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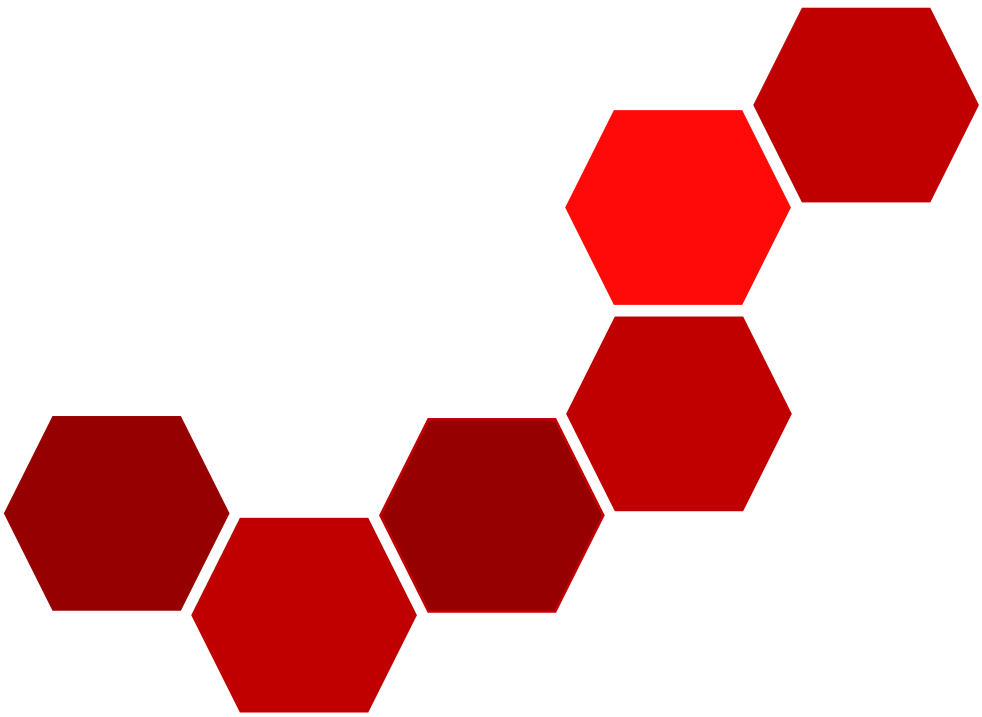
Transforming out-of-hospital care for people who are homeless

Support Tool & Briefing Notes

complementing the High Impact Change Model for transfers between hospital and home



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Download the High Impact Change Model (HICM) that this Support Tool complements at:

www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high

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Disclaimer

For Jo, Kathryn and Darren

'Implementing discharge to assess (D2A) models where going home is the default pathway, ***with alternative pathways for people who cannot go straight home****, is more than good practice, it is the right thing to do'.*

NHS England and Improvement et al. (2016 p2)

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Why homeless hospital discharge (HHD) needs to change

Support for people leaving hospital (out-of-hospital care) has been designed mainly with older people in mind, however our research shows that patients who are homelessness are at high risk of early ageing and premature death**. 1 in 3 deaths of people in our hospital discharge cohort were due to common conditions such as heart disease that could have been prevented with timely health care**. There is a strong imperative to address this not just by better preventive working, but by ensuring that out-of-hospital care is accessible to all adults who could benefit, including patients who are homeless.

Where there is limited access to out-of-hospital care, the default pathway is to 'signpost' homeless patients to the local housing authority, often without arrangements in place for meeting wider care and support needs. Unplanned discharge leads to poor patient experience and impacts negatively on hospital metrics: **Homeless inpatients have five times the rate of emergency readmission and A&E visits after discharge from hospital compared to deprived housed patients with a similar medical profile**.

Under the Care Act 2014, unplanned discharge can trigger a safeguarding concern linked to neglect and acts of omission (failure to provide access to appropriate health, care and support). Multi-agency adult safeguarding has led to increased scrutiny of poor hospital discharge practices by NHS Trusts under the jurisdiction of Safeguarding Adult Reviews (SARs).

The evidence about what works in securing safe, timely transfers of care between hospital and home has been synthesised by the Local Government Association (LGA) and partners in the **High Impact Change Model** (HICM). DHSC, MHCLG and NHSE require local Health and Wellbeing Boards to implement the HICM as part of their plans for Better Care Funding (BCF). This involves pooling health and social care budgets to deliver metrics such as reduced delayed transfers of care, A&E attendances and non-elective readmissions. **Work to address homelessness at the point of hospital discharge must be linked to implementation of the HICM to be sustainable in the longer term.**

How to transform homeless hospital discharge

1. **Strengthen existing 'HHD Protocols'** to ask housing authorities work to similar timescales as adult social care e.g. complete housing assessments within 72 hours to facilitate early discharge planning and improved monitoring of system flow (including ID of housing related 'pinch points').
2. **Integrate hospital-based specialist homeless health care teams** (sometimes called Pathway teams) alongside existing multi-disciplinary discharge coordination services. Out-of-hospital care must be integrated so people can move seamlessly between different services, depending on changing needs.
3. **Provide alternative 'housing-led' (step-down) pathways out-of-hospital** for people who need time for recovery and reablement but who cannot go home (they are homeless) but whose needs would be over-catered for in a care home.
4. **Use trusted assessment and boundary spanning** to bring the specialist clinical expertise of the homeless health care team into 'housing-led' intermediate care.

Evidence from our research that this is effective and cost-effective:

- ✓ Out-of-hospital care tailored to the needs of patients who are homeless is **more effective and cost-effective than standard care**.
- ✓ NHS Trusts with **specialist homeless discharge schemes had fewer Delayed Transfers of Care** compared to those that relied on standard care.
- ✓ Hospital based homeless healthcare teams **increased access to elective follow-up care**.
- ✓ HHD schemes with a 'step-down' service had a reduction in subsequent hospital use, with **18% fewer A&E visits** compared to HHD schemes without 'step-down'.

About this research: This Support Tool draws on the findings of our evaluation of the Homeless Hospital Discharge Fund (HHDF) to show how the HICM can be sensitised to meet the needs of patients who are homeless, and this can contribute to meeting Better Care Fund metrics. The HHDF funded 52 schemes to develop specialist discharge and 'step-down' services to tackle issues such as discharge to the street. The evaluation, led by King's College London, used a range of qualitative and quantitative methods to explore effectiveness and cost-effectiveness, exploring outcomes for over 3,882 people who used a HHD scheme.

High Impact Change Model (HICM): CHECKLIST OF SENSITIVITIES FOR HOMELESSNESS

Change 1: Early Discharge Planning

In elective care, planning for discharge should begin before admission. In emergency / unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

SENSITIVITIES FOR HOMELESSNESS:

[1:1] It is routine practice for **all staff to show 'concerned curiosity'** about housing and homelessness on admission, recognising that some patients may not wish to disclose that they are homeless due to stigma.

[1:2] Homeless Health Care Teams (or Housing Workers) undertake **specialist ward rounds** to identify patients who are homeless and start discharge planning at the earliest opportunity.

[1:3] Homeless Health Care Teams (or Housing Workers) support patients who are homeless to **have their voices heard** in discharge planning.

[1:4] There is **good legal literacy** around Annex G of the Care Act, 2014 and the Homeless Reduction Act, 2017. It is recognised that many patients who are homeless will have both housing needs and needs for care and support, including housing related support. This will trigger the issuing of both 'Assessment' and 'Duty to Refer' Notices to Adult Social Care and the local housing authority respectively.

[1:5] 'Baton-passing' and 'signposting' are not used to free up hospital beds. All staff are aware they have role to play in securing **safe, timely well-planned transfers of care**.

Change 2: Monitoring and Responding to System Flow

Develop systems across health and social care to provide real-time information about flow. All partners should work together to match capacity and demand by responding to emerging system needs, making effective strategic decisions, and planning services around the individual. Data about flow should also be used to identify and respond to system blockages.

SENSITIVITIES FOR HOMELESSNESS:

[2:1] There is a locally agreed '**Homeless Hospital Discharge Protocol**.' The protocol specifies the timescale for the local housing authority to respond once a 'Duty to Refer' notice has been issued by the hospital about a patient who may be homeless or at risk of homelessness (e.g. within 72 hours).

[2:2] Delays due to housing and waiting for housing assessments are properly recorded in monthly **Delayed Transfer of Care Situation Reports**.

[2:3] Partners use a **shared understanding of system flow** to coordinate service delivery (e.g. hospitals do not 'signpost' homeless patients to housing unannounced).

[2:4] **Local system partners work together** to address any housing related 'pinch points' and 'bottle necks' – ensuring housing schemes are able to match capacity and demand.

[2:5] **Flow across the system** is smooth, timely, safe and effective. Safeguarding referrals are raised where this does not happen.

Change 3: Multi-disciplinary Working

Multi-disciplinary/multi-agency teams (MDTs) work together to coordinate discharge around the person. Have a member of your local housing team as a real or virtual member of your discharge planning team.

SENSITIVITIES FOR HOMELESSNESS:

In hospitals that see 200+ homeless patients per year, ward staff will have access to a ***specialist*** **multi-disciplinary homeless health care team** offering:

PATIENT IN-REACH (CLINICAL ADVOCACY)

[3:1] To **reduce stigma and promote dignity** on the ward, e.g. provide patients who are homeless with toiletries and clean clothes.

[3:2] To **prevent early self-discharge,** e.g. advising on substitute prescribing for patients with substance misuse issues.

[3:3] To **improve access to elective (planned follow-up) health care**. This is especially important because research suggests 1 in 3 deaths of homeless patients are due to common conditions such as heart disease and cancer that are amenable to timely healthcare.

SPECIALIST DISCHARGE COORDINATION

[3:4] To provide patients who are homeless with a **named point of contact providing expert advice** on housing legislation and options and homelessness service provision and/or

[3:5] To **facilitate 'Discharge to Assess'** (D2A) or the coordination of a joined-up discharge plan – across all relevant agencies, e.g. adult social care, drug and alcohol services, mental health.

Change 4: Home First

The aim of Home First is for agencies to work together to discharge people from hospital as soon as they are medically optimised and it is safe to do so, recognising that hospital is not a suitable environment to carry out an assessment of someone's long term need. Discharge to Assess (D2A) or providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital.

SENSITIVITIES FOR HOMELESSNESS:

[4:1] Patients who are homeless have '**breathing space'** before making decisions about life changes, including new accommodation and support. There are *specialist* (housing-led) 'step-down' beds and units of accommodation available in the community where people who are homeless can stay while undergoing a full assessment of their health, housing and social care and support needs.

[4:2] Arrangements are in place for **'trusted assessment'**. Patients only have to tell their story once as homeless health care teams have direct referral rights into *specialist* 'step-down' intermediate care.

[4:3] There is enhanced health care (*specialist* 'clinical in-reach') to support **genuinely integrated care planning** in 'housing led' step-down. The wider out-of-hospital care system is accessible to people who are homeless where there are more complex health needs.

[4:4] Step-down support continues until longer-term community services are in place and working well. There is someone in post who can **manage the transfer from 'end to end'** ensuring appropriate follow-up and multi-agency review.

[4:5] If support extends beyond 12 weeks local system partners take **action to address 'bottle necks' and 'pinch points'**.

OTHER HICM CHANGES:

Change 5: Flexible Working Patterns – Services are available 24/7.

Change 6: Trusted Assessment – Using trusted assessment to carry out holistic strengths-based assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe timely way – ensuring for example, that homeless health care teams have direct referral rights into intermediate care.

Change 7: Engagement and Choice – Having a robust choice protocol, underpinned by a fair and transparent escalation process. This is mainly for use in the acute sector where older people and their families are exercising choice about a care home placement. However, it can be useful in specialist intermediate care to have a 'choice protocol' to address occasions where rehabilitative (physical) goals are met but the patient is waiting for a property or post code to become available through choice-based lettings, which can cause long lengths of stay.

Change 8: Improved discharge to care homes – Ensure long-term care services are easily accessible to people under 55 years of age, e.g. where chronic homelessness has led to early ageing/complex health and care needs.

Change 9: Housing – Effective referral processes and alternative pathways for people who cannot go straight home.

Briefing Notes

1: Introduction

In this briefing paper we draw on research findings to outline how commissioners and providers can develop **out-of-hospital** care that will deliver consistently, safe timely transfers of care for adults who are homeless. We draw on the findings of a National Institute for Health Research (NIHR) funded evaluation of the *'Homeless Hospital Discharge Fund'* (HHDF) (Department of Health, 2013). The HHDF provided £10 million funding to the voluntary and community sector to work in partnership with the NHS and local authorities to address problems such as 'discharge to the street' (when a homeless person is discharged in the knowledge that they have nowhere to live). We provide evidence on the effectiveness and cost-effectiveness of different models and configurations of specialist services piloted through the HHDF, and a 'road map' or checklist of the complex set of factors that decision-makers should consider in order to make services as inclusive as possible. The checklist can also be used to highlight existing areas of weaker provision and as a tool to compliment the *'High Impact Change Model for Improving Transfers of Care Between Hospital and Home'* (HICM) (LGA, 2019).

2: Better Care Integration

During the research, we gathered a large volume of evidence from our own evaluation and other local evaluations that demonstrated the effectiveness and cost-effectiveness of specialist homeless hospital discharge (HHD) schemes. We were able to demonstrate, for example, that HHD schemes that offered a period of intermediate or step-down (follow-on) care after a period of hospitalisation were associated with a reduction in subsequent hospital use, with an 18% reduction in A&E visits compared to HHD schemes without a step-down service. However, despite these positive results, once the initial pilot funding ended many of the HHD schemes were reduced in scale or not sustained at all.[1] One reason for this may have been that the schemes were often developed in isolation from other work to improve 'patient flow.'

- ✓ **The most important learning from our research is that any work to address homelessness at the point of discharge must be integrated as part of national and local strategic frameworks for developing pathways out-of-hospital.**

Developing pathways out-of-hospital (or Home First) is a key objective of the government's programme for *'Integration and Better Care Funding'* (BCF) (DHSC and MHCLG, 2019). The BCF places clear expectations on Health and Wellbeing Boards to oversee health and social care: (i) pooling budgets, (ii) integrating services to ensure more people can leave hospital when they are ready, and (iii) **following guidelines laid down by the HICM**. The latest plans for the BCF support the wider integration agenda and in particular highlight the potential for the commissioning of housing related support:

> ***'Areas have flexibility in how the BCF is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance*** **[across]…** ***the following four BCF 2019-20 metrics: Delayed Transfers of Care; Non-elective***

[1] 17 out of 41 projects reported receiving extra funding to continue their project beyond the life of the DHSC grant. Out of these only one had received funding which exceeded the DHSC grant level, seven received comparable funding to the level they had received and seven had received less (Homeless Link, 2015).

> ***admissions (General and Acute); Admissions to residential and nursing care homes; and Effectiveness of reablement'*** **(DHSC and MCHLG, 2019 p7).**

The HICM aims to support local system partners to minimise unnecessary hospital stays and to encourage them to consider new interventions (see Box 1 below). The model identifies nine system changes:

- Early discharge planning
- Monitoring and responding to system flow
- Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
- Home first/discharge to assess
- Flexible working patterns
- Trusted assessment
- Engagement and choice (person-centred and strengths-based approaches)
- Improve discharge to care homes.
- Developing housing and related services

In this briefing report, we draw on the findings of a realist evaluation of the HHDF to show how the HICM can be sensitised to the needs of patients who are homeless, and how pathways out-of-hospital can be made accessible to **all adults** who would potentially benefit from this.

Box 1: Principles of the High Impact Change Model

This HICM is not designed to be a performance management tool. Instead, it takes as its starting point a recognition that even the best performing systems will be experiencing challenges in relation to hospital discharge. Its inclusion as a national condition in the BCF is intended to support implementation of good practice.

The model is underpinned by a sector-led improvement approach which emphasises the importance of triangulating both hard and soft types of data to tease out local stories within a culture of openness and trust. This model supports genuine, honest reflection and discussion between trusted colleagues within local health and care systems and includes a suggested action plan so that decisions arising from conversations using the model can be implemented across the year (LGA, 2019).

3: Developing pathways out-of-hospital

For practical implementation purposes, Bolton (2018) summaries the evidence for out-of-hospital care as follows. First, there should be less focus on assessment for longer-term care and support at the point of discharge and more emphasis on recovery. Second, there is a specifically commissioned set of services to help people recover post hospital:

> ***'It is important that the NHS and Social Care work together to commission (procure) an out-of-hospital care system that has its own set of (intermediate care) services and which focus on supporting the recovery of patients post-hospital. It will not work at its best if services are solely commissioned from existing services where they were not established for that purpose (e.g. using standard home care agencies when they are not geared up to take a regular flow of new people). This applies to both residential care and care at home'*** **(Bolton, 2018 p11)**

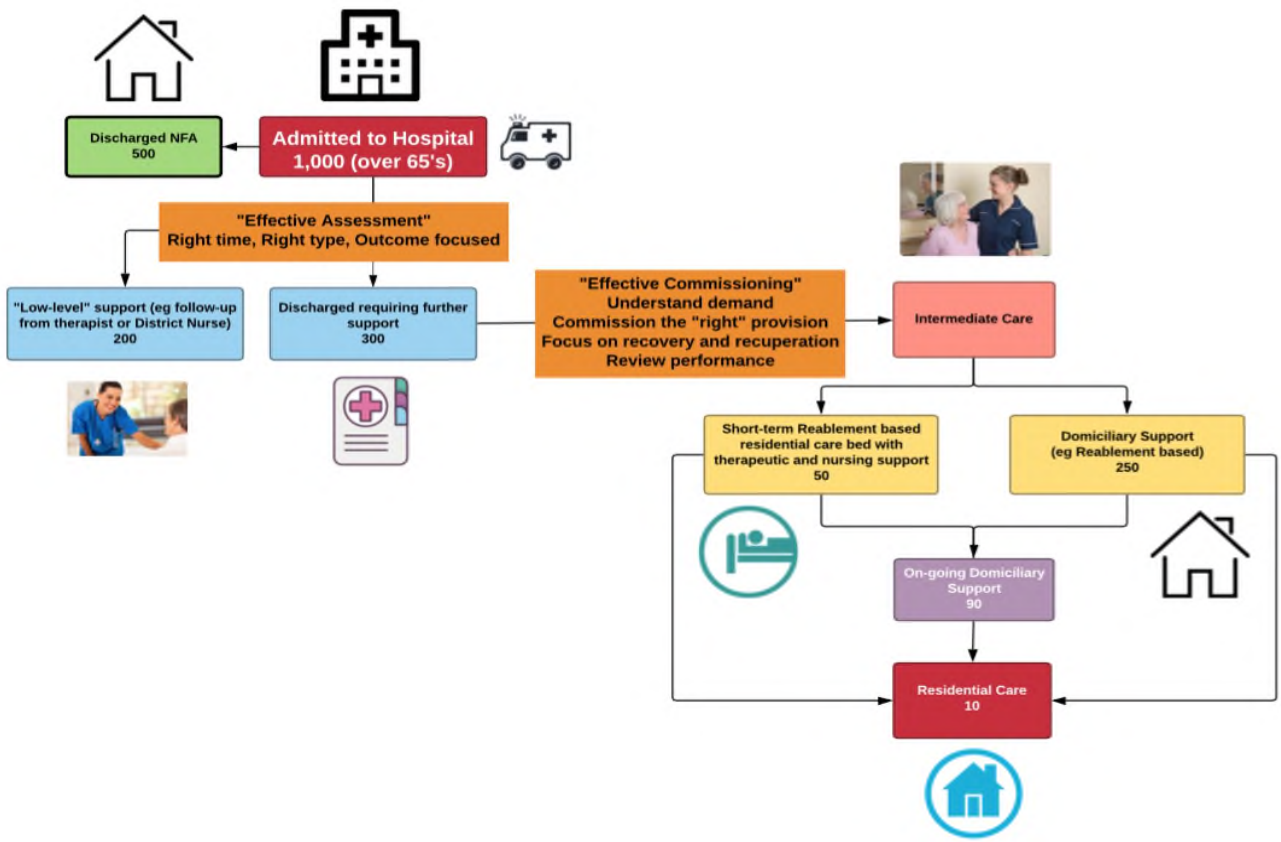
Bolton's vision for managing the flow out-of-hospital is conceptualised by way of the diagram shown in Figure 1. Within this view intermediate care (step-up/step-down) is recognised as key to managing the tension between the need for fast and efficient patient flow and person-centred care.

Intermediate care or step-down is an umbrella term for a wide range of service models including: Discharge to Assess (D2A), Home First, reablement and Safely Home. It usually comprises networks of local health, housing and social care services, which deliver targeted, short term support to individual patients/clients/service users, in order to: prevent inappropriate admission to NHS acute inpatient or continuing care, or long-term residential care; facilitate timely discharge from hospital; and, most importantly, maximise people's ability to live independently within their communities (Cowpe, 2005):

> ***'It is the responsibility of all local stakeholders to make sure patients, carers and their representatives understand that*** **[step-down]** ***is NOT about… Creating an additional transfer in a person's care pathway in order to free-up a hospital bed, without adding value to their experience of care or meeting good outcomes for the person'*** **(NHSE et al., 2016 p2)**

The NICE (2017) guideline for intermediate care recommends that commissioners should consider making home-based intermediate care, reablement, bed-based intermediate care and crises response all available locally. These services need to be delivered in an integrated way so that people can move seamlessly between them, depending on their changing needs. It is accepted that no one model can meet all the needs of all patients leaving hospital and that the aim should be to develop a 'complex adaptive system' which involves simple rules to function rather than rigid inflexible criteria (NHSE et al. 2016).

Figure 1: Managing the flow out-of-hospital



Reproduced with kind permission from Phillip Provenzano & John Bolton (2018) 'Flows Through Hospital: Commissioning Key Messages' (V3) Oxford: Oxford Brookes University.

4: Who is eligible for intermediate care?

Intermediate care entered the mainstream of health and care services delivery in England through the National Service Framework for Older People (DH, 2001). Here, it was recognised that while intermediate care services are likely to be of particular importance for older people, service planning and investment need to take account of the needs of all potential services users (DH 2001 s3.33). Updated guidance (DH, 2009) defined intermediate care as **support for anyone with a health-related need through periods of transition** and made the point that no one should be excluded on the basis of age or ethnic or cultural group. Specific reference was made in this guidance to the eligibility of homeless people and prisoners (p4). Later guidance has tended to move away from this broader more inclusive definition and to conceptualise intermediate care as primarily an older people's service.

- ✓ **In this report, we evidence the need to reverse this trend and to ensure that out-of-hospital support is accessible to every adult who may benefit from these services.**

5: The Evaluation of the Homeless Hospital Discharge Fund (HHDF)

In 2012, it was reported that 70% of homeless patients were being discharged from hospital back onto the street, without their housing or underlying health problems being addressed. This was further damaging their health and increasing costs to the NHS through 'revolving door' admissions (St Mungo's and Homeless Link, 2012). In response, the Department of Health (DH) launched the *'Homeless Hospital Discharge Fund'* (HHDF) with £10 million of investment to support improved partnership working between hospitals, local authorities, housing and the voluntary and community sector. The overall aim of the HHDF was to improve hospital discharge arrangements for people who are homeless, and to provide appropriate intermediate care 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. For those who are TB (tuberculosis) patients, homelessness is a major barrier to completing their treatment and recovery from infection.*** **[The HHDF funding]** ***will ensure adequate provision of intermediate care facilities to be available upon discharge from hospital'*** **(DH, 2013)**

In total, 52 homeless hospital discharge (HHD) schemes were funded through the HHDF. Between 2015-2019 researchers at King's College London and partners undertook an evaluation of these schemes. This comprised an economic evaluation and a 'data linkage' in which information was ascertained on outcomes for 3,222 HHD users. The study also involved in-depth qualitative fieldwork in six hospitals. Four hospitals had HHD schemes, two did not, enabling comparisons between 'specialist' and 'standard' discharge arrangements (see Box 2).

Box 2: Mixed methods used in the evaluation of the HHDF

The National Institute for Health Research (NIHR) study conducted between 2015 - 2019 involved:

- A synthesis of the hospital discharge and intermediate care literature
- In-depth fieldwork in six sites across England, exploring hospital discharge practices in areas with and without HHD schemes.
- Interviews with commissioners, managers and practitioners in health, housing, social care (n=77)
- Interviews with service users (n=70). Service users were followed for three months after they were discharged from hospital to find out about their experiences.
- An economic effectiveness evaluation.
- Data Linkage - details about HHD scheme users (n=3,222) were linked to Hospital Episode Statistics and Civil Registration death data. This enabled us to explore causes of death and a range of outcomes such as hospital readmission rates and time from discharge to next A&E

The key findings from the evaluation of the HHDF are summarised in Box 3. Overall, there is **strong** evidence to support the commissioning of specialist HHD schemes as they are consistently more effective and cost-effective than standard care. There is also evidence that HHDs can contribute to meeting BCF metrics for reducing delayed transfers of care and reductions in A&E use.

Box 3: Key Findings from the Evaluation of the HHDF

- NHS Trusts with specialist HHD schemes have lower rates of Delayed Transfers of Care (DToCs) linked to 'Housing' than standard care.
- Employing a range of different economic modelling techniques, specialist HHD schemes are consistently more effective and cost-effective than standard care.
- Employing a range of different economic modelling techniques HHD schemes with direct access to specialist intermediate care (step-down) are more effective and cost-effective than HHD schemes that have no direct access to intermediate care.
- The data linkage showed that HHD schemes with a step-down service were associated with a reduction in subsequent hospital use, with an 18% reduction in A&E visits compared to HHD schemes without step-down.
- Clinical advocacy provided by hospital-based homeless health care teams increases access to planned (elective) follow-up care. This is an especially important outcome as 1 in 3 deaths of people in our homeless hospital discharge cohort were due to common conditions (e.g. heart disease) which are amenable to timely health care.
- Outcomes following discharge show that homeless patients were more likely than others to be readmitted in an emergency, with five times the rate of unplanned hospital readmission and five times the rate of A&E visits than housed people from deprived neighbourhoods. The much higher risk of emergency admission was not explained by the poorer underlying health of homeless patients. This suggests poor recovery after discharge and may reflect barriers to accessing safe accommodation and community services.
- National audits and evaluations of out-of-hospital care for all patient groups have pointed to a lack of capacity in intermediate care (one study suggests that reablement services need to be increased by 200%). Other studies have demonstrated that where longer-term community support services are inadequate or lacking this can cause intermediate care to become blocked limiting its effectiveness.
- Many of the 52 HHD schemes struggled to secure sustainable long-term funding once the initial pilot funding ended and have stopped or been reduced in scale. The high usage of emergency rather than planned care among homeless patients after discharge suggests this trend should be reversed in a move toward better access and significantly increased capacity in out-of-hospital care.
- Housing authorities and homeless services have a vital role to play in out-of-hospital care but should not be expected to work reactively with homeless patients. The involvement of these agencies should be well planned and integrated with health and social care
- Multi-agency responsibilities for adult safeguarding and the extreme risk of death among this cohort of patients mean that it is no longer acceptable or overlook instances of neglect and acts of omission where patients are discharged to the street.

A particular strength of the evaluation is that it used 'mixed methods' and multiple modelling techniques to explore effectiveness and cost-effectiveness from many different angles and perspectives. The main limitations of the study are twofold. First, we encountered difficulties

in collecting primary questionnaire data for quantitative analysis in some of the sites (meaning that proxy data sets from other studies were used in some analysis). Second, comparing the different scheme typologies was challenging. Comparisons were difficult due to the: (i) heterogeneity of the HHD schemes (e.g. differences in size, staffing, skill mixes, remit and funding level); (ii) different resource contexts in which the schemes were operating (e.g. levels of access to move on accommodation and capacity in longer term care and support services); and (iii) potential differences in 'case mix' (i.e. schemes potentially working with different levels of need and complexity). A fuller discussion of the research findings its limitations is in the main evaluation report (Cornes et al., 2020).

6: How sick are homeless patients?

Some of the commissioners who took part in our study expressed the view that older people would have the 'highest needs' of the different population groups and should therefore be prioritised for Better Care Funding (BCF) - the main source of funding for intermediate care. However, when we consider the morbidity and mortality profile of the patients in the HHD cohort this assumption appears misplaced. As part of the evaluation, we collected information on 3,222 patients who had received support from an HHD scheme. Data were collected from across 17 different hospitals in England. Information about this group was compared to a comparator group of patients who were housed and living in lower super output areas in England in the most deprived quintile, as measured by the index of multiple deprivation (IMD). Box 4 below presents key findings from this analysis.

Box 4: The Morbidity and Mortality Profile of People Using HHD Schemes

- As compared to the general population, homeless people have extreme levels of co-morbidity. 8% of the HHD cohort had five or more co-morbid conditions compared with 5% for the comparator group.
- In the HHD group, 600 patients died between 1st November 2013 and 30th November 2016. Males made up 78% of deaths.
- The median age of death was 52 for the HHD group and 72 for the comparator group.
- The top three underlying causes of death in the HHD group were external causes of death (such as drugs, alcohol and suicide) (22%), cancer (19%) and digestive disease (19%).
- When age and sex are accounted for, the underlying causes of death for the HHD group due to alcohol, drug related deaths and suicide all decreased and the number of deaths due to cardiovascular and respiratory disease increased. This highlights the importance of more common causes of death such as coronary heart disease, respiratory disease and cancer that have previously been underestimated in homeless populations.
- Our analysis focused on amenable deaths as these are causes that could be avoided through good quality healthcare. We found that nearly one in three of deaths in our homeless group could have been prevented. This highlights that people with experience of homelessness are not only dying earlier than the housed population, but they are more likely to die of causes that could be avoided with better health and care provision.
- Overall, these findings demonstrate the large unmet need and significant inequity experienced by this excluded population. The results also confirm that that the HHD schemes are identifying and engaging with an excluded population at extreme risk of death.

These results demonstrate that HHD schemes are engaging with a very sick population with high levels of multimorbidity and unmet healthcare needs, especially for common conditions such as heart disease. Homeless patients are not only dying earlier than housed patients but are more likely to die from conditions amenable to healthcare. We know from other research that this population also experiences the early onset of 'gerontological conditions' such as frailty 10 to 15 years before the rest of the population. A Scottish study for example, estimated that the levels of multimorbidity among homeless patients registered with a (specialist) general practice, were comparable to patients aged 84 years in mainstream practices, despite an average age of 43 years (Lowrie et al., 2017). Orpen (2019) in a blog for the Wellcome Trust captures the implications of our findings as follows:

> ***'The notion that this group are mainly killing themselves through reckless lifestyle choices is modified; they are also suffering the diseases associated with poverty, but to a significantly greater extent than, for example, the people living in the most deprived areas of England who are just poor. Yet despite this higher need, they are not receiving a commensurate response from the health service'.***

The data linkage also shows that homeless inpatients have very high rates of emergency readmission and A&E visits after discharge from hospital. After an acute illness with treatment in hospital, patients are usually expected to recover at home. Housed patients with certain diseases such as digestive and musculoskeletal diseases have relatively low readmission rates, reflecting recovery or ability to manage the condition in the community. This is not the case for homeless patients, who often do not have a good place to recover and consequently have a high risk of readmission regardless of the cause of hospitalisation

This morbidity and mortality profile of patients in the HHD cohort and their outcomes after discharge, reinforces the point that homelessness is rarely just a housing issue. There is strong evidence from this and many other studies to show how homelessness intersects with mental health problems and drug and alcohol use, often with roots in adverse childhood experiences and other forms of trauma (Bramley and Fitzpatrick, 2015). Our research also draws attention to the need for a much broader focus that is encompassing of physical health and long-term condition management especially for more common conditions such as cardiovascular disease. Box 5 below presents a profile of the needs of one HHD scheme patient showing how 'housing issues' sit as part of a long list of multiple needs. This alerts us to the need for out-of-hospital care to integrate both housing and ***enhanced*** health and social care support, as part of a robust multidisciplinary response that can address both the challenges of ageing and health inequality.

- ✓ **For the majority of homeless patients housing is unlikely to be their primary or only need at the point of discharge.**

Box 5: Needs of an HHD scheme patient at point of discharge

Jason* is 49 years old and has had a ten week hospital admission due to a seizure requiring intensive care and intubation. Jason was 'self-neglecting' prior to his admission. He could not return home due his rented property being in an unfit state and an eviction notice having been served. At the point of discharge, Jason's needs were:

Health

- Has suffered a hypoxic brain injury. There is a query regarding his decision making capacity (due to his age he does not meet the criteria for memory clinic assessment).
- Has diabetes and is forgetful and unable to manage own medications, including insulin. He often refuses to eat. He is having frequent hypoglycaemic episodes and also some high blood glucose levels. He is unaware of the symptoms of hypoglycaemia and is unable to look after himself in this situation. This can be life threatening.
- He has a mild learning disability.

Co-existing mental health and substance misuse

- Complex mental health history, past episodes of psychosis. Hears voices episodically and these are usually telling him to harm himself.
- Has a history of drug and alcohol misuse. There have been numerous occasions where he has had periods of being heavily intoxicated. This has then had a significant impact on his ability to self-care, including taking vital medication, such as insulin. They have also been associated with anti-social behaviour and disturbances to other residents of accommodation services such as hostels.

Care and Support Needs

- Safeguarding concerns. Neighbours were financially abusing Jason.
- Self-neglect of personal care. Occasional urinary and bowel incontinence.
- Cannot maintain a habitable home environment without support.
- Has difficulties reading and writing, engaging in work, employment, education.
- He is also unable to use public transport (make use of community facilities including GP access), due to being unable to read numbers, letters and has no sense of direction unless he is accompanied by staff.

Housing Problems

- Is homeless.

** This is based on a real case example, with the name changed. Later in Box 6 we to return to explore how Jason's needs were addressed through a specialist HHD scheme.*

7: Standard care

We emphasise the point that housing is unlikely to be the primary or only need at the point of discharge for Jason and other people like him, as it remains standard practice in many hospitals to 'signpost' patients who are homeless to housing authorities or day centres. This is often before a housing assessment has taken place and before arrangements are confirmed for meeting wider care and support needs. A recent report suggests that the number of patients discharged to 'No Fixed Abode' has increased by 30% since 2014 (Marsh and Greenfield, 2019).

Unplanned discharges are nearly always spur of the moment decisions (resulting from pressure to free-up a hospital bed) and **risky and unsafe**. This is because once discharged *'to housing'* hospitals will not keep the patient's bed open while they follow-up the outcome of the referral. Thus, if things do not work out at the housing authority the patient can find themselves having to sleep rough. Risks leading people to sleep rough shortly after discharge include:

1. Being discharged late in the day without regard to the fact that the housing office will be closed.
2. Ward staff overestimating the patient's capacity or motivation to present to the local authority housing office, including whether or not they have money for the journey.
3. Being found ineligible for accommodation.
4. Where temporary accommodation is arranged, the patient may struggle to get to the property especially if it is out of area and a long way away. This can be due to frailty (being too physically weak to make the journey), being intoxicated or not having the money for transport. The directions given to patients by housing authorities can also be poor (a scrap of paper) leading to difficulties finding or accessing the property.
5. Housing authorities discharging their statutory duty through a 'single service offer' that places people too far out of the area they are familiar with or in a service that does not meet their needs. For example, placement in a 'wet' hostel (accepting of alcohol use by residents) after they have undergone a detox while in hospital and want to remain in recovery.
6. Placing people in poor quality accommodation with no bedding, towels or food, or where they feel frightened or isolated leading them to abandon the property.

Returning to the street shortly after discharge is a highly distressing and traumatising experience. Risks relate to the usual harms caused by being on the street (e.g. threat of assault and violence) but are confounded by additional problems such as having nowhere to store medication or get advice about how to take it. The psychological distress is perhaps most acute where there has been a lengthy hospital admission enabling a 'detox' or a move off street drugs onto substitute prescribing, with time for rest and recuperation and for people to start to feel positive and hopeful about the future. To return people to the street at this point is to waste a significant 'window of opportunity'. This also leads people to lose faith in the system and to become more resentful of professional intervention and support.

For primary care and other staff working in the community, having to deal with patients presenting in crises due to an unplanned discharge is frustrating and highly disruptive to their day-to-day practices. When people fall through the cracks or have no choice and control in the discharge planning process, they will usually return to hospital quite quickly. Appendix 1 presents two case studies of unplanned discharge.

- ✓ **Homeless inpatients have five times the rate of emergency readmission and A&E visits after discharge from hospital compared to deprived housed patients with a similar medical profile.**

8: Strengthening adult safeguarding responses to unsafe discharge

According to the National Institute for Health and Care Excellence (NICE, 2015) the overarching principle of care and support during transition is person-centred care. This involves being mindful of people at risk of less favourable treatment or with less access to services, for example people who misuse drugs or alcohol (s1.1.1).

It is important to ask why patients who are homeless are not always permitted to occupy an acute hospital bed until arrangements for their ongoing housing, care and support are confirmed and in place? Common justifications for unplanned discharges include "*Patients cannot occupy an acute hospital bed when they are medically fit*" or *"Discharges cannot be delayed due homelessness*".

However, guidance on managing delayed transfers of care (NHSE, 2018) is clear that patients should only be transferred from the acute sector once they are confirmed as 'clinically optimised' ***and*** when a multi-disciplinary team decision has been taken that it is safe to transfer (NHSE, 2018). Situation Reports for Delayed Transfers of Care (DToC) are indicative of large numbers of older adults being permitted to remain in an acute hospital bed once they are medically optimised. This can be for a variety of reasons including '*Awaiting a Care Package'* or *'Patient and Family Exercising Choice'* (waiting for a specific care home place to become available).

When DToCs reach crisis point the Government will usually intervene to create extra capacity in adult social care. In the winter of 2016/17 DToCs hit an all-time high when, on average, 6,660 people were delayed every day in NHS beds. In March 2017, the Government introduced a new target to reduce the level of bed days 'lost' to 3.5% and announced an extra £2 billion of funding for social care services.

Accurate recording of DToCs is thus an important lever for system transformation. Indeed, it might be argued that because people who are homeless are more likely to be discharged prematurely, out-of-hospital care for this group remains underdeveloped and under-resourced. This is despite the fact that **housing issues** are known to incur exceptionally long lengths of hospital stay, further exacerbating the drivers to discharge people unsafely.

> ***'The average length of stay of a homeless patient is 7.5 days. However, being homeless on admission and needing re-homing (i.e. not being discharged to the street) generates the longest lengths of stay between an average of 110.1 days and 173.8 days'*** **(Dorney-Smith and Hewett, 2016 p25)**

In our research we observed many instances of where professional discretion and negotiation were used to decide whether a homeless patient might stay in a hospital bed once they were identified as medically optimised (i.e. have their transfer delayed rather than be discharged to the street). Evidence came from different perspectives:

> ***'We would rather have someone in an extra night or two while they are waiting for a placement as opposed to, "Let's discharge them now". If they are going onto the street they are only going to come back to A&E two hours later. What's the point? Everybody wins*** **[this way]** ***especially the patient'*** **(Staff Nurse)**

> **'[The doctor]** ***is totally ignorant and it was on the Wednesday I saw*** **[the nurse]** ***and I said "Look, I'm disabled, I can't handle*** **[being discharged homeless]***". The nurse says, "Look don't worry" and he put his hand on my shoulder and he said, "We will not kick you out onto the street" which is what the doctor wanted - he wanted me out. Well, I didn't want to be in hospital. I was taking up a bed that someone desperately needed. All I wanted was a roof over my head.'* **(Homeless Patient)**

Frontline staff on the wards talked openly about the need to *'pick their battles'* with consultants and hospital managers as regards which patients might be permitted to stay an extra few nights. As a result, some homeless patients received more leeway to remain than others. Our observations pointed to those with drug and alcohol issues and those whose behaviour was perceived to be challenging were more likely to be discharged prematurely. This may reflect that substance use is a highly stigmatised condition, and when resources are stretched there is less tolerance of the challenging behaviour that can be associated with this. Again, it is important to draw attention to potentially discriminatory practice. NHS incident reports suggest that the most likely demographic involved in aggressive incidents in the acute sector is men aged between 75–95 (with their female peers not far behind) and that dementia and delirium lie behind much of this distress (Harwood, 2017). However, it would be unusual for this group of older patients to be discharged unsafely on 'behavioural grounds' alerting us as to how different conditions and vulnerabilities garner more or less sympathy:

> **'[Discussing homeless patients]** ***Some of them feel judged and that the whole aim of their admission is to get them out because they are difficult to manage on the ward. If you have got a drug dependent patient who's constantly leaving the ward to score that's really difficult to manage from a practical point of view'*** **(Staff Nurse).**
>
> ***'Some of the nurses are brilliant, but there's hell of a lot of nurses that talk down to you as soon as they find out you are on the gear (illicit drug using)… It's not as bad if they see you are in a hostel but if they know that you are actually living on the street and you're on the gear or on the ale (alcohol) and that's when they change they really do look on it as like "Well they put themselves out there"'*** **(Homeless Patient).**

Investigations into unsafe discharge by the Parliamentary and Health Services Ombudsman (2016) have taken issue with discharging vulnerable patients without consideration as to whether their 'home environment' (housing) is suitable. Viewed through the lens of adult safeguarding, it is difficult to see how discharging a patient to the street can be justified within the parameters of *'safe to transfer'*. There is a specific category of abuse defined in the Care Act, 2014 under: '*Neglect – Acts of Omission*' to describe circumstances where there is a '*A failure to provide access to appropriate health, care and support; a neglect of medical, emotional and physical needs; and withholding necessities of life, such as adequate nutrition and heating'* (DHSC, 2018 s14.17).

Local Safeguarding Adult Reviews (SARs) have increasingly drawn attention to instances where poor discharge arrangements have contributed to the deaths of people who are homeless. In particular, they have highlighted the **poor practice** associated with seeing each hospital admission in isolation, the failure to provide appropriate multidisciplinary responses and to initiate safeguarding where unsafe discharge occurs. In one case a man was signposted to a homeless resource centre shortly before his death with known risks that he was unlikely to receive any support there due to his incontinence (Martineau et al., 2019).

In summary, where hospital patients have care and support needs, including the need for housing related support, the aim should always be to move them swiftly to a safer, more familiar environment that will encourage supported self-management, speed recuperation and recovery and have them feel better. Discharging people without appropriate support is a safeguarding issue. As case law and learning from SARs develop, so too will expectations for good lawful practice (Bateman, 2019):

> ***'Implementing discharge to assess (D2A) models where going home is the default pathway, with alternative pathways for people who cannot go straight home, is more than good practice, it is the right thing to do' (*****NHSE *et al.* 2016 p2)**

9: Developing alternative pathways for people who cannot go straight home

In this section we outline how local system partners can build capacity in out-of-hospital care so that it is accessible to patients who are homeless. We focus on the specialist supports that can be integrated as part of two key changes outlined in the HICM:

- ***Multi-disciplinary Working***: Focussing on the role of the (hospital based) multi-disciplinary homeless health care team
- ***Home First***: Focussing on the role of 'housing-led' step-down intermediate care

In the discussion, we show how both these specialist services can be integrated in a single locality as part of the wider complex adaptive system for out-of-hospital care. We touch on other HICM changes throughout the discussion such as *'early discharge planning'* and *'trusted assessment'.* We examine the cost-effectiveness of different types and configurations of specialist care and the issues that can impact on scheme fidelity. First, we return to the issue of managing 'patient flow' and the protocols that are needed to underpin out-of-hospital care, including the new statutory 'duty to refer' outlined in the Homeless Reduction Act 2017. Having robust protocols in place is also a key change in the HICM.

9:1 Monitoring and responding to system flow

HICM Change: *Develop systems across health and social care to provide real-time information about patient flow. All partners should work together to match capacity to demand by responding to emerging system needs, making effective strategic decisions, and planning services around the individual. Data about flow should then be used to identify and respond to system blockages.*

In this section we begin by outlining the protocols that are used to identify and manage delayed transfers of care (DTOC) in adult social care, contrasting these to those currently used for housing delays. We then highlight the steps that can be taken to develop a more robust understanding of system demand for housing assessments and schemes. As noted earlier, areas have flexibility in how to spend the BCF across health, care **and housing schemes** so it is important to have good information relevant to each local context (DHSC and MCHLG, 2019 p7).

One of the most successful measures introduced in England to reduce the number of DToCs was the reimbursement policy (Delayed Discharges Act, 2003). This put in place robust protocols for joint working between the NHS and adult social care including provision for the local NHS body to charge the local authority if it was responsible for causing a DTOC, for example, if a patient could not leave hospital because they were waiting for a home care package to be arranged. Reimbursement also brought significant additional resources so that local system partners could develop discharge coordination teams and intermediate care. This twin approach of 'carrot and stick' dramatically reduced the number of delayed discharges between 2001 and 2007 before the figures began to steadily rise again (Godfrey et al., 2008).

With the advent of the Care Act 2014 the Delayed Discharge Act 2003 was rescinded, but the protocols for joint working continue as statutory duties detailed in Annex G (DHSC, 2018). Under these regulations, a hospital trust must issue the local authority with an Assessment Notice (formerly called Section 2). The local authority then has 2 days to undertake a Care Act assessment and put a care package in place. To ensure that a local authority receives fair advance warning of the discharge, the hospital must also issue a discharge notice (formerly a

Section 5) indicating the date of the patient's proposed discharge. The minimum discharge notification allowed is at least one day before the proposed discharge date. If the local authority has failed to put arrangements in place, leading to a delay, then each day for which the patient remains in hospital from the day after their proposed date of discharge represents a DToC:

> ***'The aim of counting and attributing delays is not to apportion blame, or to punish or fine systems, but to… enable partners to work together to take action to address pinch-points… The accurate and consistent reporting of delays by reason code will enable a detailed understanding of the factors contributing to unnecessary delays' (NHSE, 2018 p5)***

Within the guidance for reporting DToCs, there is a code for delays due to *'Housing -Patients Not Covered by the Care Act'* (NHSE, 2018). All delays under this category are attributable to the NHS because it only covers patients who need rehousing but who have been assessed by the local authority as not meeting the eligibility criteria for care and support. This category definition is currently under review by NHS England and Improvement.

The Homeless Reduction Act (HRA) 2017 implemented in England from April 2018 places a new statutory '**duty to refer'** on hospitals (including Accident and Emergency Departments) and other public bodies to notify the local housing authority where a patient is homeless or threatened with homelessness. However, the protocols contained in the HRA 2017 are not as directive as that for adult social care described above. There is no set timescale for the housing authority to complete its assessment on receipt of a referral notice, and nothing to prevent hospitals from discharging a patient before an assessment is complete.

At the time of this study's fieldwork, the Homeless Reduction Act 2017 had not been fully implemented. However, some local system partners had already developed agreements for joint working as part of a locally agreed *'Homeless Hospital Discharge Protocol'*.[2] In one site, for example, it was agreed that the housing authority would undertake an assessment within 72 hours of receiving a referral (a so called *'bed blocking'* form) from the hospital. In this site, it was rare for patients to be discharged to the housing authority unannounced. Appointment times and workflow issues within this housing authority were respected, as were those in the hospital. In other areas, without agreements, we found that appointments for a housing assessment could be fixed three or four weeks distant with the consequence that ward staff would ignore them and 'signpost' the person to the housing authority unannounced. Discharging patients to the housing authority in such an unplanned way, rather than delaying the discharge had the knock-on effect of rendering any 'pinch-points' invisible, arguably weakening the case for BCF investment in HHD and other housing schemes.

Indeed, it is important to be mindful that the definition of care and support is much broader under the Care Act 2014, for example, encompassing housing related support and that as a result many people who are homeless will likely be eligible for an assessment under the Care Act 2014 (Cornes et al., 2016). In facilitating '**early discharge planning'** it will be important to ensure that both 'Duty to Refer' and 'Assessment Notices' are issued to the local housing authority and adult social care respectively (they may be different authorities in two-tier local

[2] Templates for homeless hospital discharge protocols can be found at:
www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Other_reports_and_guidance/Admissions_discharge29.11.pdf
www.homeless.org.uk/sites/default/files/site-attachments/Evaluation%20of%20the%20Homeless%20Hospital%20Discharge%20Fund%20FINAL.pdf

authorities such as County and District Councils) and that there is coordination between assessments:

- ✓ **Given that the protocols in the Homeless Reduction Act, 2017 are 'light touch' it will be important for the new 'duty to refer' to be embedded as part of a locally agreed 'Homeless Hospital Discharge Protocol'. This should specify the timescale for the local housing authority to undertake its assessment, and hospitals should agree to respect this, recording delays accurately and avoiding discharging patients in an unplanned way.**

9:2 Multi-disciplinary working – the role of the homeless health care team

HICM Change: Multi-disciplinary working. Multi-disciplinary/multi-agency teams (MDTs), including the voluntary and community sector, work together to coordinate discharge around the person. Effective discharge and good outcomes for people are achieved through discharge planning based on joint assessment processes and protocols, and shared and agreed responsibilities

Many hospitals in England now employ discharge coordinators to manage the most complex discharges. As recommended in the HICM, these roles are usually embedded in multi-disciplinary teams comprising senior nurses and social workers. The main focus of their work is usually on manging transfers of care for older people requiring continuing health care or moves into care homes. It is a key recommendation of the HICM to have some sessional in-reach from housing representatives in these teams (such as housing officers or home improvement agency staff). This reflects the importance of viewing housing as the *'third pillar'* of health and wellbeing and how safe timely discharge is unlikely to be achieved if this is overlooked.

However, where there are high numbers of homeless patients (200+ per year) then some hospital trusts have developed specialist homeless health care teams, often called **Pathway Teams**.[3] Homeless healthcare teams are multi-disciplinary and are usually 'clinically-led' by a GP or nurse (with a 'special interest' in homelessness). Additionally, they employ housing link workers and peer navigators (people with lived experience of homelessness). Some teams also include social workers and occupational therapists. These teams offer a range of services to homeless patients, including primary care or patient 'in-reach' (clinical advocacy), discharge coordination and (in some areas but not all) continuity of clinical support into intermediate care.

Patient 'in-reach' (clinical advocacy): This brings highly specialist knowledge and understanding of homelessness onto the hospital ward. One of the key mechanisms for achieving this is the 'homeless ward round' in which clinicians from the homeless team will identify and support homeless patients located across the hospital site. Identification of homeless patients at an early stage of admission is key to ***early discharge planning.*** Teams will use 'concerned curiosity' to understand a patient's housing circumstances mindful of the stigma of homelessness and that some patients will not want to reveal they are homeless. They will then work with patients in psychologically informed ways to build relationships and support them to remain in hospital, have their voices heard and complete treatment:

[3] This is by virtue of their affiliation with the Pathway Charity www.pathway.org.uk

> ***'The role of the clinician in the homeless healthcare team is less about 'hands on' care and the treatment of specific clinical conditions, and more about complex case management, working with people in crisis, challenging stigma, and changing hospital systems so that they work better for disenfranchised people'*** **(Dorney-Smith, 2019)**

Often, when working with patients who are homeless the main challenge is not delayed discharge but more usually preventing 'early self-discharge'. Often this can be a result of substance misuse and the patient wanting to discharge themselves against medical advice due to the onset of unpleasant withdrawal symptoms. Withdrawal can also be at the root of much challenging behaviour on the wards, for example, where the patient feels that his or her withdrawal is not being appropriately managed and leaves the ward to use street drugs. Ward staff will then often take issue with absenteeism from the hospital bed issuing behavioural contracts that can lead to conflict. In such circumstances, homeless team nurses and GPs can intervene to deescalate the situation through more appropriate clinical management (e.g. correct titration of opiate substitution medication such as methadone). The homeless team will also raise awareness among ward staff about many other forms of 'silent stigma' that lead people who are homeless to feel uncomfortable in hospital, such as being mindful that they may have no visitors to take home their washing and provide access to clean clothes and toiletries.

Ultimately, the main goal of the homeless health care team is to maximise the benefits of a hospital admission. Our research shows that through ***'clinical advocacy'*** homeless health teams increase access to elective readmissions (planned follow-up health care) as compared to both standard care and HHD schemes that are uniprofessional (housing-led). This is an especially important consideration given the figures we outlined earlier about the numbers of deaths in the HHD cohort that are due to common conditions that could potentially be avoided with more timely access to health care:

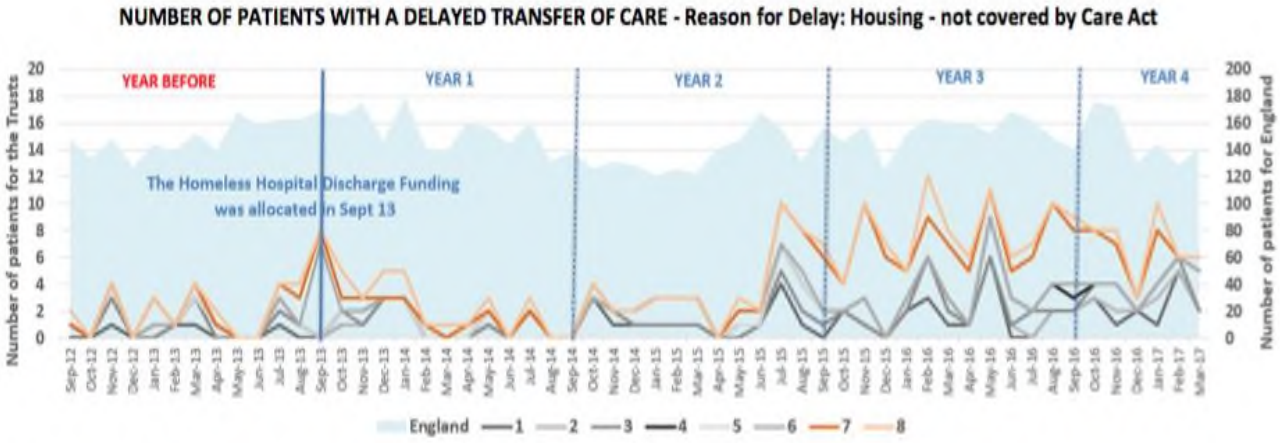
> ***'We see ourselves more as a Homeless Health Team rather than just a Discharge Team… We work with homeless patients at the level they're at - optimising their stay - making sure that they've had their jabs, that they been seen by the substance misuse services even though they've come in for a broken arm; that they have a sexual health screening if the need that; that they get the things done that the Homeless Nurses in the Community have been trying to get them have done for ages, for example, a particular set of bloods. This might not be indicated in terms of why they've come in with, but it's about maximising the stay and following this up with outpatient appointments'*** **(Homeless Health Care Team Nurse)**

Specialist discharge coordination: Homeless healthcare teams also contribute to discharge planning and will usually act as the named point of contact for patients who are homeless. Just as social workers provide detailed knowledge of the Care Act 2014 and other legislation and the local care market, the homeless team will provide expertise on housing legislation and local homeless service provision. In terms of delayed discharge for all patient groups it is recognised that lack of staff awareness and understanding of services available prevents people from making the most effectives possible decisions at the pint of discharge (Newton-Europe, 2019). Housing workers in the homeless health team will also take on responsibility for the considerable administrative burden that can be associated with making an approach to housing or maximising income (e.g sorting out access to benefits or helping people ascertain ID or to establish a local connection). Because homeless health teams are co-located (avoiding the need for ward staff to make external referrals and wait for a response) they are highly appreciated by ward staff and credited with playing a vital role in maintaining patient flow and

reducing delays. Figure 2 shows that hospital trusts that have access to an HHD generally have lower rates of delayed transfers of care due to housing than standard care:

> ***'Before we had a homeless team, homeless patients were referred to the social work team, but the social work team would say its housing not care and signpost them to outside…. Now that we have a*** **[homeless worker based at the hospital]** ***it's a massive bonus for the Trust, someone we can turn to, specialising in homelessness and who knows the processes, policies, laws, benefits and everything that comes with that than an everyday nurse wouldn't be able to deal with… It's a massive bonus'*** **(Ward Manager)**

Figure 2: Number of patients with a delayed transfer of care



NHS Trusts with HHD (black shades)	1-6
NHS Trusts without HHD (orange shades)	7-8

The data is taken from NHSE Monthly Situation Reports* (2012-Mar 2017). It reports the number of patients delayed on the last Thursday of the month. This data was no longer collected after April 2017. From April 2017 the reported data was the total delayed days during the month for all patients delayed throughout the month. Data are shown at provider organisation level, from NHS Trusts, NHS Foundation Trusts and Primary Care Trusts. The 8 Trusts are those that took part in the fieldwork for this study.* www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

What are the drawbacks of specialist homeless MDTs?

One of the drawbacks of specialist discharge coordination is that ward staff may become over-reliant on specialist support (DH, 2010). It can also lead to siloed rather than integrated care. For example, in one of the sites we visited patients with care and support needs were referred into what was perceived as either the *'homeless pathway'* or the *'adult social care pathway'*. The assumed separateness of these meant that patients who were channelled down the *'homeless route'* did not routinely receive the **specialist input** of the social worker and were therefore denied access to a Care Act 2014 assessment[4] and the increased choice and control that come with access to a personal budget.

[4] Note the Care Act 2014 now encompasses provision for housing related support (i.e. help to maintain a tenancy/pay bills) and that anyone with an appearance of a need for care and support is entitled to an assessment. As discussed earlier, in hospital there are protocols for the discharge of people requiring care and support contained in Annex G of the Care Act, 2014.

Indeed, as recommended in the HICM, it is important to actively nurture a collaborative and integrated working culture and to ensure that arrangements are in place for 'joint assessment'. For example, we observed one discharge arrangement where the patient was seen by the homeless team, the alcohol team and the dietician. On the day of discharge, each 'specialist' visited the patient to offer advice, but this was not linked-up or connected in a single discharge plan. In this case, the patient was given a food parcel by the dietician, but she was not aware that the patient was living in a hostel with 'concierge only' service and lived mainly by consuming sandwiches donated charitably to the hostel. He subsequently wasted most of the food parcel as he did not know how to use the microwave (or even if there was one in the kitchen) as he did not prepare any food for himself.

9:3 Home First – The role of 'housing-led' step down intermediate care schemes

HICM Change: *Home first requires staff across the health, housing and social care system (including the voluntary and community sector) to understand that a hospital is not a suitable environment to carry out an assessment of someone's long term need, and to work together to discharge people from hospital as soon as they are medically optimised and it is safe to do so.*

Through the HHDF, two principle models[5] of ***specialist homeless*** step-down intermediate care were developed:

- Housing-led (residential/bed based) step-down
- Housing-led (home-based/floating support) step-down

In this section we provide case studies of each of these. As noted earlier, the NICE (2017) guideline for intermediate care recommends that both models should be developed locally to cater for different levels of need.[6] We also show how multi-disciplinary homeless health care teams and 'step-down' can be integrated through ***'trusted assessment'*** and ***'boundary spanning'*** to create an alternative pathway out-of-hospital for people who cannot go straight home because they are homeless.

Model 1: Housing-led (residential/bed based) step-down

Only one of the original HHDF funded schemes falling into this category is currently operational. The Bradford Respite and Intermediate Care Support Service (BRICSS) is built on a partnership arrangement between a Pathway Homeless Health Care Team and Horton Housing Association. Here, HHDF capital funding was secured to refurbish former student

[5] Capital funding was secured through the HHDF for a number of medical respite facilities. Here, the plan was to establish residential (bed based) step-down facilities with 24-hour clinical staffing. However, difficulties securing premises and securing revenue funding for clinical staffing meant that these schemes never became operational or were short lived. None of the HHDF planned medical respite facilities are currently operational. Pathway (2016) has produced a comprehensive review of the learning for commissioners in trying to develop medical respite facilities.

[6] Across the research, we did not find any examples of sites that had achieved the NICE guideline for both residential and community 'step-down' in a single locality. For a short time, one project did achieve this, opening a residential unit in addition to its floating support services, but the unit did not receive continuation funding. Having a dedicated facility that could be staffed 24 hours a day was recognised as key to facilitating earlier discharges for those homeless patients with more complex needs.

accommodation into a 14-bed dedicated intermediate care step-down facility (BRICSS). A newer, more accessible residential facility has since been secured, offering 17 places with 13 beds in a former care home and 4 adjoining self-contained flats. This is owned and managed by Horton Housing Association and is staffed 24 hours a day (with housing/resettlement workers during the daytime and security staff at night). Revenue funding is mainly sourced in the same way as for other hostels in the district (e.g. from housing benefit), but the facility is only accessible to people who are homeless and assessed as needing intermediate care due to having a physical health need. Additional funding for BRICSS is also provided through the BCF. The BCF pays for support staff and manager, who are on duty 7 days per week. Without this additional BCF funding BRICSS would be unable to operate.

Embedding pathways out-of-hospital in the wider integrated care community: Seen from the perspective of the patient, the journey into BRICSS starts in the hospital and is facilitated by the Bradford Pathway Homeless Team. At the time of the research, the Bradford Pathway Homeless Team comprised a Team Manager (a Band 7 Nurse), a nurse, a housing worker and a care navigator, with sessional support provided by a GP and a mental health nurse. The Pathway Team is managed through the Bevan Specialist Homeless Primary Care Practice. Staff from the Pathway Team also provide sessional in-put into other local inclusion health services provided by Bevan, for example the mobile outreach services for sex workers. This makes for a strong community of practice, in that workers get to know clients over time and what is going on in related services.

The Pathway Team housing worker and navigator offer a service to those patients who do not need intermediate care). The Pathway Team Manager (Band 7 Nurse) is employed by the acute trust and the other housing and clinical staff by Bevan. The team operates extended working hours on some evenings, but there is pressure for the service to operate 24/7 should funding allow. In a recent mapping exercise of inclusion health across England, this site was recognised as one of the few to have achieved the highest level of integration as defined by the DH's Office of the Chief Analyst (2010 p18):

> ***'Fully coordinated primary and secondary care that provides an integrated service, including specialist primary care, outreach services, intermediate care beds, and in-reach service to acute beds'***

Trusted Assessment and Boundary Spanning*:** In Bradford, the Pathway Homeless Team will start to assess and work with patients while they are in hospital and will continue to work with them ***('boundary span') when they move into BRICSS. Importantly, the Pathway Team has direct referral rights into BRICSS and the Pathway Nurse and GP are ***'trusted assessors'*** meaning that BRICSS staff will accept their assessments and judgements about a patient's suitability for the service. Thus, when medically optimised, people move seamlessly from hospital into BRICSS, such that hospital discharge is an 'uneventful' event (a short taxi ride). The Pathway GP and nurse undertake a weekly 'ward round' at BRICSS (reviewing the care of each resident) and work flexibly so that they are always on hand to provide housing staff with advice and back-up on health issues.

- ✓ **For patients this integration confers a high degree of continuity in which *"I only have to tell my story once."***

In another site we visited, the homeless health care team did not have partnership status as ***'trusted assessors'*** and did not have direct referral rights into intermediate care. As a result, patients were discharged and reassessed by the intermediate care team on presentation. If a 'step-down' bed was not available on the day, this could leave some patients in limbo having been discharged from hospital with nowhere to go.

Discharge to Assess (D2A): Once settled into BRICSS, a fully integrated assessment commences of the patient's health, housing and social care needs. Importantly, admission to BRICSS enables Pathway clinical staff and BRICCS housing workers to work together to observe needs over time and ascertain a fuller picture, rather than relying on a verbal snap-shot at the point of discharge. These 'snap shots' can be unreliable given that people are 'not themselves' when in hospital and in crises or unwell. This opportunity for comprehensiveness is at the heart of the *Discharge to Assess (D2A)* model. Below we consider the different elements or components that make for effective D2A step-down intermediate care:

- ***Convalescent atmosphere:*** Staff at BRICSS work hard to ensure a quiet convalescent atmosphere at all times. One consequence of this, is that people with active addictions, loud, disruptive or challenging behaviour are perceived to be less suitable for the service. Rather than actively exclude this group, the aim is always to have a balance of residents with different needs. One resident captured the success of this approach as follows: *'Prior to going into hospital, I was living in a homeless hostel. It was noisy, doors slamming all night long and there were stairs I couldn't manage... This place is completely quieter, nicer, there's medical care and its just lovely.'*
- ***Reablement*** is a time-limited person-centred intervention that aims to restore self-care and daily living skills and to support access to, or reconnection with the local community, social and leisure activities. Support for physical reablement (e.g. helping people re-establish 'Activities of Daily Living' such as washing and dressing) is however, perceived to fall outside of the skill set of the BRICSS housing support worker role and as requiring referral into the support provided by (adult social care) reablement teams. Accessing adult social care was particularly challenging for workers across all the HHD schemes involved in the study, and often required strong and persistent advocacy with good legal literacy. This boundary was successfully negotiated for some BRICSS residents who received a Care Act 2014 assessment and subsequently six weeks of 'free' reablement, with reablement workers visiting the BRICCS facility each day. If longer-term care and support are needed this will be assessed at six weeks with plans put in place for transfer to sheltered housing or a care home. Patients with palliative care needs can remain at BRICSS if that is their wish.
- ***Self-management:*** Time in BRICSS enables staff to support people towards improved '*self-management'* (e.g. to better manage conditions such as diabetes through healthier diet and understanding of medication regimes). This can also encompass support for managing addictions, for example, encouragement for residents to reduce their alcohol consumption.
- ***Early discharge planning and resettlement:*** Plans for 'move -on' (rehousing) commence at the point of entry to BRICSS. BRICSS staff are 'housing workers' employed by Horton Housing Association and are skilled resettlement workers. Resettlement involves supporting people to find and establish a home, maximise their income, maintain a habitable home environment and to (re) establish independent living skills. Resettlement is a close cousin of reablement but tends to focus more on inclusion outcomes such as preventing social isolation and supporting people to take part in education, employment and other community activities.
- ***Link work:*** A key aspect of the inclusion work undertaken by BRICSS housing staff is to support people to register with a GP and to manage any outpatient appointments. Workers keep a central database of all appointments and will accompany people to them. In effect, this further maximises the benefits of the hospital stay by providing the practical 'link work' needed to ensure continuity of access to health care in the community.

- ***Engagement and choice (person-centred care):*** Enabling people to have some 'breathing space' between hospital and (finding a new) home is key to opening up opportunities for *person-centred care* and increased *choice and control*. At BRICSS people have time to build trusting relationships with staff and are fully involved in all decisions including those about where they want to live. Staff accompany residents to view properties and will help them set up a home. Indeed, for BRICSS staff a particular challenge is how to manage choice where people may have reached their goals as regards their physical health, but where they are waiting solely for the right property or post code to become available. This reflects the need for residential HHD schemes to have clear protocols around the management of patient choice such as those in place for acute care.[7]
- ***Length of Stay/Monitoring Flow:*** It is anticipated that the usual timeframe for intermediate care will be between 10 days to six weeks (DHSC, 2010). However, for most HHDs the anticipated timeframe was between 8 and 12 weeks primarily because of the need for home finding alongside more traditional reablement and rehabilitation activities. Even despite this extended timeframe, it was often the case that people stayed much longer in BRICSS, sometimes for up to a year. As noted above, patient choice was a significant factor here as people waited for the right housing option to become available. The other main cause of delay was the shortage of suitable longer-term care and support services, especially for people aged under 55 who needed care.
- ***Continuity***: For BRICSS residents, the integration of these different elements meant that the 'holy grail' of a **single integrated care plan** was often achieved with health, housing and social care professionals all coordinating their work toward the achievement of a common set of outcomes (see Box 6 below). To maintain *continuity* post BRICSS, the Pathway Team is host to a monthly multidisciplinary meeting that brings together the 'multiple and complex needs community' (i.e. practitioners from across health, homelessness and criminal justice services). This affords an opportunity to review cases of concern. However, there was a recognised unmet need for some BRICCS residents to have a further period of 'step-down' in the form of floating support in the community where they were moving into a new home of their own. To compensate for this, BRICCS workers often had 'secret caseloads' of former residents who they kept an eye on until they knew longer-term community services and (relationships) were in place and working well (see Box 7).

[7] See Quick Guide to Supporting Patients Choices: https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf

Box 6: Discharge to Assess (D2A) – a case history (continued…)

Box 5 (above) outlined Jason's needs at the point of discharge. Jason was admitted to BRICSS where his length of stay was eight months.

Care Planning Outcomes to be achieved through BRICSS stay

- Improve self-management of diabetes (including medication)
- Maintain personal hygiene/address self-neglect
- Make use of necessary facilities (e.g attend hospital appointments)
- Address co-existing mental health/substance misuse
- Develop family relationships (with children)
- Maintain habitable home environment (including benefits, money management).

Multi-disciplinary working coordinated through BRICSS:

(Pre-discharge)

- Pathway nurse issues Assessment Notice to adult social care.
- Initial Care Act 2014 and occupational therapy assessment carried out

(Weeks 1 -6 post discharge)

- Ongoing day to day assessments by Pathway nurse and BRICSS staff plus weekly review/ward round at BRICSS led by Pathway GP.
- Insulin administered and blood sugars monitored twice per day, by district nurses.
- BRICSS staff prompt Jason to take his other medication 4 times per day. BRICSS have organised for this to be put into a dosset box and for repeat prescriptions to be automatically ordered and delivered to scheme. Medication is kept locked in medication safe, to prevent accidental overdose.
- Following discharge from hospital, Jason was provided with six weeks free reablement support (with care workers visiting BRICSS facility 2x per day).
- BRICSS staff complement reablement package providing support with shopping, paying bills, attending appointments, medication, opening and reading post, and encouraging Jason to undertake activities and engage in community/social life.

(Weeks 7+ [total length of stay at BRICSS 8 months]

- Reablement care workers struggle to work with Jason who continues to refuse care. Addressing self-neglect remains a challenge for staff.
- Allocation of a community social worker and new Care Act 2014 assessment completed. Social worker considers Extra Care housing most suitable option due to Jason's care and support needs.
- Reablement team withdraw/transition to private domiciliary care provider, until place in an Extra Care facility can be found. As these facilities are often restricted to Over 55, Jason effectively becomes delayed in BRICSS for six months plus until a place can be sourced.
- Before the move takes place, Jason suffers a stroke and is admitted to hospital.
- On leaving hospital he spends a short time in another intermediate care facility (due to need for 24 hour nursing) before moving in to an extra care flat with 24 hour care on site. Jason loves his new home and enjoys the company of the older people who live there. He doesn't mind being the youngest resident!

Box 7: Patient experience of Specialist Residential Step-down Intermediate Care

"BRICSS is a hostel. I did have some initial concerns about staying in a hostel, but staff worked hard to maintain a peaceful environment and reminded residents constantly that this a place for convalescence and for people who were not well. I had my own room, bathroom and cooking facilities with the use of a laundry. I was provided with bedding, towels, toiletries and cooking utensils and a microwave. I felt that my stay there, apart from very possibly saving my life, was an extremely beneficial halfway house to helping me begin to re-construct my life. During my stay, I had access to a nurse and a GP who were attached to the hospital. They visited every Thursday to undertake a 'ward round' (or visited when anyone needed medical attention). On their advice, I had a further six nights in hospital due to pseudo-gout in one of my knees which was excruciatingly painful and required aspirating. I was on bed rest for six days… I often wonder what would have happened to me if I had not been able to stay at BRICSS. The staff gave me social support, helped me to apply for Personal Independent Payment and took me shopping for a bed and a chair for my new flat. I couldn't have done that on my own. A member of staff also physically helped me move into my flat once it became available. They gave me all the bedding and kitchen utensils from my room at BRICSS. This was marvellous as I had very little income and was worried as to how I would pay my bills for the flat with enough left over for food. On the same day that I moved into my new flat, the BRICSS worker took me to register at the local doctor's surgery. My feet continued to be gangrenous and I continued to need the service of the District Nurses. This was arranged without problem" (BRICSS Former Resident)

What is the alternative to a dedicated residential facility?

In other areas of England, the main residential 'bed-based' alternative to a dedicated intermediate care step down facility is a 'health bed' in a mainstream hostel. These are often commissioned by local authorities (LAs) and/or clinical commissioning groups (CCGs) to maintain patient flow through the acute sector. Overall, our evidence lends additional weight to Bolton's view about the need for a specifically commissioned set of out-of-hospital services. Where LAs and/or CCGs were funding 'health beds', these were not always occupied by people recently discharged from hospital, and thus not available for the purpose for which they were commissioned. Additionally, mainstream hostels rarely provide an enabling environment that allows for quiet convalescence and recovery and may struggle to access the required enhanced clinical support.

Do people who are homeless need separate residential intermediate care services?

There is considerable debate between the need for 'generic' and 'specialist' intermediate care provision. Dorney-Smith, Hewett and Burridge (2016) suggest that mainstream intermediate care facilities (usually targeted at people aged over 65) do not currently meet the needs of people who are homeless. The argument for 'specialist' provision stems in large part from the challenges of co-housing people with different needs and vulnerabilities (Lephard, 2015). For example, Lane (2005) charts the advantages and disadvantages of admitting people who homeless and use substances and are experiencing homelessness to mainstream intermediate care. On the one hand, it is considered that when someone is in recovery they should not be accommodated in hostels or other forms of emergency accommodation where drug and alcohol misuse is commonplace. On the other hand, it is recognised that the behaviour of people who use substances may be disruptive or challenging to other residents of mainstream intermediate care facilities (Lane 2005).

Furthermore, rather than being understood in the context of patient choice and the need for person-centred care planning, debates around 'place of care' may be conflated with potentially

stigmatising assumptions about the characteristics of different user groups. For example, Lane (2005) reports how some GPs and hostel managers he interviewed expressed concerns that *'homeless people'* would not mix well with other users of intermediate care who *'tend to be elderly and extremely fragile both emotionally and physically'* (p44), thus overlooking the potential for complex and unique behaviours related to a variety of life chances and conditions (e.g. dementia).

Model 2: Housing-led (home based / floating support) step-down

The overall aim of this model is to provide housing-related support (floating support) in the community for between 6-12 weeks post discharge. Usually a 'housing worker' or team of housing support workers[8] will 'in-reach' into the hospital in order to identify and build relationships with patients. They will then link the patient to local homelessness services (sometimes having direct referral rights into these services) or offer some direct resettlement support. Workers may work on their own or within a larger (uniprofessional) hospital based homeless team or be seconded to a (generic) complex discharge or safeguarding team. Box 8 presents an example of a 'housing-led' HHD scheme.

Box 8: Healthy Futures, Derventio Housing Trust, Derby – Example of a Housing-led (Home Based/Floating Support) Step-down Scheme

The aim of Healthy Futures is to act as a bridge between hospital and home for people who face multiple and complex challenges cross cutting homelessness, mental health and drug and alcohol issues. The objectives are:

- To work with homeless people in hospital to broker housing and other related support in order to prevent delayed discharge from hospital and to deliver more timely and safer transfers of care.
- To work with people who disproportionately use acute services, known as "high impact users" in order to break the cycle of repeated use and make better use of primary care

Healthy Futures offers two levels of service:

1. **Full service**: to secure accommodation, broker an appropriate support package, provide liaison and advocacy, support the individual during the move from hospital to the community and intensive support in the community to help them live independently and use health services appropriately. The anticipated duration of this service is 12 weeks. 10 units of accommodation were initially earmarked by Derventio Housing for 'step-down' purposes. The housing worker has **'trusted assessor'** status and can carry out housing assessments on part of the local housing authority.
2. **Brief intervention**: For people whose situation is easier to sort out, to provide one-off housing advice, advocacy, signposting on the wards, supporting ward staff to ensure speedy discharge.

Initially, the project team consisted of a manager and 2.5 FTE link workers, funded by Clinical Commissioning Groups and local authorities working across three hospital sites. However, despite winning a national award and being able to demonstrate effectiveness and cost-effectiveness (to NICE standards), the service continues to rely on non-recurrent funding. This has led to a reduction in staffing and support being withdrawn from one hospital site. Currently, Healthy Futures is funded by a local authority (Chesterfield Borough Council) to provide 1FTE (full time equivalent) link worker, with management support. The link worker covers the Chesterfield Royal Hospital and the north Derbyshire area. It has three dedicated bed spaces in a house in north east Derbyshire to use to assist timely discharges. Derventio is also sourcing accommodation in Chesterfield for the project to use, starting with one self-contained flat.
www.derventiohousing.com/news/69/two-year-evaluation-of-healthy-futures.html

In terms of the need for a specifically commissioned set of out-of-hospital services, what distinguishes specialist HHD (step-down/floating support) schemes from other (mainstream) homeless resettlement services, is daily presence in the hospital and the connections and relationships that are built-up as a result. The fact that ward staff do not have to make a referral and then wait for an external agency to respond is key to maintaining patient flow and preventing delays. Importantly, delays will also be prevented because the HHD workers will have established good relationships with the housing authority and other homeless services. As noted in Box 8, the HHD worker is a ***'trusted assessor'*** and can carry out housing assessments on behalf of the local housing authority.

30 of the 52 HHD schemes funded through the HHDF operationalised this model of housing-led support. The early evaluation of the HHDF by Homeless Link (2016) highlighted that those schemes with direct access to units of step-down accommodation achieved much better outcomes than those schemes that did not have access to accommodation. Where patients are being discharged to Bed & Breakfast (or other forms of unsuitable accommodation) then patient experience is seriously compromised. However, the fact that the patient has access to an HHD worker at this difficult time is hugely valued for the advocacy and moral support this brings (see Box 9).

Box 9: Case Study – Discharge to Bed and Breakfast

Fred was in hospital for nearly three months and had nine operations linked to a heart condition. He had recently lost his home due to tenancy problems. While in hospital, Fred described how once his legs started to get better, social workers, housing officials and the ward manager all started *'kicking in'*. He was also referred to the HHD scheme in the hospital which was a 'housing-led' (floating support) step-down scheme (with no attached accommodation).

When it came to discharge planning, Fred described himself as, *"Getting stuck in a big battle… I nearly got evicted* [from the hospital to the street]. *They said `right you're medically ready to be discharged'.* [My HHD worker] *was there* [arguing my case] … *He got onto the Council and the Council sorted me out for that night in the Premier Inn of all places.'* Having spent two nights in the Premier Inn, Fred was then sent to another B&B in a seaside resort. The second B&B was up a big hill and a way out of town. This caused numerous problems for the management of his health conditions. Fred was told by his consultant that he must rest and *"do very little for the next six weeks".* However, to get his leg dressings changed he had to walk (in his slippers) down the hill to the local NHS walk-in centre: *"I did so much walking, I'm surprised my heart didn't give out and that I didn't have another heart attack."* Although the B&B provided breakfast Fred also struggled to eat at other meal times due to the distance to the town centre and lack of cooking facilities. Fred was placed in the seaside B&B for the weekend before being moved into a hostel and then back into B&B accommodation.

It was over a year before Fred was provided with somewhere he could call home. During this time, he had a succession of different key workers as he moved between hostels and B&B accommodation. During this time, he relied heavily on his HHD worker to chase things up, for example, if a housing application was started but not followed up. Although the HHD worker could not 'magic-up' a solution to Fred's housing crises, his continuous support and kindness made an enormous difference to him: *"He's done a lot for me… I've had really bad days and he's seen me when I've been in complete agony crying my eyes out because I haven't got anywhere* [with the housing] *and I can't do anything with my legs… It's just having somebody I can banter with, I know it sounds stupid, because sometimes we don't talk about the housing, we talk about everything else'*

Indeed, the value of this kind of very practical support post discharge should not be underestimated. We observed that one of the riskiest points in the transfer process was immediately after the person leaves hospital. Just as charities such as Age UK and the British Red Cross provide a vital service for older patients, such as turning their heating on and putting milk in the fridge, it is important to be clear **that a much enhanced logistical and intensive support service is required for patients who are homeless**. For example, in addition to the logistical challenges which go with trying to set up a new home from a hospital bed (often by means of patient transport), patients may also need to organise a methadone prescription on the day of discharge. They may be given a strict time slot when they can present for this. If this element of the discharge plan goes wrong, then the huge health and wellbeing benefits of a hospital stay (rest, care, kindness, treatment, emotional support, good food, detox for alcohol and getting off heroin and onto methadone) can evaporate in an instant (see Box 10).

What are the drawbacks of this model?

The main drawback of the 'housing-led' or link worker model is that it is uniprofessional, relying on the skill mix of a single profession to understand and resolve multiple support needs. Housing workers may not for example, be able to advocate as effectively on behalf of patients on clinical issues, such as methadone titration or around the need for elective or planned follow-up care. However, as we shall explore in the next section, this model can represent a very cost-effective compromise for hospitals that have a smaller number of homeless patients (as noted earlier a full homeless healthcare team would not be viable where there are fewer than 200 homeless patients seen in a year). In these contexts, key ingredients for successful transfers (*patient in reach, specialist discharge coordination and intermediate care*) can be delivered within a single job role, on a full- or part-time basis as required. In such circumstances, securing the support of a 'clinical champion' or some sessional in-reach by a specialist GP or nurse can compensate for the lack of a fuller homeless health care team.

Box 10: Need for practical help on the day of discharge

Dave spent 12 weeks in hospital due to a serious infection. On discharge, Dave was to be relocated to a supported housing project many miles from the hospital. He was taken by patient transport to the town where he was moving to. Heavily laden with all his worldly possessions, his first task was to collect a methadone prescription. The hospital had informed him that an appointment had been made for him at the drug service. On arrival at the drug service, he was told that they were not expecting him. Had he not been able to advocate for himself this would have jeopardized the huge steps toward recovery that had been made while in hospital as the only alternative would have been to use street heroin to avoid experiencing crippling withdrawal symptoms.

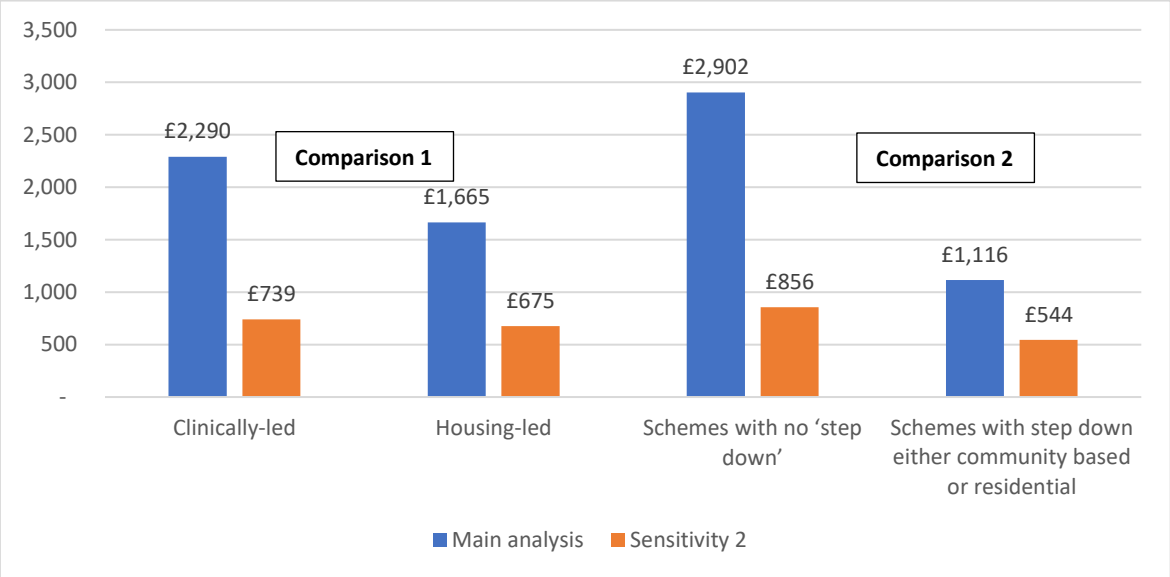
The 'move-in' day was further complicated as the supported housing provider assumed that patient transport would wait for Dave while he was at the drug service, transporting him and his belongings to the new property. As this was not the case Dave was left stranded in town. Having made his way to the new property, Dave was then upset by the fact that the project worker was unfriendly and seemingly only interested in extracting money from him for the upfront payment of his service charge. This would have left him without any money for basic necessities. In the weeks that followed, very little practical support materialised from the supported housing provider. There was no support to get registered with a GP and no attempt to put in place a 'recovery care plan'. Was it not for Dave's own resilience and high levels of motivation the benefits gained through the hospital stay could easily have been lost.

10: Cost-effectiveness of specialist homeless MDTs and 'housing-led' step-down models

As part of the study we carried out an economic evaluation of HHD schemes. First, we looked at the cost-effectiveness of 17 HHD schemes comparing these to a standard care control. In the standard care control (i.e. the patient was given a leaflet about homelessness but no other specialist support). Information about what happened to each person was then followed-up through linkage with Hospital Episode Statistics. There were 3,882 patients in the HHD cohort and 206 in the control group. We assessed cost-effectiveness by looking at the NHS costs associated with 'bed days avoided'.

As shown in Figure 3, specialist HHD schemes were more cost-effective than standard care.

Figure 3: NHS resources to be invested per bed day avoided



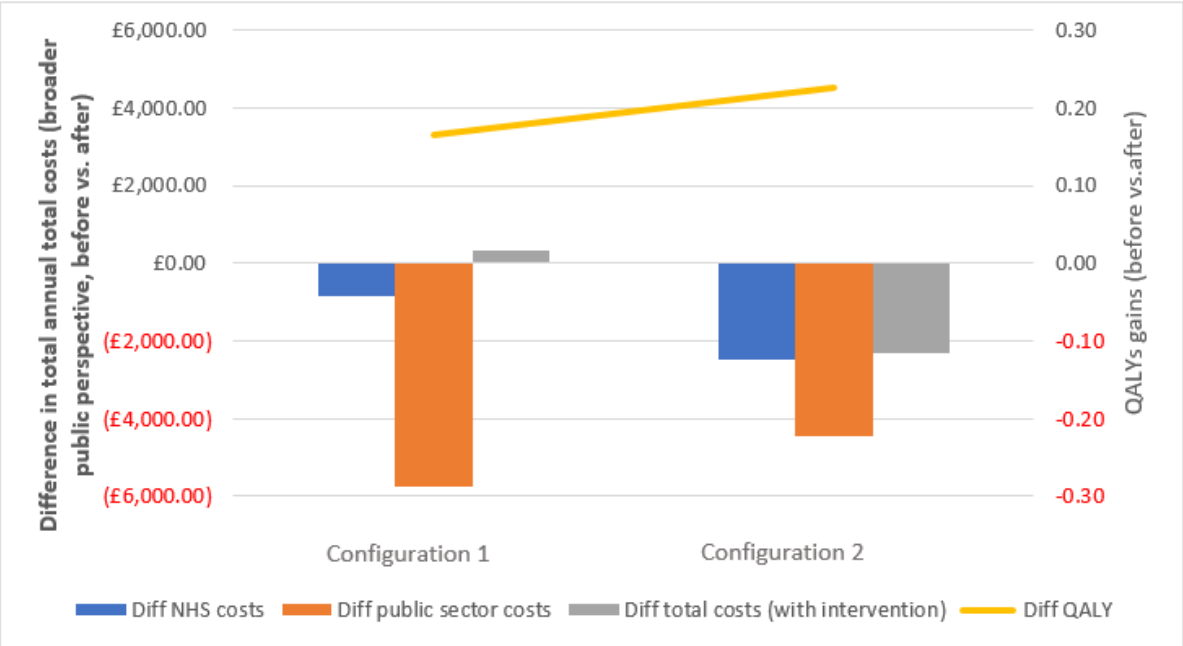
Comparison 1: Clinically-led v housing-led schemes (vs. standard care); Comparison 2: Schemes with and without 'step down' (vs. standard care). Main analysis: NHS resources included costs for all re-admissions (without service delivery costs); Sensitivity analysis 2: NHS resources covered costs for non-elective (emergency) re-admissions without service delivery costs).

Multidisciplinary HHD schemes that were clinically-led used more NHS resources than those that relied on housing-led floating support alone. However, the increased costs were associated with higher numbers of elective readmissions (that is planned readmissions for more treatment) (see Figure 3 [Comparison 1]). As 1 in 3 deaths among people in the HHD cohort are due to conditions that are amendable to timely health care, we see this as positive outcome. When looking at cost-effectiveness linked to bed days avoided for emergency readmissions, then both clinically-led and housing led schemes are equally as effective and cost-effective (Figure 3 [Comparison 1-Sensitivity 2]).

We also compared HHD schemes with and without access to step-down intermediate care. Again, looking at the NHS costs associated with bed days avoided, HHD schemes with direct access to intermediate care were more cost-effective (Figure 3 [Comparison 2]). In another outcome modelling exercise, we used a different control group comparing users of the 17 HHD schemes to homeless people admitted to the same hospitals but without being referred to the specialist scheme. This exercise also confirmed the finding about the advantages of HHD schemes with direct access to step-down. Schemes with direct access to 'step-down' saw an 18% reduction in A&E attendances.

