Evaluation of Plymouth Hospital to Housing Support Service

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Final

Evaluation of Plymouth Hospital to Housing Support Service

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Commissioned by:
Bournemouth Churches Housing Association

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Executive Summary

Introduction

Bournemouth Churches Housing Association (BCHA) applied for funds under the Homeless Hospital Discharge Fund 2013-2014. This Department of Health funding aims to improve hospital discharge for the homeless after treatment and to secure appropriate facilities for those requiring ongoing medical support after discharge.

BCHA received £74,350 funding from April 2013 to April 2014. It has supported 2 FTE case workers to deliver the project. The Plymouth Hospital to Housing Support Service (H2H) aims to provide advocacy and support to individuals who have presented at hospital and are homeless or at risk of becoming homeless. The overall objective of the service is to ensure that these people are supported into appropriate accommodation, and that they are engaged or re-engaged with appropriate health and community services such as GP's and Harbour drug and alcohol support services.

Methods

BCHA commissioned SERIO at Plymouth University to undertake an evaluation of the project to consider how well the project has met its objectives. At the time of the research, the project had been fully operational for six months so much of the evaluation focused on early impact and lessons learnt.

The evaluation needed to provide good value for money and used the following methodology;

- A review of project-related monitoring and strategic documents;

- In depth interviews with project workers and stakeholders including Plymouth City Councils Adult Social Care Team, Plymouth City Councils Joint Commissioning Team, Plymouth City Council's Housing Options Team, and one of Derriford Hospital's Discharge Teams;

- A review of client case files to produce case studies.

Key Findings

At the time of this evaluation the project had made good progress in achieving its objectives. The project has set up a draft protocol, promoted the service to hospital wards and partners and delivered direct support for beneficiaries. Of the 54 referrals received in the first six months of being operational, 34 were eligible for project support and had been supported from hospital discharge into appropriate accommodation. The remaining 20 who were ineligible were signposted to other services. All of the referrals were dealt with within 24 hours.

The service has supported people with a range of complex issues into appropriate housing. Ensuring the person is in the most appropriate housing, often not Bed and Breakfast, has meant that they can be supported to take prescribed medication following discharge, that they prioritise their health needs and continue to access support from other agencies such as Drug and Alcohol Services. Case files suggest that the issue of frequent re-admission to

hospital for some people has been stabilised. Of the 34 beneficiaries supported only 4 had been re-admitted within the next 28 days.

> *'It has contributed to supporting complex and vulnerable people in accessing a pathway for them to access support and prevent presentation…this is in line with the strategic direction of what we are trying to achieve'.* Project Partner

Early indications are that the service is starting to alleviate some of the pressure on other agencies such as Housing Options, Adult Social Care and Derriford Hospital.

> *'we know that it is time consuming to help someone and arrange transport to Plymouth's housing… and it's a one word referral, it frees up time for us'*. Project Partner

This support takes a variety of forms including organising transport and accommodation, ensuring other agencies such as Housing have the information they need and advocacy to get the support individuals need and prevent more expensive and time consuming crisis intervention.

The data available from the hospital at present isn't detailed enough to quantify the savings in bed stays and re-admissions although similar projects in the country have demonstrated financial savings. However, interviews with partner organisations and the details in the beneficiary case studies would suggest that there has been a reduction in bed stays for individual cases and less frequent re-admissions which would result in a financial saving to the NHS.

"the one thing we have seen is a reduction in those individuals that are delayed transfer in care due to accommodation since the project started"

Conclusions

Setting up and delivering a service within a multi-agency setting and relying on referrals from another organisation can be difficult for a short term project, particularly when working with the different priorities and more medical model of the NHS. The project has made good progress and is starting to show clear signs of impact on beneficiaries and agencies and the case studies suggest that frequent re-admission is stabilising.

Going forward there are a number of areas for the project and partners to focus on including:

- Seeking funding to continue the service past the end of the years' funding;

- Building on the good relationships with the hospital and seek further buy-in to the project. In particular the project partners need secure office accommodation at the hospital for the workers. Having a desk, landline and space to meet would make the project more efficient;

- Continuing to develop ways to evidence the impact of the project where possible. This could include a short feedback questionnaire and ideally follow up with beneficiaries after six months to ascertain longer term impact;

- Continuing to push forward on developing full strategic buy in with the protocol. This needs to be picked up by statutory agencies and developed and implemented;

- Promoting the success of the project to date to partners and to wards to help the flow of referrals;

- Running short training sessions for ward staff around homeless identification and the need for earlier identification, again using some of the project examples to engage staff.

Contents

Section One: Introduction

Bournemouth Churches Housing Association applied for funds under the Homeless Hospital Discharge Fund 2013-2014. This Department of Health funding aims to improve hospital discharge for the homeless after treatment and to secure appropriate facilities for those requiring ongoing medical support after discharge. It follows on from the Government's first report from the Ministerial Working Group on tackling and preventing homelessness *Vision to end rough sleeping: no second night out nationwide and included a commitment to improve hospital discharge for the homeless.*

BCHA received £74,350 funding scheduled to run from April 2013 to 2014. It has supported 2 FTE case workers. The Plymouth Hospital to Housing Support Service aims to provide advocacy and support to individuals who have presented at hospital and are homeless or at risk of becoming homeless. The overall objective of the service is to ensure that these people are supported into appropriate accommodation, and that they are engaged or re-engaged with appropriate health and community services such as GP's and drug and alcohol support services.

The rationale is that by providing this service at an early stage in the admission process, discharge of these individuals to make an inappropriate homeless approach, bed blocking, and re-admissions to hospital may be prevented. According to the funding bid submitted by BCHA (2013/14), the service will '*support patients who have been identified as homeless or at risk of homelessness (NFA) who are being discharged from hospitals in the Plymouth area.*' The bid went on to state that the intended beneficiaries will be:

'*patients who have been admitted into hospital or require on-going medical support following discharge and: are homeless/ at risk of homelessness, do not have suitable accommodation to return to, and have additional support needs including drug and alcohol misuse, mental and physical health issues.*'

The gap that the Plymouth Hospital to Housing Support Service is attempting to fill is the lack of a coordinated approach to supporting a group of particularly vulnerable individuals by assisting them through a pathway of care across multiple agencies.

To be eligible individuals must be aged 18 or over, be a Plymouth resident or have a local connection, be homeless or at risk of homelessness, not have suitable accommodation, have additional support needs and be willing to work with the project and its partners.

BCHA commissioned SERIO at Plymouth University to undertake an evaluation of the project which would address the following broad questions:

- To what extent did the projects meet their objectives to support people into appropriate accommodation?

- How has the project impacted on the work of other agencies? Is there any evidence of cost effectiveness of the service?

- What lessons have been learnt ?

- Should the project be continued and what changes should be made?

The evaluation needed to provide good value for money and used the following methodology;

- A review of project-related documents (e.g. the funding proposal, letters of support, project monitoring data and case files including Client Form: completed by support providers)

- In-depth interviews with project workers and stakeholders including Plymouth City Councils Adult Social Care Team, Plymouth City Councils Joint Commissioning Team, Plymouth City Council's Housing Options Team, and one of Derriford Hospital's Discharge Teams.

- A review of client case files to produce case studies reflecting the impact of the project on intended beneficiaries.

Due to timing, client interviews were not within the scope of the evaluation therefore SERIO reviewed client case files containing a range of monitoring forms, and spoke with project workers and project partners about client pathways through the project. During interviews, interviewees were asked to provide details around the overall impacts on beneficiaries of the project, as well as specific details for case study individuals.

All interviews were confidential. The report is independent, reflecting the results of the information collected and conclusions drawn from this information.

The report is structured as follows:

Section 2 briefly outlines the national context.

Section 3 provides an overview of achievements against targets. This draws upon monitoring data kept by BCHA.

Section 4 provides detail on overall achievements.

Section 5 focuses on the impact on agencies and beneficiaries and considers the strategic context.

Section 6 outlines four beneficiary case studies.

Section 7 is the Conclusion and Recommendations

Section Two: National Context

> **Key points**
>
> - **The Government has committed to improving hospital discharge for the homeless.**
> - **Homeless people are five times more likely to attend A&E as people who are non-homeless; with an associated cost of around £5m per year.**
> - **Projects which have been implemented to improve admission and discharge practice have demonstrated cost benefits by lower readmission rates and being able to be discharge more quickly into appropriate housing.**
> - **Despite this, only 27 percent of those who are classed as homeless received help with housing before being discharged.**

National Context

The Government's first report from the Ministerial Working Group on tackling and preventing homelessness included a commitment to improve hospital discharge for the homeless. Following on from this the Department of Health launched the Homeless Hospital Discharge Fund 2013-2014. This Department of Health funding aims to improve hospital discharge for the homeless after treatment and to secure appropriate facilities for those requiring ongoing medical support after discharge.

There is relatively little research relating to homeless people leaving hospital. Research by Deloitte (2012) found that 107,240 approached their local authorities as homeless in 2011; a 10% increase from 2010.[1] The study also found that up to 70 per cent of people who use homeless services suffer from mental ill health. There were also high levels of alcohol and drug dependency, which tended to exacerbate health problems. Due to a reduced access to normal healthcare services, many homeless people let their conditions deteriorate until a point where emergency care is required.

In addition to the impact on individuals, research has started to focus on the cost of homelessness. Research by Homeless Link (2013) estimated that each homeless person represents a cost of £26,000 per year to the public fund[2]. Therefore services that prevent homelessness and help a transition away from this situation will likely result in a saving to the public purse.

A joint report by Homeless Link and St Mungo's in 2012 found that when homeless people finally leave hospital, more than 70 percent will be discharged straight back onto the streets without their housing issues being addressed[3], which will likely result in readmission due to the conditions being adverse to recuperation. Due to challenging behaviour sometimes displayed by these patients and their subsequent disciplinary discharge, and also frequent readmission due to unsuitable conditions post-discharge, it was found by the Department of

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[1] http://www.qni.org.uk/docs/Homelessness_is_bad_for_your_health.pdf

[2] http://homeless.org.uk/sites/default/files/site-downloads/Value%20of%20the%20homeless%20sector.pdf

[3] http://homeless.org.uk/sites/default/files/attached-downloads/HOSPITAL_ADMISSION_AND_DISCHARGE._REPORTdoc.pdf

Health (DoH) in 2010 that they will often have a series of short admissions, rather than one long admission that adequately resolves the problem. This invariably results in higher costs[4].

Deliotte (2012) found that homeless people are five times more likely to attend A&E as people who are non-homeless, resulting in a total of around 53,000 visits are made annually by people who are homeless, with an associated cost of around £5m per year. Also, one in ten homeless people who do access A&E will do so at least once a month. DoH research in 2010 found that overall the total cost of hospital usage by homeless people is estimated to be £85.6 million[5]. This figure is around four times higher than the cost associated with a similar sized group of non-homeless people. The same DoH (2010) report found that inpatient costs represent the majority of the care provided to this client group, and are approximately eight times higher than for the comparison group, possibly because the homeless have an average length of stay in hospital three times as long as the general population. In total this equates to over £2,100 per person, compared with £525 for the general population (Deloitte, 2012). The Deloitte (2012) study found that regardless of the extra care, the life expectancy for a homeless person is still 30 years below the national average at 47.

Despite the circumstances described above, the DoH (2010) report highlighted that in 2010 only 39 percent of Local Authorities indicated that they had specific policies dictating protocol for the admission and discharge of homeless people; furthermore only 27 percent of those who are classed as homeless received help with housing before being discharged. A report by the Centre for Health Service Economics & Organisation (CHSEO) in 2011 showed that projects and models which have been implemented to improve admission and discharge practice have demonstrated cost benefits in two different ways: firstly the average length of stay will change due to a reduction in 'bed blocking' as homeless people are more likely to be discharged sooner if their housing and next steps are adequately catered for (however some may stay longer if this is deemed necessary)[6]; and secondly if patients are discharged at a clinically appropriate time and to suitable accommodation they are in a position to more ably recover from an illness, and thus there are fewer emergency readmissions to hospital within 28 days.

Three case studies demonstrate these predicted cost savings in action. A report published by the Housing Learning & Improvement Network in 2009 revealed that in West Sussex an interim housing project was piloted for a year, in which homeless patients would be discharged to interim accommodation rather than remaining in hospital beds. At the nine month review it is estimated that the housing model saved 251 hospital bed days in total, saving £63,000 of funding and resources[7]. The cost to the PCT was £10,000, which was mostly reimbursed through rental income; effectively, the service removed the problem of bed blocking at a relatively low cost to the PCT.

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[4] http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/Healthcare_for_single_homeless_people.pdf

[5] http://homeless.org.uk/sites/default/files/attached-downloads/HOSPITAL_ADMISSION_AND_DISCHARGE._REPORTdoc.pdf

[6] *www.chseo.org.uk/downloads/nhsbrief2-homelessdischarge.pdf*

[7] http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Practice_examples/Housing_LIN_case_studies/Case_Study_46.pdf

At UCH in London, London Pathway provides a specialist nurse practitioner to visit and decide future arrangements with all admitted homeless patients. The 2010 report by the DoH showed that of the beneficial effects produced, the most significant was a reduction in the average duration of stay by the patients of 3.2 days (from 12.7 days to 9.5 days). If there are 250 admissions in a typical year, this equates to a potential reduction of 800 bed days annually. The reduction in bed days per patient results in a cost reduction of £1,600 (at £500 per day), and it is estimated that after taking account of costs to the PCT, the project saved a total of £100,000 in hospital resources by reducing bed blocking.

At the Arrowe Park Hospital in the Wirral, a link worker was hired to ensure that those who were homeless were accounted for in policy and supported during discharge. The same DoH study in 2010 found that during the year there was a fall in the number of episodes (26%), admissions (18%) and bed days (26%); there was also an increase in the self-discharge rates. The amount of delayed discharges was also reduced, saving an estimated £45,000 in six months. Furthermore due to increased support and appropriate discharge times, the amount of emergency readmissions within 28 days fell by one third during the year.

The majority of case studies that demonstrate cost savings, including two of the above, involve funding for specialist posts, which the Homeless Link study from 2013 shows improved care for those who are homeless and reduces A&E visits at least by 25-30%. Although the research is limited, the studies available do seem to support the development of discharge procedures and housing support not just to benefit the individual but also to produce financial savings for the public sector.

Section Three: Review of Monitoring Data

> **Key Findings**
>
> - The project is at an early stage which is reflected in the monitoring data
> - The project received 54 referrals over the first 6 months against an annual target of 116
> - Agencies suggest there has been a reduction in bed stays but there is a lack of date to quantify the impact
> - There is a very high level of satisfaction with the service and only four people have been re-admitted (within 28 days)

This section provides an overview of available data based on the project's outcomes as set out in the projects funding application and subsequent evaluation plan (Appendix One – Evaluation Plan).It specifically looks at the project's achievements against targets.

The data needs to be seen in the context of the project life. Although a one year project, late funding has resulted in it only being operational for 6 months when this report was written. Given the multi-agency nature of the work, the initial months were spent promoting the service to staff on the wards to aid referrals and in developing the protocols of working together. It is therefore very early to assess the performance against monitoring data.

The Hospital to Housing Support Service aimed to assist 116 clients over the life time of the project (one year in the first instance up to April 2014). This figure was initially based on data from health agencies in Plymouth and referred to the number of homeless patients identified in a twelve month period.

Since its operational inception in October 2013, the project has received 54 referrals (26 in Q3- October to December 2013, 28 in Q4 - January to March 2014), all of which were contacted by the Hospital to Housing Support Service within 24 hours of the referral being made.

The project target was 116 people assisted in a year and 58 in six months. Given that the project supported all 54 referrals in the first six months, it achieved 93% of the 6 month target.

Looking just at those eligible for support (those from outside Plymouth weren't always eligible unless a connection to the area could be demonstrated) the project achieved 59% of its 6 month target of eligible support. Given that the project is new and in the set up phase, it would be reasonable to expect the number of beneficiaries to increase over time as referrals increase. Overall these figures should therefore be seen as an excellent start to the project.

Table One

Performance Indicators	Target for year	Q3 (Oct-Dec)	Q4 (Jan-Mar)
How many people commenced with the service?	116	18 (eligible)	16 (eligible)
Of the number that commenced with the service how many were homeless	n/a	16	16
% of homeless people successfully supported into accommodation	100%	100%	94%
% people supported to access community health services	90%	67%	94%
How many people were readmitted to hospital within 28 days?		3	1
% of people satisfied with the service they received	90%	100%	100%

In addition, Table One shows that the project has successfully supported the majority of clients into accommodation. From discussions with project workers, it was evident that one individual was not supported into accommodation in Q4 as a result of advice provided by a partner agency. Specifically, the individual was advised to return to their parent's home to await the outcome of a preventative homeless approach.

The project also supported 94% of their clients in Q4, to gain access to community-based health services, which again has exceed their initial target of 90%. Discussions with project staff highlighted that in Q3, the target had not been achieved since five of the clients had existing, strong links with external agencies prior to engaging with project. Similarly, in Q4 94% of clients were supported to access community-based health services, rather than 100%, as a result of one individual already engaging with external agencies for support.

Table One shows that that across Q3 and Q4, four clients have been readmitted to hospital (within 28 days). Given the longer term and multiple complex needs of this client group there is inevitably going to be some level of readmission. There has been a reduction in the numbers re-admitted from three in Q3 to one in Q4. Similarly, there has only been one emergency readmission (within 28 days) noted across Q3 and Q4 (see Appendix One).

> **Case study One**
>
> Beneficiary One's last presentation at Derriford Hospital was in January 2014 following an overdose of prescribed medication. This beneficiary has long term health issues including some mental health difficulties and a history of prescribed medication mismanagement. This beneficiary had previously been admitted to Derriford in excess of 40 occasions. Following referral from the Care Coordination Team at Derriford Hospital, the client was visited within twenty-four hours of the referral being received. His housing issues were explored and he was then supported through the process of accessing appropriate accommodation.
>
> *'…[their] entire wellbeing has improved, [they] have got their life back…and it is quite noticeable…they are now looking after [themselves]'.*

Table One also shows that 100% of those that engaged with the service were satisfied with the service that they received, again exceeding the target of 90%. It is of note that according to project staff, the client's satisfaction with the service also extended to an improved client experience with health staff in addressing issues of homelessness. However, this particular outcome is difficult to measure, and is based on anecdotal evidence collected by project staff.

Monitoring Data: challenges

A key task for project workers, as set out in the projects funding bid was to:

> *'collect data to illustrate the level of need and outcomes, ensuring an accurate recording system is developed to record homeless patients and to provide evidence for future commissioning'.*

To date, project workers have recorded their engagement with clients and the pathways that have been taken to support each individual, as seen in the service utilisation section of this report. In addition, anecdotal evidence from project partners indicates that there may be positive outcomes emerging with regards to the number of patients who are not discharged as early as they could be as a result of their housing issues:

> *'the one thing we have seen is a reduction in those individuals that are delayed transfer in care due to accommodation since project started…its very crude data'.* [adult social care at hospital]

Although the H2H project's focus was predominantly around providing a joined up and holistic service to support those that are homeless or at risk of homelessness on discharge from hospital, it was envisaged that project could result in cost savings to the partner agencies. Specifically, it was hoped that the H2H project would lead to reductions in costly emergency re-admissions and a reduced length of bed stay for clients.

However, discussions with project staff have indicated that collecting data to evidence 'reduced length of bed stay' and 'reduced rate of (emergency) readmissions' attributable to the project has proved challenging. Table Two is an example of the type of data that is provided to project staff for the purpose of monitoring these outputs.

Table Two: Homeless Emergency Department and Inpatient Admissions (Patients With Address Of 'No Fixed Abode') April 2010 - March 2014

	2010/11	2011/12	2012/13	2013/14
ED Attendances	223	255	226	199
Inpatient Admissions	67	73	54	45
Inpatient Discharges	68	71	54	35
Bed Days	278	174	85	125
30 Day Readmissions	7	13	3	5

Source: Plymouth Hospitals NHS Trust

The data in Table Two highlights that 'Homeless Emergency Department and Inpatient Admissions' were reduced by 27 and 9 respectively in 2013/14 compared to the previous year. In addition, inpatient discharges have decreased from 54 in 2012/13 to 35 in 2013/14. However, bed days and 30 day readmissions have increased marginally between 2012/13 and 2013/14.

Discussions with project staff have reiterated the concern that the available data isn't detailed enough to evidence the impact on bed stays and hospital costs, especially in light of the length of time that the project has been operational:

> 'It is difficult to link the impact of this service with any change in bed nights with such a short pilot.'.

Going forward, more detail around this data is required to enable the project to demonstrate potential cost savings associated with the project. In addition, project partners have suggested alternative data sets that could be used to explore the impact of the project including; delayed transfers of care obtained from the Department of Health website, and data around individuals that are discharged with No Fixed Address (NFA).

Section Four: Overall achievements

Key Points

- In the first six months of being operational the project has developed a multi-agency protocol, developed partnership working with the NHS and supported 34 homeless people on leaving hospital

- Referrals have started to come through at an earlier stage and for a wider range of homeless people but are still from just a few wards

- While useful, the draft protocol needs higher level strategic buy-in

Project deliverables

This section provides an overview of available data related to the project's deliverables as set out in the projects funding application, and subsequent evaluation plan. Data has been collected from project staff and stakeholder interviews as well as comments provided by project staff around the projects key performance indicators.
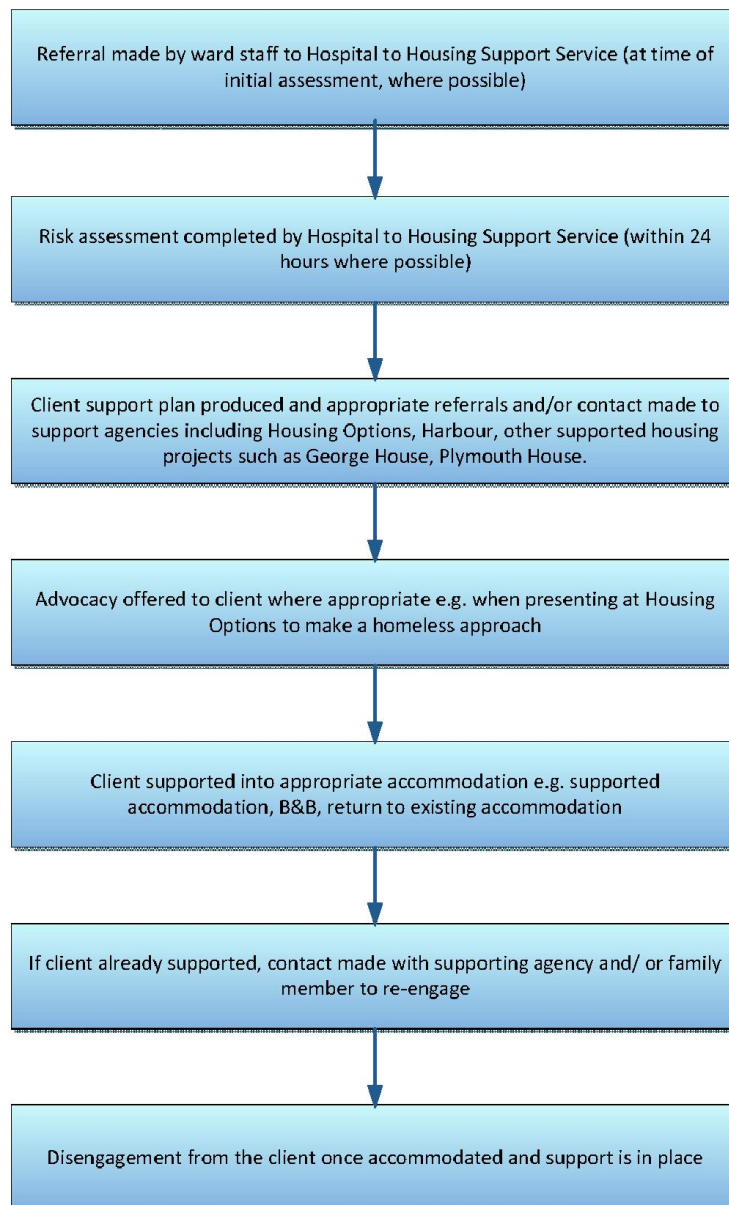
Project Delivery

Figure One (overleaf) illustrates the processes that underpin the success of the Plymouth Hospital to Housing Support Service with regards to accessing and supporting eligible clients. It is adapted from the flowchart developed as part of the draft 'City of Plymouth Hospital Admission and Discharge (Prevention of Homelessness) Protocol (January 2014). This approach has been developed by the project and is now used. Developing this delivery model has been a key achievement for the project.

Figure One

Hospital Homeless admission & discharge Flowchart

Referral made by ward staff to Hospital to Housing Support Service (at time of initial assessment, where possible)

Risk assessment completed by Hospital to Housing Support Service (within 24 hours where possible)

Client support plan produced and appropriate referrals and/or contact made to support agencies including Housing Options, Harbour, other supported housing projects such as George House, Plymouth House.

Advocacy offered to client where appropriate e.g. when presenting at Housing Options to make a homeless approach

Client supported into appropriate accommodation e.g. supported accommodation, B&B, return to existing accommodation

If client already supported, contact made with supporting agency and/ or family member to re-engage

Disengagement from the client once accommodated and support is in place

Referrals

Although referrals to the project have been reasonably successful as outlined in the previous section, the timing of referrals is still proving to be a challenge for the project. Discussions with project workers indicate that having early referrals impacts greatly on the success of their engagement with the client, as well as the final outcome. Earlier referrals give the project workers time to organise accommodation and support services as opposed to referrals on discharge which result in an emergency plan being undertaken. As one project worker highlighted:

> *'The biggest challenge is the referrals themselves – we get them too late, so when the patient is going to be discharged…'*

Comments received from other project staff reaffirmed that some hospital staff are still contacting the service at the point of discharge rather than following admission. Interviews conducted with other project stakeholders also cited the impact that late referrals can have on statutory services:

> *'it* [the project work] *has been reactive but it's not their fault but is due to the wards giving them last minute referrals…the case could have been worked on before presenting to us…*

The project workers also indicated that the immediacy of the interaction with the client (within 24 hours) has positive knock-on effects for other support agencies:

> '*it is working well, we are able to see them within 24 hours… and get referrals to other agencies in 24 hours…it also prevents a discharge to make a homeless approach to Housing Options.*

However, as awareness of the project has increased within the hospital setting and as the project develops, referrals have become more prompt as one of the project workers indicated:

> *'Now that the service is known about, they hang onto the patients, and referrals are coming in quicker, but identification of the patients is still slow….also they are beginning to identify others that are sofa surfing not just the rough sleepers…'.*

Project staff also indicated that referrals are beginning to emerge from external agencies, which is a positive indication that awareness of the project is growing outside of the hospital setting:

> *'…we are getting referrals from external agencies…for example, someone knocked on Plymouth House's door and they phoned us…there is more awareness of the project now'.*

In addition to the issue of timeliness of referrals, project staff also commented that gaining referrals is often *'personality led'* and dependent on those who understand the value of the project.

During the initial set up of the project, a number of forms and leaflets were set up to support referrals including; a referral form, risk assessment forms, support plans, and a monitoring spreadsheet and workbook. Discussions with the project staff highlighted that as the project has progressed, the referral form has become redundant:

'we did have a referral form but it didn't take off, the wards have lots going on and that's where the risk assessment form comes in, so we get the referrals by telephone, and then we get to them in 24 hours. Then we do the risk assessment with the client'.

In order to support the referral agency, project workers produced a folder with forms outlining the processes involved in referring a patient to the service including guidance around eligibility criteria. These folders were subsequently given to wards across Derriford Hospital. Despite this awareness raising, the majority of referrals still come from just a few wards.

The Protocol

The eligibility criteria set out in the Homeless Hospital Discharge Fund 2012/13 guidelines states that one of the outputs for a project such as the Plymouth Hospital to Housing Support Service is a *'discharge protocol developed and in place locally'.* The projects Homeless Hospital Discharge Fund bid document subsequently cited this outcome as a key project deliverable which aimed to;

> *'ensure hospital staff identify patients who are homeless or at risk of homelessness and refer to this service to deliver emergency housing advice and support to access suitable accommodation'.*
> (Homeless Hospital Discharge Fund 2013-14, BCHA)

By January 2014, project staff had successfully drafted the protocol which set out a series of principles and pathways designed to prevent a patient being homeless on discharge. The intention was for the protocol to gain acceptance across key partner agencies including Plymouth Hospitals NHS Trust, Plymouth City Council's Housing Options, Adult Social Care and other project stakeholders such as BCHA and supported housing providers.

The protocol was also designed to ensure that the processes of identifying the target group were clear to agencies providing referrals to the service. It specifically sought to address a gap in the appropriate identification of these individuals as highlighted by a BCHA member of staff:

> **'***Questions around homelessness need to be prompted more, is that your permanent home, is it a family member? and if that is asked at the point of contact, a referral to H2H, who assesses the person and works with them, that saves a lot of resources and will pick up everyone who is homeless or at risk of becoming homeless'.*

Similarly, project staff indicated that the protocol was about ensuring that there was a common understanding of different types of homelessness, and how these can be identified:

'it's about getting under health's skin and them understanding homelessness…there are different strands of homelessness and they need to ask the right questions around, for example, do they have a temporary or permanent address…'.

According to project stakeholders, the draft protocol as it stands, is viewed as a valuable document, however, it is seen as a work in progress which requires a level of strategic input in order for it to be adopted by partner agencies. For one project partner, the expectations around the development and adoption of the protocol were too high:

'we expected too much, a protocol needs buy-in from health, housing and social care from a high level, and it is difficult for a short term project to do this…H2H cannot introduce a protocol like this...it should be implemented at a strategic level and that is a piece of work we need to move forward with…'.

Similarly, discussions with staff at BCHA reiterated the sentiment around a need for greater strategic input to drive the protocol forward:

'the protocol is succinct and easy for services to adopt but requires buy-in from very senior people that see the benefits of the service'.

The protocol has been an achievement for the project in that is now a working document, however, according to key project stakeholders the willingness to drive the protocol forward requires not only strategic input, but a change in practices:
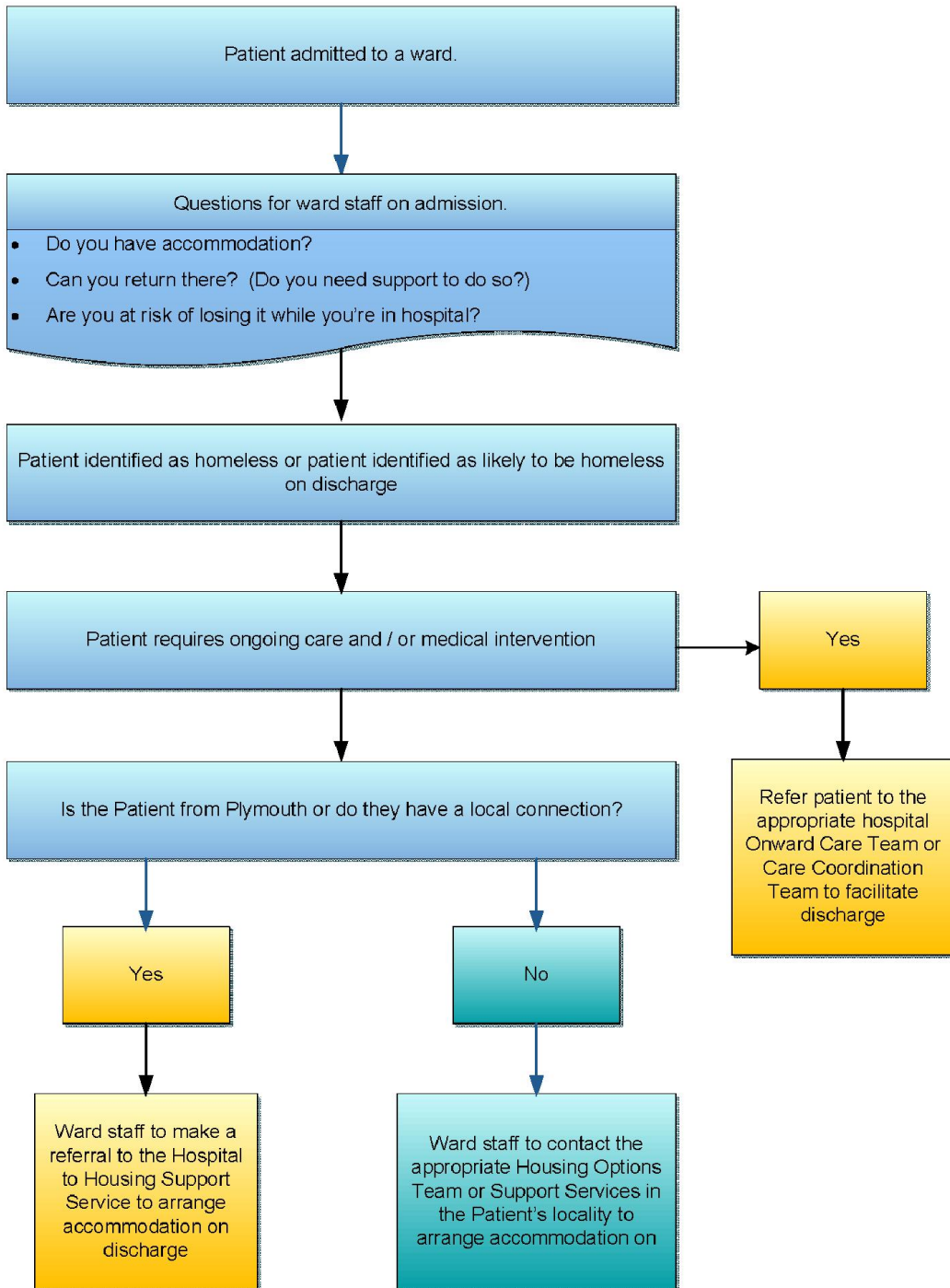
'there is a pressure to develop a partner approach, but how can this be taken forward in a hospital setting where there are different routes for accountability…it is about establishing and embedding new practice'.

Through discussion with the project workers, the research team have produced an amended version of the flowchart which was set within the protocol. It illustrates the steps that are necessary to take in the effective identification of those that are homeless or at risk of homelessness in a hospital setting (Figure Two).

Figure two

bcha
find a way forward bcha.org.uk

Hospital Homeless admission & discharge Flowchart

Patient admitted to a ward.

Questions for ward staff on admission.

- Do you have accommodation?
- Can you return there? (Do you need support to do so?)
- Are you at risk of losing it while you're in hospital?

Patient identified as homeless or patient identified as likely to be homeless on discharge

Patient requires ongoing care and / or medical intervention → Yes

Refer patient to the appropriate hospital Onward Care Team or Care Coordination Team to facilitate discharge

Is the Patient from Plymouth or do they have a local connection?

Yes

No

Ward staff to make a referral to the Hospital to Housing Support Service to arrange accommodation on discharge

Ward staff to contact the appropriate Housing Options Team or Support Services in the Patient's locality to arrange accommodation on

Section Five: Impact on agencies and beneficiaries

Key Findings

- Joint working and problem solving is viewed as a success

- The project has reduced the pressure on the services of other agencies

- Not being located at the hospital has created logistical issues for the project and weekend coverage needs to be considered

- The holistic approach of the project in supporting with wider health issues as well as housing is seen as a key factor in the projects impact

Multi-agency relationships

One of the key success factors for the Plymouth Hospital to Housing Support Service funding bid is the ability to engage and interface with a range of partner agencies to enable a smooth process for the client group. Interviews with project staff and stakeholders explore how the project is currently operating alongside external agencies, as well as the successes and challenges associated with this interaction.

A number of key areas for consideration have emerged from the interviews including:

- Joint working to problem solving and resolving barriers to accommodation is viewed as a key success of the project especially the links with supported housing providers and the confidence in project staff to make good assessments of housing and support needs;

- Approaches to client group are varied across agencies, which may result in conflicting cultural issues between the project and the partner agencies;

- There is more work to be done around engaging with the referral agency regarding awareness of what the project does and the importance of early identification of the client group;

- The inability to co-locate staff has not supported the effective engagement with the referring agencies and has presented project staff with logistical problems;

- There need to be increased communication around cases before crisis cases occur; and,

- There is a need to develop training for staff at the hospital to raise awareness of the project's offer.

Although joint working was built into the funding bid, an interview with a key project partner believed that more work could have been done on this prior to the project becoming operational, and going forward to address 'partnership blocks':

> '…references to key stakeholders, could this have been nailed harder as part of the submission phase…I see some stakeholder commitments set out but not realised,

for example around health, could there be better leadership, and with social care around strategically selling the relevance of the project'.

However as with many bids for project funding, they are often written quickly without time to plan out the operational issues in any great detail. The research did find that the service has alleviated the pressure on some external agencies. For example, for one project partner, the value of having the project workers engaging with this client group has enabled their resources to be more effectively used:

'from our perspective we have utilised the team as a resource and that has released some social worker capacity that would historically been used to interface with housing rather than doing community care'.[adult social care]

Similarly, another partner agency highlighted that the project takes pressure off of their staff with regard to addressing the practicalities of supporting the client group:

'we know that it is time consuming to help someone and arrange transports to Plymouth's housing and it's a one word referral, it frees up time for us'.

In addition, the ability of project staff to obtain vital information from clients has meant that other agencies can address their needs more effectively, as one project partner commented:

'people receive more support, it is good for vulnerable groups and it will provide more information around their needs so they are able to pass that information on to us, so for the people that we do have a duty to, we can work with them more effectively'.

There was a slight difference in the understanding of the project's offer across agencies. This is important for the evaluation since expectations of the project may not appear to be fully met if agencies are uncertain of what the project's intentions are.

One of the projects key project partners saw the project as having two main strands; firstly supporting a group of individuals with multiple complex needs and secondly raising awareness of the issue of homelessness within hospital wards.

'it was about breaking the cycle by establishing an opportunity to plan a pathway to sustainable and supported living at the point of entry, and planning this whilst they are in hospital'.

Another interviewee took a more direct approach to the project's objectives highlighting that the project was about '*getting patients home safely and preventing them from coming in with homeless and social issues'.*

In the main, interviewees were clear about the projects rationale and were able to identify its key objectives. However one interviewee wanted to see the support move to provide more direct housing advice and less of an advocacy and capacity building role.

'…the discharged have been facilitated to make homeless approaches, I would like to see housing advice and work done on the wards, an outreach housing advice service…we have an advocacy service that brings people to Housing Options….but prevention is what we need to focus on'

The issue of managing expectations for a project with a limited timeframe was also highlighted by another key project partner:

'The reality check is that it is not going to prevent the numbers of clients presenting, it will enable them to drop down but this will happen over years, not months...it will need two or three years to bed in, it's still very early on in the project'.

In addition, this stakeholder indicated that expectations of the project in a short time frame were idealistic to some extent:

'…the project enables people at risk of not making a presentation at Housing Options less likely, it does not alleviate service pressure, this is where expectations are unrealistic, but this may happen over a longer period of time'.

Strategic context

As a result of short term funding, the project's future is to some extent uncertain. It is in this context that the evaluation explored how embedded the project felt at a more strategic level. Specifically, the project is set against a backdrop of wider strategic priorities occurring in the provision of adult social care and health in Plymouth. As such, it would be prudent to examine the projects fit with these priorities which will inevitably impact on its future sustainability.

The Homeless Hospital Discharge Fund 2013/14 eligibility criteria specified that funders would expect *'applications to be able to demonstrate that local commissioners are engaged in the work from the outset'.* Building on this, the project's funding bid subsequently indicated that the sustainability strategy for the project was based on joint commissioning post April 2014. Furthermore, letters supporting this bid were received from the Northern, Eastern and Western Devon Clinical Commissioning Group and from the People Directorate, joint commissioning and adult social care within Plymouth City Council.

Interviews with a key project partner indicated that on a practical level, the project is contributing to some strategic priorities in Plymouth, namely the prevention of homelessness agenda, and the better integration of health and adult social care resources:

> *'It has contributed to supporting complex and vulnerable people in accessing a pathway for them to access support and prevent presentation…this is in line with the strategic direction of what we are trying to achieve'.*

According to the same project partner, the approach to this is, as yet, uncertain, and may take the guise of specific roles around homelessness and housing with a care coordination team, rather than a separate team. The project partner went onto state:

> *'it's about embedding and aligning the approach to the changes happening, and which model to take forward'.*

With regards to the timings associated with these changes, both project workers and partners are in agreement that it is likely to take many months and potentially years for strategic plans to materialize and be embedded in the current health and adult social care system. For one project partner, projects such as Plymouth Hospital to Housing Support Service are likely to play a role in the process, however there still exists partnership blocks:

> *'We are as a local authority looking at points of join up, its 18 months or 2 years down the line. The driver is about integration and how we are joining services up, I see the third sector forming part of that...but it rubs up against the medical model, so the links in the process are missing...'*

For another project partner, the view was that the project has the potential to *'knit'* the various agencies together in order to provide a mutual understanding of the support available around housing for the client group.

According to both project staff and stakeholders, the future of the project is highly dependent on being jointly commissioned, working alongside key agencies within the health authority, housing support agencies, and adult social care.

With regard to highlighting the value of the project for commissioning purposes, one BCHA member of staff stated:

> *'it would be great to be part of joint commissioning as a pilot for bringing the benefits of agencies working together, it's a great caveat to show the benefits of partnership working'.*

Based on interviews with project staff and partners, future considerations for the project with regard to joint commissioning include:

- A higher level understanding and adoption of the 'City of Plymouth Hospital Admission and Discharge (Prevention of Homelessness) Protocol (January 2014);

- Embed the project and its ethos into the wider joint commissioning agenda;

Impact on agencies

The interviews highlight that the service has alleviated the pressure on some external agencies. For example, for one project partner, the value of having the project workers engaging with this client group has enabled their resources to be more effectively used:

'*from our perspective we have utilised the team as a resource and that has released some social worker capacity that would historically been used to interface with housing rather than doing community care*'.

Similarly, another partner agency highlighted that the project takes pressure off of their staff with regard to addressing the practicalities of supporting the client group:

'*we know that it is time consuming to help someone and arrange transport to Plymouth's housing… and it's a one word referral, it frees up time for us*'.

In addition, the ability of project staff to obtain vital information from clients has meant that other agencies can address their needs more effectively, as one project partner commented:

'*people receive more support, it is good for vulnerable groups and it will provide more information around their needs so they are able to pass that information on to us, so for the people that we do have a duty to, we can work with them more effectively*'.

Project staff and partners have alluded to the challenges associated with the different approaches taken by agencies when engaging with the client group. For example, for one project partner, the issue is that statutory agencies are experiencing a number of pressures and are working under 'tight and prescriptive approaches'. In addition, discussions with other project staff and partners highlighted that cultural differences between partner agencies, such as those that take a more medical approach, can make joint working difficult.

Impact on Beneficiaries

According to project staff, the value of this project for their clients is centred on minimising the stress that a client might experience whilst in a hospital setting as a result of housing issues, as well as supporting them to access housing and longer term support. One project worker specifically highlighted that '*…they are grateful that we are taking the time to support them. They are so anxious about being homeless…so there is a reduction in their anxiety*'.

In addition, project staff indicated that their support extends beyond support around accommodation, but also addresses some of the more complex factors that may be contributing to an individual's readmission to hospital. To this end project staff may support patients by re-engaging them with their GP's, mental health or drug and alcohol services as one BCHA staff member indicated:

> '*Success for the client is appropriate accommodation and an ongoing support plan…in the long term it is for them to go into their own housing, in the short term we provide the support to prevent re-admission so making sure they are taking their medication…*'

Project partner interviews also support these observations, especially with regard to the holistic support provided by the project workers and the impact that this has on this client group. For one project partner this related to spending time with the individual and providing wrap around care based on an assessment of their needs:

> '*if they didn't have the intervention, they would present at the civic…the project brings spending time with the individual and looks at the person's priorities and trajectory and tailors that around the individual*'

In addition, project partners perceived there to be great value in the project workers' ability to 'hand hold' an individual, especially when they are at their most vulnerable.

Case Study Two

Beneficiary Two was admitted to Derriford with reduced renal function and a range of medical conditions including substance misuse. During his stay he lost his job and accommodation and was referred to H2H. Following a risk assessment, it was recommended that he moved into supported accommodation as it would enable the workers to keep track of his health issues. He was supported to attend interviews with housing providers and to re-engage with his family. Being in supported accommodation as opposed to a bed and breakfast is seen as being a factor in minimising re-admission to hospital.

The project was set up to engage with clients during a particularly vulnerable point in their lives, and support them on their pathway to a more stable, accommodation and health status. For example, one project worker indicated the value of supporting a client at the start of their journey through a housing pathway:

'*They have support right from the beginning, so if they present at the council [housing options] they could be sat for two or three hours, I would imagine people may get fed up and leave, so we having a support worker there [H2H] keeps them there and we advocate on their behalf to the housing team*'.

Interviews with project partners reiterated the value of a more 'hands-on' approach to engaging with this particular client group:

'*It's an active piece of work, it's not just taking people down to the Civic but it's about helping people make the steps- its advocacy and support…a practical support function and liaison*'..

In addition, project staff highlighted that they would signpost those patients who may not be eligible for the service:

'*we offer signposting to those who are not eligible for the service, so we would, [for example] contact the local authority and make them aware of the individual [client]. We are known as the homeless support service project so we cannot walk away from those that are not*'

Challenges and areas for development

Going forward, there are a number of strands of work that will support more effective partnership working. According to project staff and partners, one of the key areas to consider is around knowledge sharing. For one project partner this was about the project staff sharing their knowledge with ward staff about the different agencies and community

services that they refer to. Alongside this, another project partner felt that it would be useful to have some specific training:

> *'it would be good to spend a day with them to provide an insight into what they could do, they gave us a file and explained how to refer to them, a presentation might be good, there are others on ward that would be interested, so a ward presentation, I organise training sessions, the project could be part of that'.*

Other suggestions around improving partnership working included; the provision of a leaflet that could be given to the client group explaining that the service is free of charge, and, closer partnership working with statutory housing services around the provision of housing advice by the project staff.

One area for development is around having provision in place if the discharge happens out of hours. Currently, the project staff work from Monday to Friday, however, it is highly likely that the target group will present in hospital during the weekend. Discussions with project workers have indicated that as awareness of the project has increased, they assume that ward staff now 'hang onto patients over the weekend' if they present out of hours. However, this approach is unlikely to be sustainable over the long term.

As far as project staff are concerned, the absence of desk space at the hospital has also proved to be challenging especially with regard to receiving calls, and not being able to be systematic in their approach to their work. Moreover, project staff felt that this was not a sustainable situation going forward. One project partner particularly concurred with this assessment and felt that had an impact on the project workers and partner agencies ability to share knowledge effectively:

> *'we are missing a trick around re-location, some located space, hot desking would be helpful for project staff, the we could share knowledge and experiences, and that is powerful, that is what the team want, but it's down to logistic*s..'[housing options]

Section Six: Beneficiary case studies

Key issues

- The beneficiaries of this project often have multiple health issues and need support from a range of agencies

- Access to supported housing can help maintain improvements in health and reduce the chances of re-admission

- Referrals close to the time of discharge can limit housing options resulting in having to make a homeless approach

Clients' case studies

This section outlines the experiences of four Plymouth Hospital to Housing Support Service clients. Specifically, it presents details around motives for engaging with the service, pathways through the service, as well as the impact that the service has had on the individual's stability, both in terms of their health and housing needs. The development of these four case studies is based on information taken from a number of sources including risk assessment forms, support/ action plans, client running logs, and interviews with their Advocacy and Support Project Worker (H2H).

Beneficiary One

Beneficiary One's last presentation at Derriford Hospital was in January 2014 following an overdose of prescribed medication. This beneficiary has long term health issues including some mental health difficulties and a history of prescribed medication mismanagement. In addition, this beneficiary has previously been admitted in excess of 40 occasions.

A referral for this Beneficiary One was received by the H2H project in early January from the Care Coordination Team at Derriford Hospital and the client was visited within twenty-four hours of the referral being received. Although this beneficiary did not present as homeless prior to admittance to hospital, H2H's Advocacy and Support Workers identified, via their risk assessment with the client, that his current accommodation was sub-standard and contributing to his deteriorating health. As highlighted by his H2H worker:

> '...not going back to the old accommodation was the biggest issue…preferred to be in hospital…'

In addition, to compound his housing issues and subsequent return to the property, the current accommodation had been taken over by acquaintances.

As a result of this initial assessment, Beneficiary One was supported over a number of weeks prior to being finally discharged from hospital. The actions taken by the H2H project's advocacy and support workers to assist this client included; contact with the Private Rental Team at Plymouth City Council to assess the condition of the existing accommodation; support given to Beneficiary One to terminate the existing tenancy; assistance given to make a homeless application at Housing Options, referrals made on client's behalf to supported accommodation.

The H2H approach also enabled the Advocacy and Support Workers to add value to the support given to Beneficiary One by assisting them to access health support services, and applying for move-one accommodation.

Considering this beneficiary's medical history, which was exacerbated by inadequate housing, it was felt that without the intervention from the H2H project, this client would have been likely to return to hospital. The impact of the project on this beneficiary was highlighted by their project worker:

> '…[their] entire wellbeing has improved, [they] have got their life back…and it is quite noticeable…they are now looking after [themselves]'.

This beneficiary last received support from H2H staff in February 2014.

Beneficiary Two

Beneficiary Two was admitted to Derriford Hospital in the second week of January 2014 with reduced renal function. This client has historical medial conditions which may have been compounded by substance misuse. In addition, Beneficiary Two did not present as homeless when admitted to hospital, however, throughout his stay in hospital, their job and accommodation was lost. A referral to the H2H service was subsequently made on the back of this information.

On receiving the referral, the H2H Advocacy and Support Worker conducted a risk assessment within 24 hours of receiving the referral with the client identifying both their accommodation issues as well as longer term support needs. One of the key areas identified by staff was that Beneficiary Two would benefit from supported accommodation, which would enable them to keep track of their health issues.

Beneficiary Two was provided with a range of support from the H2H Advocacy and Support Workers including making referrals to supported housing providers, attending interviews at housing providers, and supporting this beneficiary with engaging with family members. From the H2H worker's perspective, the ability to place this individual prior to discharge was particularly significant in minimising stress:

> '…it helped maintain [x's] general wellbeing, on the day of discharge [Beneficiary Two] went straight into supported accommodation…they didn't have to worry about having to sell their case at the Civic…'

Beneficiary Two has now been assisted into supported accommodation and has been provided with a Support Worker. Although there are continuing challenges around this individual's substance misuse, the impact of being in supported accommodation rather than being placed in a bed and breakfast, has been particularly positive, especially with regards to minimising a re-admission to hospital.

Beneficiary Two disengaged from the H2H service in Mid-February.

Beneficiary Three

Beneficiary Three was last admitted to Derriford Hospital towards the end of February 2014. This client presented with multiple complex health needs including a recent history of substance misuse for which they have a Harbour Worker for support. Referral to the H2H project was made one day prior to the planned date of discharge.

A risk assessment was conducted by the H2H worker to identify Beneficiary Three's care and future needs. As a result of the referral being made close to the time of discharge, the options available for this client were limited, and as a result of this, H2H staff supported the client in making a homeless approach at Housing Options.

Additional forms of support offered to Beneficiary Three by the H2H service included; engaging with their Harbour Worker to ensure re-engagement with the Harbour service; support with contacting family members; and advocating on their behalf. The H2H project worker specifically provided Beneficiary Three with support by interfacing with hospital staff to identify concerns around the client being discharged with excessive amounts of medication. In addition, H2H staff advocated for Beneficiary Three with Housing Options staff to ensure accommodation was identified.

Beneficiary Three was finally accommodated in a bed and breakfast, although H2H staff indicated that they felt it would be more appropriate to accommodate this client in supported housing.

Although Beneficiary Three continues to present as chaotic, it is evident from discussions with their H2H worker that engaging with the service has provided a safety net for this particular individual. Specifically, H2H staff prevented their client from being discharged to potentially make an unsuccessful homeless approach due to their vulnerable state. From the perspective of the H2H worker who supported this beneficiary, the assistance provided has enabled this individual to re-engage with crucial, longer term community services:

> *'it was a short intervention but it needed lots of support, helping to get to the doctor, engaging with the Harbour worker and even when she was discharged, it was about helping get [X's] methadone prescription'.*

In addition, advocating on this individual's behalf was felt to add value to this case with regards to ensuring agencies was linked in with the individual, albeit in the short term.

Beneficiary Three was discharged from the H2H service in early March and is being supported by a Harbour worker, other health professionals, and Housing Options.

Beneficiary Four

Beneficiary Four last presented at Derriford Hospital in February 2014 with long term health issues including substance misuse. This client is an unusual case in that they had previously been in a nursing home, having then transferred to a care home where they were served with an eviction notice which expired during their last period in hospital. This has resulted in Beneficiary Four presenting to H2H staff as homeless.

Once a risk assessment had been completed, the H2H Advocacy and Support worker provided Beneficiary Four with advocacy support around her housing needs engaging with

Housing Options to assess the most appropriate accommodation for the client. H2H's involvement in this process enabled a number of key issues to be highlighted around Beneficiary Four's inability to live independently as well as the need for support from Adult Social Care. The impact of this involvement has been particularly positive as the client's H2H worker indicated:

> *'we have established that [Beneficiary Four] is unable to be accommodated independently and is in need of social care support…if we had not been involved, [x] would have been found on a park bench…we have insisted [X] be in adult social care at least'.*

Although Beneficiary Four has been readmitted to hospital as a result of longer term health issues, the advocacy support provided by the H2H service prevented the client from being inappropriately discharged.

The H2H staff will continue to engage with Beneficiary Four, however at this time immediate assistance for this client would be met by Adult Social Care workers.

Section Seven: Conclusions and Recommendations

Setting up and delivering a service within a multi-agency setting and relying on referrals from another organisation can be challenging for a short term project particularly when working with the different priorities and more medical model of the NHS. The project has made good progress and is starting to show clear signs of impact on beneficiaries and agencies and the case studies suggest that frequent re-admission is stabilising.

At the time of this evaluation the project has made good progress in achieving its objectives. The project has set up a draft protocol, promoted the service to hospital wards and partners and delivered direct support for beneficiaries. The service has supported people with a range of complex issues into appropriate housing. Ensuring the person is in the most appropriate housing, often not Bed and Breakfast, has meant that they can be supported to take prescribed medication following discharge, that they prioritise their health needs and continue to access support from other agencies such as Harbour Drug and Alcohol Services. Case files suggest that the issue of frequent re-admission to hospital for some people has been stabilised. The case studies highlight the benefit of the service to individuals.

Early indications are that the service is starting to alleviate pressure on other agencies such as Housing Options, Adult Social Care and Derriford Hospital. This support takes the form of direct support in organising transport and accommodation, ensuring other agencies such as Housing have the information they need to address their needs and advocacy to get the support they need and prevent more expensive and time consuming crisis intervention.

The data available isn't detailed enough to quantify the savings in bed stays and re-admissions although similar projects in the country have demonstrated financial savings using similar project models. This requires a baseline before the project starts and more detailed tracking of individuals than happen sat present. However, interviews with partner organisations and the details in the beneficiary case studies would suggest that there has been a reduction in bed stays for individual cases and less frequent re-admissions which would result in a financial saving to the NHS.

Going forward there are a number of areas for the project and partners to focus on including:

- Seek funding to continue the service past the end of the years' funding;

- Build on the good relationships with the hospital and seek further buy in to the project. In particular secure office accommodation for the workers. Being co-located has been one of the strengths of projects elsewhere in the country and has undoubtable made the project more challenging to run. Having a desk, landline and space to meet would make the project more efficient;

- Continue to develop ways to evidence the impact of the project where possible. This could include a short feedback questionnaire. Ideally follow up beneficiaries after six months to ascertain longer term impact;

- Continue to push forward on developing full strategic buy in with the protocol. This needs to be picked up by statutory agencies and developed and implemented;

- Promote the success of the project to date to partners and to wards to help the flow of referrals

- Run short training sessions for ward staff around homeless identification and the need for earlier identification, again using some of the project examples to engage staff

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