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Home First Discharge to Assess and homelessness

Updated support tool and briefing notes complementing the High Impact Change Model for managing transfers of care

March 2023

Local Government Association | directors of adass adult social services | Partners in Care and Health

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In memory of Darren O'Shea (1977-2021)

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Disclaimer

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Foreword

I am a 48-year-old woman who has "lived experience" of being discharged to the street from hospital. This often happened late at night. I would be wearing my slippers, hospital gown and cardigan (no coat). I would have a few carrier bags of belongings and a large paper bag of medications. I am disabled and need to use a walking frame. When I left the hospital, I was told that I should not be using my "gutter frame" outside. The fact that I had nowhere to stay was not seen as the hospital's concern. My experience was far from unusual. In 2012 it was reported that up to 72 per cent of people who were homeless were discharged back to the street.

Since I first told my story in the "gutter frame challenge" much work has been done to evidence the importance of out-of-hospital care. I now volunteer as a peer researcher and have been talking to people using the new step-down services that have been set-up across the county as part of a Department of Health and Social Care's (DHSC) £16 million funding programme. I have been asked to write this forward to explain why these services are so important and why they should be commissioned in every area of England. Once pilot funding ends these services are still vulnerable to the perception that areas can do without them. We need to challenge this and to use this report to guide the development of high-quality services that care for both patients and staff.

Having somewhere safe to stay after hospital is vital if you are experiencing homelessness. After you have spent time in hospital, especially if you have had surgery, you are still recovering, your body is still healing, so you need to rest up while your body gets over the trauma or whatever the reason was why you ended up in the hospital in the first place. For people who are homeless rest and recuperation is more important than ever to enable you to feel human again.

Step-down can also be the starting point for turning your life around. It can be the beginning for someone to either get clean, to stop drinking and to help someone get in a routine with their daily activities. It also gives the person the chance to talk about what they have been through and if they need extra support like counselling or help with their addictions. It also stops the hospitals from becoming "bed blocked" with patients that have nowhere to go but who still need further assessments and support.

When a step-down facility is being set-up, you need to think about the environment. As many homeless people will be frail after leaving hospital, the building needs to have disabled accesses. Wet rooms are especially important to enable people to manage their personal care. Step-down should be for everyone who has a need for health and social care including people experiencing domestic violence, asylum seekers, and people with No Recourse to Public Funds (NRPF).

Most important of all, you need staff who are caring and empathetic. Being a good listener is so important. Trust me, speaking from experience all people want is someone to talk to them and to really listen to what they have to say.

I saw a gentleman in step-down recently who had smoked a substance that morning and I was told by staff that I couldn't see him to which I replied if he wants to talk to me then I would like to see him. When I met him, he sobbed his heart out because "No one EVER wants to talk to addicts" that was his own words. It broke my heart because I know where he is coming from as people treated me the same way for so many years. Putting YOUR prejudices to one side and ensuring everyone has a voice and is included is so important when developing and delivering out-of-hospital care.

At the same time, you need to make sure that you have enough staff so they can really take the time to listen and work with step-down patients. Often there is much practical work to be done, helping people get physically and mentally better and then helping them to get ready to move on. Having one staff member do the job of five people ends up with that staff becoming burnt out and leaving, and people feeling like they are just being warehoused. We must make sure there is proper support for the staff working in step-down as well as the patients. It is a tough and emotionally challenging job, but one that makes the world of difference to people like me.

Joanne Coombes

Discharge to Assess and homelessness

What works?

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). This was updated in 2020 to reflect the emerging learning from responding to the COVID-19 pandemic and the national policy shift that put a Home First Discharge to Assess (D2A) approach centre stage.

D2A requires staff across the health, housing and social care system (including the voluntary and community sector) to understand the importance of discharging people from hospital as soon as possible after their acute treatment and that assessment of a person's long-term care needs is best made in their usual place of residence, after a period of reablement or rehabilitation support where appropriate.

Support for people leaving hospital has been designed mainly with older people in mind, however research shows that patients who are homeless are at high risk of early ageing and premature death. One in three deaths of people in this hospital discharge cohort were due to common conditions such as heart disease that could have been prevented with timely health and care support.

There is a strong imperative to address this not just by better preventive working, but by ensuring that D2A is accessible to all adults who could benefit, including patients who are homeless. A recent guideline from the National Institute for Health and Care Excellence (NICE) draws on evidence from research that shows specialist intermediate care and other out-of-hospital care services for homeless patients are value for money. These services need to be integrated as part of D2A Pathways (0-3) ensuring alternative options for people who cannot go straight home. The briefing notes attached to this support tool give examples of specialist services that can be developed as part of D2A, highlighting the local innovations that are happening to tackle such a significant health inequality. Below we highlight the importance of embedding the nine High Impact Changes in these new service developments.

Evidence from our research that specialist out-of-hospital care 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 hospital discharge teams had fewer delayed transfers of care compared to those that relied on standard care.
- Homeless hospital discharge teams employing specialist GPs and nurses **increased access to elective follow-up care.**
- Homeless Teams with direct access to a 'step-down' service had a reduction in subsequent hospital use, with **18 per cent fewer A&E visits** compared to teams without 'step-down'.

What does the 'Hospital Discharge and Community Operating Model' (DHSC, 2022) say about D2A and homelessness?

- The needs of people who are homeless need to be considered as part of D2A and local commissioning plans should include the provision of specialist support.
- Multi-disciplinary teams working though transfer of care hubs should include Homeless Hospital Discharge Teams and other housing expertise.
- All D2A pathways (0-3) should be accessible to patients who are homeless and organised via a referral through the transfer of care hub.
- The statutory 'duty to refer' (Homeless Reduction Act) should be embedded as part of the D2A process and should not be seen as a separate "Homeless Pathway".

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, a joint crisis response for people living at home and in care settings can prevent unnecessary admission. However once admitted, an expected date of discharge should be set as soon as possible.

Sensitivities for homelessness:

- 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.
- Homeless Hospital Discharge Teams (or Housing Workers) undertake specialist ward rounds to identify patients who are homeless and start discharge planning at the earliest opportunity.
- Homeless Hospital Discharge Teams, