating the pilot.
- Report any concerns or difficulties encountered to the steering group.

Coastline Housing

- Provide suitable staff to sit on both the steering and operational group.
- Provide support, advice and assistance as required to the service users.
- Provide assistance with move on from accommodation as necessary.
- Offer support and assistance to the Homeless Patient Advisor as required.
- Allow access and full use of the Inform database to the Homeless Patient Advisor.

Cornwall Housing

- Provide a suitable pathway to assist the HPA with enquiries for both priority need and non priority need clients.
- Provide suitable staff to sit on both the steering and operational group.
- Provide statistical and monitoring information to facilitate a review of the project.
- Client information will be stored using the INFORM database.

NHS Royal Cornwall Hospital Trust

- Refer any new admission fitting project criteria.
- Provide a work space to Hospital Patient Advisor.
- Provide access to Groupwise internal email system.
- Provide suitable staff to sit on both the steering and operational group.
- Provide statistical and monitoring information to facilitate a review of the project.

Inclusion Cornwall

- Enable access to Cornwall Works Hub (01872) 355015, www.inclusioncornwall.co.uk for progressing back to work through training, volunteering and work, to improve long term outcomes for the homeless.
- Co-ordinate and account for the flexible “enabling” fund for the project.
- Provide suitable staff to sit on both the steering and operational group.
- Provide statistical and monitoring information to facilitate a review of the project

NHS Cornwall Foundation Partnership Trust

- Provide suitable staff to represent on both the steering and operational group.
- Provide statistical and monitoring information to facilitate a review of the project.
- Refer any new admissions fitting project criteria.
Cornwall Council
Public Health

- Chair, Note and Arrange the Homeless Hospital Discharge Group.
- Provide suitable staff to represent on the steering group.
- Provide statistical and monitoring information to facilitate a review of the project (with NHS Kernow - see below).
- Provide support for the implementation and operation of the protocol.
- Ensure links are made with Health and Well Being Board, as a wider determinant of “fairer life chances for all”.

NHS Kernow

- Provide suitable staff to represent on the steering group.
- Provide statistical and monitoring information to facilitate a review of the project (with Cornwall Council - Public Health).
- Provide support for the implementation and operation of the protocol.
Patient identified as likely to be homeless or in housing need on discharge

Referral to HPA – complete initial assessment with patient & liaise with appropriate parties

Patient did have settled accommodation prior to admission, can they return with assistance from Enabling Funds?

Yes, apply to fund

Application to Homechoice with OT report

No

Patient did not have settled accommodation prior to admission

HPA to advise & discuss options with patient, and refer as required, possible options.

Hospital Discharge Accommodation

Homeless applications

Staying with family or friends

Housing Options

Referral to supported housing

HPA to liaise with partner agencies and co-ordinate safe discharge of patient

Continue support as required. With aim to address longer term wellbeing outcomes

Patient safely discharged into appropriate accommodation

Refer to appropriate support agencies & services.

Patient discharge NFA or returns to unsuitable or inappropriate accommodation

Continue support as required, to reduce health risks & further admissions. What went wrong, could this have been prevented?
## Appendix 3: Cornwall Hospital Discharge Bid - Budget Plan (July 2013)

### Capital Costs

<table>
<thead>
<tr>
<th>Property</th>
<th>Cost</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lease Costs</td>
<td>£40,470</td>
<td>1 x FTE for 7 months - Protocol £23,400</td>
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<tr>
<td>Repairs and Maintenance</td>
<td>£4,500</td>
<td>1 x FTE for 6 weeks - Evaluation £5,800</td>
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<tr>
<td>Building &amp; Contents Insurance</td>
<td>£750</td>
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### Utilities

- Gas: £3,000
- Electric: £4,500
- Water: £3,600
- Council Tax: £6,600
- TV Licence: £660

### Fixtures & Fittings

- White Goods: £3,000
- Furniture: £6,000
- Fire Protection: £750
- Sundry Items: £2,438

### Publishing

- Protocol Document: £2,750
- Evaluation Report: £2,750
- Distribution: £400
- Gas: £3,000
- Electric: £4,500
- Water: £3,600
- Council Tax: £6,600
- TV Licence: £660

### Launch Event

- Venue: £1,000
- Catering: £500

### Fixtures & Fittings

- White Goods: £3,000
- Furniture: £6,000
- Fire Protection: £750
- Sundry Items: £2,438

### Fixtures & Fittings

- White Goods: £3,000
- Furniture: £6,000
- Fire Protection: £750
- Sundry Items: £2,438

### Summary

- Total Capital Bid: £83,894
- Total Revenue Bid: £65,780
- Overall Bid: £149,674

<table>
<thead>
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<th>Total Capital Bid</th>
<th>£83,894</th>
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<tbody>
<tr>
<td>Total Revenue Bid</td>
<td>£65,780</td>
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</tbody>
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- Management Fee (10%): £7,627
- Training & Monitoring: £2,500
- Refreshments: £500
- Monitoring: £4,500
- IT: £2,500

- Inclusion Cornwall - Enabling Fund: £7,500

- Management Fee (10%): £5,980
- Sub Total: £59,800

- Management Fee (10%): £5,980
- Sub Total: £59,800