Additionally, the economic evaluation took a more in-depth look at two out-of-hospital care configurations. The first configuration was a specialist housing-led residential step-down unit incorporating the input of a clinically-led homeless health care team (as described above). The second configuration (also described above) was a housing-led step-down (community/floating support scheme) that did not have access to clinical in-put. Here, we looked at cost-effectiveness in terms of costs to the NHS and wider public perspective for Quality Adjusted Life Years (QALYs). These are the costs associated with improvements in an individual's health and well-being that can be attributed to an intervention. We found both configurations to be cost-effective well within NICE parameters for QALY gains (see Figure 4).

Figure 4: Difference in total annual total costs (broader public perspective) and QALY outcomes per patient



According to the public provider perspective the average service delivery costs per homeless patient was £6,092.62 (configuration 2 [clinically-led/residential step-down]) and £2,036.62 (configuration 3 [housing-led/community step-down]). These figures are broadly comparable with those for other types of generic intermediate care (bed-based and reablement).[9]

When considering the economic evaluation findings, the different HHD scheme models and configurations cannot be compared like with like, as they are often meeting different levels of need and fulfilling different functions. The clinically-led homeless health care teams are mainly hospital based and most will not have direct access to step-down intermediate care. These HHDs are focussing mainly on patient in-reach and discharge coordination. The residential step-down scheme meanwhile, has higher costs compared to the housing led floating support scheme due to 'hotel costs' and will be catering for patients with more complex needs.

- ✓ **For system partners, the main implication of the economic evaluation is about the cost-effectiveness of each of these elements and the potential gains from having as many of these specialist supports in place as local resources will allow relative to need.[10]**

[9] NHS Benchmarking (2018) see: https://s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC%20(Providers)/2018/NAIC%202018%20England%20-%20infographic%20-%20brochure%20v3.pdf

[10] Bolton argues that the numbers of people who are likely to need support post hosptial are fairly consistent week by week from particular hospitals (though they do vary significantly between hospitals). So those who will need support from

While we have highlighted the importance of 'clinically-led' MDTs in increasing access to planned health care, it is also important to note just how effective and cost-effective are uniprofessional housing led HHD schemes. Most likely this is reflecting the value of good quality 'floating support' in bridging the gap between the hospital and the community. This is an important point because housing and community (voluntary) led services are often assumed by commissioners to be the *'icing on the cake'* and the therefore the most easily dispensable part of the out-of-hospital care system (Cornes et al., 2006). Arguably, this economic evaluation establishes that they are far more important than has hitherto been assumed in terms of adding value for both the NHS and the wider public sector.

11: What can dampen the effectiveness of HHD schemes?

There are a number of factors which can impact negatively on the performance of HHD schemes. The first is a lack of investment. As noted in the introduction, many of the HHDF schemes struggled to secure sustainable funding once the HHDF programme ended. Some ceased to operate altogether while others were progressively reduced in reach and scale, sometimes reducing the numbers of hospitals they were able to work with or reducing the size of the team (workforce). In one site, the increasing gap between workforce capacity and demand led to a range of problems including recruitment and retention difficulties (low team morale) and, ultimately, poor intervention fidelity. High, complex case-loads and insufficient staff led to an increasing focus on 'patient flow' (discharge coordination) at the expense of other aspects of the service such as engagement and relationships building (patient in-reach). Windows of opportunity for undertaking meaningful work with patients were also perceived to have become narrower, arguably reducing the ability of the team to impact on readmission rates. Here, patients described themselves as having only brief contact with the homeless health care team and the feedback was generally less positive than for the other sites:

> ***'At times our caseload feels really, really high and difficult to manage and at that point we do have to prioritise people who are going to be leaving within the next couple of days. When things feel a bit more settled we're able to do more of the inclusive, holistic work… Interestingly summer feels busier because we've got more annual leave in summer and I think that there is something about the winter in that there are more services open for homeless people'*** **(Homeless Healthcare Team Nurse)**

Nationally, it is recognised that all types of intermediate care (for all patient groups) remain 'curiously invisible' to commissioners and that there is a need for a step change in investment in intermediate care services to ensure great impact on the full range of key metrics such as reducing DTOCs and readmission rates (National Audit of Intermediate Care, 2015 & 2017). In one study for example, it is suggested that reablement provision needs to be increased by 200% (Newton Europe, 2019). It is a commitment of the NHS Long Term Plan that:

> ***'Over the next five years all parts of the country will be asked to increase the capacity and responsiveness of community and intermediate care services to those who are clinically judged to benefit most… Recovery, reablement and rehabilitation support***

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domiciliary/home care each week; who may require bedded facilities (for a short period) can be calculated. He suggests that once we know the percentage figures for each hosptial it is realtively straightforward to predict demands on the care system. Broadening this audit to include needs for 'housing-led' step down would be relatively straightforward. See also guidance by Pathway on undertaking a needs assessment for medical respite: www.pathway.org.uk/wp-content/uploads/How-to-do-a-needs-assessment-for-a-medical-respite-service-July-2018-v2.pdf

> ***will wrap around core services to support people with the highest needs'*** **(NHSE Long Term 2019 p14)**

However, by far the most important factor that can limit the performance of the HHDs is the wider context in which they are situated. The findings of this study strongly support those of the national evaluations of intermediate care for older people where it is reported that:

> ***'The effectiveness of interventions to improve the speed and quality of discharge will depend to a large extent on the broader service context in which they take place. Interventions that are shown to work well in areas with well-resourced and efficient community support services may have little or no impact where services are inadequate or lacking'*** **(Barton et al., 2006)**

This is especially the case in areas where there is a shortage of step-down accommodation and where floating support is provided into Bed and Breakfast accommodation or other kinds of unsuitable accommodation. The shortage of services and move on options also means that intermediate care can quickly become blocked, and that these 'time limited' interventions start to substitute for long-term care:

> ***'You might refer them to the Personality Disorder Services or whatever, and the person won't hit their criteria… The you'd start pushing onto social services… and slowly and slowly everybody says, "Well they're not my problem." That's the cohort we are dealing with. All the services have raised their criteria, so these people are missing out…'*** **(HHD Scheme Worker)**

12: Commissioning specialist support as part of the wider out-of-hospital care system

In this final section, we consider how HHD schemes might be conceptualised and commissioned as part of the wider out-of-hospital care system.

First, we suggest that it may be helpful if local system partners (especially those with responsibilities for BCF) view these specialist developments as part of the broader imperative to integrate housing as the ***third pillar*** of intermediate care. Recently, a National Memorandum of Understanding was signed by over 25 stakeholders, emphasising the importance of housing in supporting people's health - setting out a shared commitment to joint action across Government and health, social care, and housing sectors in England:

> ***'Integrated health, care and support, and housing solutions could make best use of the budgets across the NHS, local authorities and their partners to achieve improved outcomes for less; for example, drawing on the Better Care Fund to support service transformation'*** **(National Memorandum of Understanding, 2018 p2)**

It should be noted that 'housing-led' intermediate care does not cater exclusively for people who are homeless. Many schemes have already been developed nationally catering for older people and people with mental health problems as well people who are homeless. For example, One Housing Group in London provides ten step-down beds in an Extra Care facility for older people (for more examples, see National Housing Federation and Housing LIN, 2017):

> **'*The key components of this 'housing' sector wide offer are: more step-down units or beds nationally which can facilitate efficient discharge and more housing staff seconded to discharge schemes locally to coordinate and speed up transfers of care'* (National Housing Federation and Housing LIN, 2017 p3).**

Housing-led intermediate care is important because it provides an alternative pathway out-of-hospital for those adults who do not require the support of a 24-hour care home, but who are not quite fit enough to receive reablement at home or whose discharge/reablement at home is not possible due to a housing problem. This might be:

- A need for major adaptations to the home;
- A need for a 'deep clean' due to self-neglect; or
- No home to return to due to homelessness.

If we encompass housing as the third pillar of intermediate care, then Bolton's *'Managing the Flow Out-of-hospital'* road map would be reconceptualised as shown in Figure 5b (below). We stress that it is important to conceptualise the 'out-of-hospital 'care system as an **integrated whole** because, as discussed above, there is a need for people to be able to move seamlessly between the different components depending on their needs. As noted earlier, periods of rough sleeping are associated with early ageing meaning that some people in their 40's and 50's will be frail or in need of palliaitve care. As a result, their needs may be better catered for in a (generic) care home (with nursing) facility especially if there is no dedicated specalist residential facility for people experiencing homelessness. In Bradford, for example people will sometimes spend time in a care home with nursing before being moved to BRICSS for a further period of step-down and reablement. Having this further tier of housing led step-down, provides reassurances to commissioners and managers that people who are homeless will not become stuck in expensive care home beds because they have no home to go to. We heard reports in our fieldwork of exclusions from services (e.g. care homes and neurological rehabilitation facilities) being applied to people who were homeless due to this reason.

However, perhaps the most compelling economic case for 'housing-led' intermediate care comes from recent diagnostic research where it has been shown that older people who experience a delayed discharge are often discharged to a setting where their needs are **over-catered** for (i.e. to a setting providing a more intense level of care than would have maximised the individual's independence) (Newton Europe, 2019). In other words, housing-led intermediate care would offer some patients with a better (more enabling and more likely to help them build their independence rather than dependence) alternative to the much more expensive option of a potentially long-term care home arrangement. For patients who are homeless, where the problem has traditionally been **under-catering** for their needs with consequent high numbers of readmissions, then these 'housing-led' developments with support from clinically-led MDTs will offer a much more cost-effective, compassionate, humane option.

Figure 5a Home First Road Map (prior to implementation of HHDF)

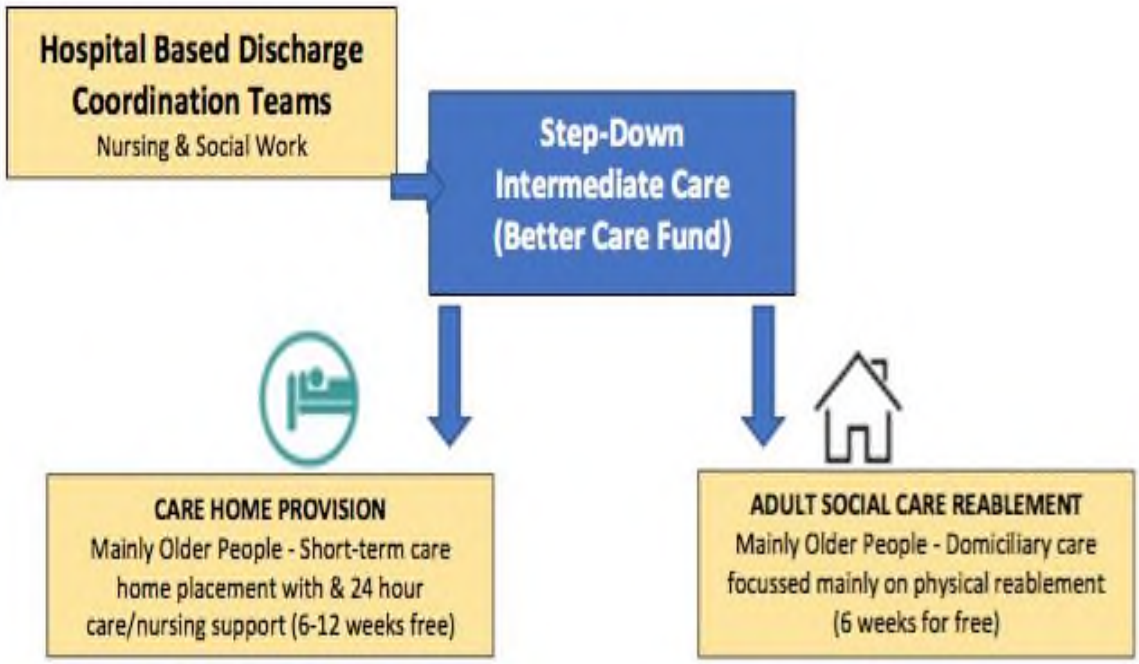
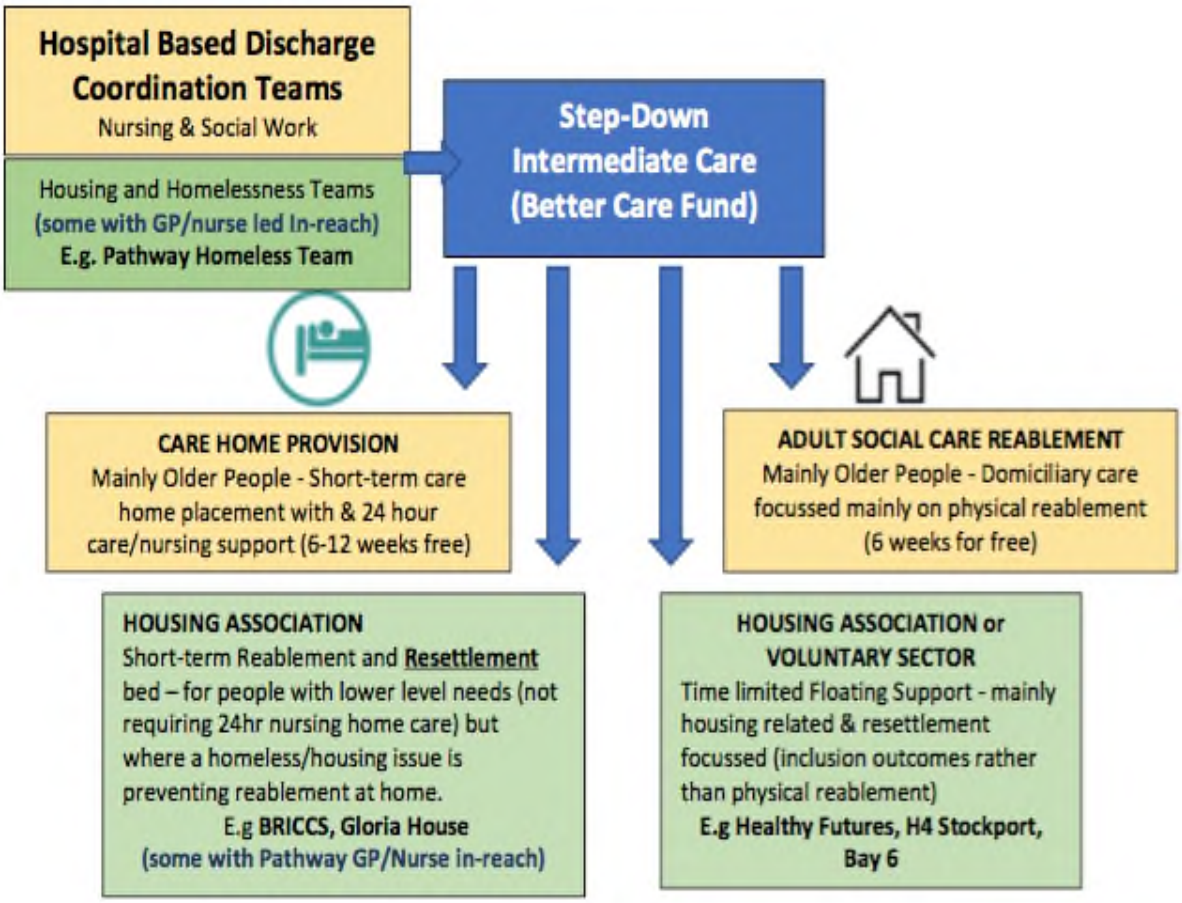


Figure 5b: Home First Road Map Reconceptualised Post HHDF – Integration of Specialist Clinical MDTs and Housing as Third Pillar of Out-of-hospital Care



13: SUMMARY

1. Hospital discharge has always been a challenge for the NHS. However, there is increasing evidence about '*what works'* to facilitate safe timely transfers of care. This evidence has been synthesised by the Local Government Association and partners in a High Impact Change Model (HICM).
2. The HICM aims to support local system partners to minimise unnecessary hospital stays and to encourage the implementation of new interventions. Interventions outlined in the HICM include:
    - multi-agency discharge coordination teams and
    - Home First, encompassing 'discharge to assess' (D2A) and intermediate 'step-down' care.
3. The evidence underpinning the HICM is mainly focussed on older people, and much of the funding (e.g. Better Care Funding) for out-of-hospital care is targeted at this patient group. This Support Tool draws on new research to show how HICM interventions can be tailored to meet the needs of patients who are homeless.
4. We need to ensure out-of-hospital care is accessible to patients who are homeless because they are at high risk of early ageing and premature death. A third of the deaths among patients in our homeless hospital discharge study cohort were due to common conditions such as heart disease that may have been prevented with better access to timely health care.
5. Strengthening out-of-hospital care for this group is also important because homeless inpatients are more likely than others to be readmitted in an emergency, with five times the rate of unplanned hospital readmission and five times the rate of A&E visits than housed people from deprived neighbourhoods.
6. The overall aim of this research was to explore the effectiveness and cost-effectiveness of specialist integrated homeless health care targeted at improving hospital discharge. We worked with 52 specialist homeless hospital discharge (HHD) schemes that were being piloted in different locations across England (from 2013 onwards) with grant funding from the DHSCs 'Homeless Hospital Discharge Fund' (HHDF).
7. The HHDs were employing HICM interventions in different ways and in different combinations. Some offered a specialist discharge coordination service (ending support when the patient left the acute sector/hospital) while others combined discharge coordination with a period of 'step-down' intermediate care. Specialisation or sensitisation was mainly at the level of skills and staffing (e.g. employing clinicians and other professional and non-professional workers who had specialist interests or knowledge of housing and homelessness). The integration of housing alongside health and social care was another defining feature of the HHDs, for example, using 'step-down' accommodation provided through a housing association as an alternative pathway out-of-hospital to a care home placement.
    - The most common model was for a housing worker to 'in-reach' into the hospital - building relationships with patients on the ward, assisting with discharge coordination and then offering short term 'step-down' peripatetic (floating) support until housing and longer-term community services were in place and working well.
    - In hospitals with high numbers of homeless patients (200+ per year) housing and resettlement support was often embedded as part of a specialist 'clinically-led' multi-

disciplinary team comprising General Practitioners (GPs), nurses, therapy and social work staff. Homeless health care teams undertake discharge coordination, but also offer 'clinical advocacy' (or primary care or patient in-reach) to address common problems such as early self-discharge. These teams usually close cases at the point of discharge and do not routinely provide step-down.

- A smaller number of sites developed dedicated residential step-down facilities exclusively for patients who were homeless. Others allocated 'step-down' beds in homeless hostels or earmarked accommodation that was dispersed in the community.
- One of the sites had access to both a clinically-led multi-disciplinary homeless health care team and also a 14-bed dedicated residential step-down facility. This site was employing additional HICM principles to create a fully joined-up or integrated pathway out-of-hospital. For example, using 'trusted assessors' so that homeless patients had to tell their story once (i.e. staff at the hospital had direct referral rights into the intermediate care facility thus preventing the duplication of assessments) and 'flexible working' with staff from the hospital based homeless care team providing clinical support into the step-down unit to ensure continuity of health care.

8. The research employed mixed methods to evaluate a range of possible combinations/schemes. This included in-depth qualitative fieldwork in 6 sites, comparing sites with (different) specialist homeless hospital discharge arrangements to those which relied on standard care. Additionally, quantitative data were collected on outcomes for 3,222 homeless patients who had used a specialist discharge scheme. The economic evaluation used a range of different modelling techniques to explore different local configurations from different perspectives.
9. There was strong evidence from the research that the introduction of specialist homeless hospital discharge arrangements that sensitised key HICM interventions for multi-disciplinary discharge coordination and/or intermediate care 'worked' to improve patient experience and outcomes by delivering safer transfers of care, reducing delayed discharges and increasing access to planned health care. Overall, specialist care was shown to be more effective and cost-effective than standard care.
10. HHD schemes that combined both discharge coordination with direct access to intermediate care were more effective and cost-effective than those schemes that did not, reducing A&E attendances by 18%. This points to the importance of developing out-of-hospital care as a 'complex adaptive system' with many different component parts (depending on local need) rather than as single service or stand-alone intervention. Importantly, people should be able to move seamlessly through the whole range of supports in the complex adaptive system depending on their needs. Age-restrictions and other barriers should not apply.
11. Where community services were inadequate or lacking then this could dampen the effectiveness of HHD schemes. Monitoring patient flow through the complex adaptive system and identifying any pinch points was key to preventing intermediate care from becoming 'blocked'.
12. Despite these positive results many of the HHDs did not secure continuation funding once the initial pilot funding ended. One reason for this may have been that they developed largely in isolation from other work to improve 'patient flow' through the hospital.

The most important learning from our research is that any work to address homelessness at the point of discharge must be integrated as part of national and local strategic frameworks for developing pathways out-of-hospital.

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Appendix 1: Unplanned Hospital Discharge Case Studies

The story of the Gutter Frame Challenge

Tuesday

0 miles

Mrs A has been in hospital for nearly three weeks. She is offered a flat many miles from the area she calls home but does not want to take it - her preference is to go to a local hostel where she would have some company and support. Having spent many years living on the streets, Mrs A does not feel ready to have her own place yet. Mrs A is told that the flat is the only option available and that she must leave hospital if she does not take it.

0.6 miles

Mrs A is discharged from hospital to the street and told to present at a specialist homeless GP practice at 9am the following morning to organise a methadone prescription. She has had a long wait for her medications to arrive and it is now 7.30pm. She is very upset and crying. It is the middle of winter and cold and wet outside. Following a brutal assault on the street which put her in hospital, Mrs A is unable to walk without a gutter frame. This is heavily ladened with all her worldly possessions in plastic bags. Walking is painful and slow and any unevenness in the pavement causes dangerous instability. Mrs A has no money and it is a 0.6 mile walk to her usual sleep site: she sleeps in a shop doorway where there are security cameras and where the security guards know and look out for her. She has a panic alarm, but the batteries are dead. The man who assaulted her was never apprehended.

Wednesday

1.7 miles

Mrs A sets off early to get registered with the GP and to get a methadone prescription. It is a 1.1 mile walk to the surgery and access is on a first come, first served basis. Mrs A gets there in good time but the gate to the disabled access ramp is locked. By the time someone opens it, there is a long queue and Mrs A is now at the back. The surgery is warm and welcoming and caters specifically for people who are homeless. Mrs A is offered a much needed cup of tea.

2.3 miles

At 10.30 am Mrs A is called in to see the nurse. The nurse calls in the GP immediately as she is concerned that Mrs A has been discharged to the street. The GP phones the ward to find out what has happened and is angry that responsibility for this situation has been passed to him. It is agreed that Mrs A's health needs are such that she should not be on the streets, but that she cannot return to hospital. The only option is an intermediate care bed - these are hostel beds funded by the NHS. There are only two intermediate care beds for women in this borough and they are in exceptionally high demand. The GP does not have 'referral rights' into the beds so she tells Mrs A that she must come back to the surgery first thing in the morning to be assessed by the scheme coordinator. Mrs A is advised to go the local homeless day centre to see if she can access emergency accommodation for tonight. The receptionist phones ahead to make the case that Mrs A is a priority. The centre is 0.6 miles from the surgery.

3.7 miles

At the homeless day centre, there is no disabled access to the service user reception area so Mrs A must access the building through the entrance reserved for visitors. The message from the Doctor's surgery has not been received and she must tell her story once more. The worker agrees that Mrs A is vulnerable and rings around to see if she can find her a bed for the night. Good news! There is a bed available in a local women's hostel. However, the doors do not open until 9.30pm and Mrs A must now kill a significant amount of time as it is only 3.30pm. Mrs A is exhausted and feeling sick. She has been laid-up in a hospital bed for the last three weeks, and

today's exertions are a shock to the system. Just as she is about to leave the day centre, Mrs A thinks to ask if the hostel has disabled access. The worker goes off to check and returns to tell her that there are stairs. Mrs A has now run out of options. The day centre tells Mrs A there is nothing more they can do. It is a 1.4 mile walk back to Mrs A's sleep site.

Thursday

4.8 miles

Mrs A is physically exhausted and emotionally drained from yesterday. She does not complain, but there is a grimace on her face when she tries to push the heavily laden gutter frame. She has septic arthritis and her joints are painful and inflamed. She is still on antibiotics. Before getting back to the Doctor's surgery for 9.15am, Mrs A must collect her methadone. The GP insists that Mrs A uses a specific chemist which is a 1.1 mile walk from her sleep site. From the chemist, it is a further 1.6 mile walk back to the Doctor's surgery. The surgery is exceptionally busy. Although advertised as a flexible service, in reality everyone has the same appointment time and late comers are turned away, such is the demand for this service.

6.4 miles

At 11.30am Mrs A sees the nurse who assesses people for the intermediate care beds. Mrs A recounts her story once more. The nurse tells Mrs A that these beds are for 'health and not social reasons'. Hearing this, Mrs A's heart sinks as she assumes that she will not be eligible. However, the nurse is concerned about Mrs A's ability to manage her medications: Mrs A has a carrier bag full of pills. The nurse phones through to the intermediate care bed coordinator to try to reserve a bed for Mrs A, but there is no reply. She tells Mrs A to wait for news in the reception area.

6.6 miles

While she is waiting, the nurse advises Mrs A to go to a local chemist to see if she can get the medications put into a dosset box. The nurse says she will have to pull in a favour, as pharmacists usually only handle medication they have dispensed. It is an 0.2 mile walk to the chemist. The pharmacist is concerned by what he sees in the carrier bag that has been dispensed by the hospital and phones the GP to alert her. A plan is hatched to box-up a few day's supply, and for Mrs A to have a medication review next week. The chemist is busy and asks Mrs A if she can return at 3pm. It is now 12.30pm so she has a long time to wait around in the cold. Mrs A is exhausted and wonders if it just might be easier just to give-up and go back to her sleep site.

6.8 miles

After picking-up the dosset box, Mrs A walks the 0.2 miles back to the Doctors' surgery and takes a seat in reception. After half an hour the receptionist comes over to ask why Mrs A is here. Mrs A explains that she is waiting to hear news about an intermediate care bed. Another receptionist makes some phone calls and returns to say that a bed will be available tomorrow night. She asks Mrs A where she will be sleeping tonight. When she hears that it will on the street she goes off again and later returns to say that a bed has now been found and that a taxi will be coming to pick her up. Mrs A is very grateful that the receptionist is so kind and has gone the extra mile. Seeing how tired Mrs A is, the receptionist organises the paperwork that Mrs A must sign. This includes a 'care plan' outlining the rules by which she must abide. At 3.30pm the taxi arrives. The bed is only short term, but at least Mrs A now has ten day's grace from the cold and wet.

Postscript

In order to access care and support following her discharge from hospital, Mrs A was expected to walk 6.8 miles in winter with her gutter frame and all her worldly possessions. The researchers who helped Mrs A tell this story paid for her to have taxis and hotel accommodation rather than let her sleep on the street. Without this practical assistance, we believe this would have been an impossible challenge.

A story about the cycle of A&E attendances, discharges to the street & multiple readmissions

Mr B visits the GP on 1 May 2019 as his health has worsened. He suffers from COPD, PTSD and bi-polar disorder and recently started to drink heavily to manage his deteriorating mental health. Mr B is referred to the CMHT but the referral is not accepted. He is a former rough sleeper now living in supported accommodation for veterans but feels unsupported by staff and fellow residents.

13 – 16 May 2019

Mr B has severe stomach pains and is taken to A&E and admitted to Hospital 1 for two nights. He is discharged with 20 codeine, but the following day takes an accidental overdose. He has forgotten how much codeine he has already taken due to his drinking. Mr B is re-admitted to A&E but discharged the same evening, after assessment by psychiatric liaison, with no follow-up plan.

20 May – 2 June 2019

Mr B has been drinking heavily – he has a violent outburst and damages his accommodation. He is evicted to the street with one hour's notice. A friend is so concerned about his mental health and substance misuse they take him back to A&E at Hospital 1 where he is admitted to the assessment ward. After two nights Mr B is told he is fit for 'discharge home'. Mr B does not have a home and his friend reminds staff that they have a 'duty to refer' so Mr B's discharge is delayed. The friend makes a safeguarding referral to adult social care. Meanwhile, Mr B is passed between the psychiatric liaison and medical teams until finally, a case conference is convened. The hospital discharge team start a Care Act 2014 assessment.

3 - 17 June 2019

Before the Care Act or any other assessments are complete, Mr B is discharged from Hospital 1 to the local authority housing service with no discharge letter or plan. Mr B is placed in temporary accommodation, but it is inappropriate for his needs. Two days later concerned accommodation staff call the CMHT, who in turn call an ambulance. Mr B is readmitted to Hospital 1 A&E, and from there to the psychiatric unit. After six days on the unit Mr B is discharged to the street because of drinking on the ward. It is 6pm and Mr B is homeless. He travels to the centre of London to sleep rough. The next morning Mr B is found unconscious on the street by police and taken to A&E at Hospital 2. He spends five days on an assessment ward and when a bed becomes available, he is admitted to a psychiatric unit at Hospital 3, in another area of London.

18 June – 3 July 2019

Whilst in the psychiatric unit at Hospital 3 Mr B asks that a 'duty to refer' notice be sent to the housing service. This is refused, so his friend contacts the housing service to make an appointment. The first available is 4 July. After 11 days in the unit Mr B is discharged to the street with no support, and no inhalers for his COPD. Staff know there are six days until his housing appointment. Having nowhere else to go, Mr B sleeps rough in the hospital garden. Staff take him food but do not act to safeguard him. After five nights Mr B is found collapsed, due to exacerbation of his COPD. He is taken to Hospital 3 A&E but self-discharges to the street as he is made to feel unwelcome by staff.

4 – 12 July 2019

It is finally the day of Mr B's housing appointment, but he is very ill due to exacerbation of his COPD from sleeping rough. Instead of attending the vital appointment, Mr B attends Hospital 4 A&E and is admitted to hospital. After one week, Mr B is 'signposted' to the local housing authority where he is at last provided with temporary emergency accommodation. However, the property is a bus ride away and Mr B has no money or directions. Mr B has to sleep rough that night. The following day he moves in. The accommodation is temporary so now Mr B is looking for somewhere to go next…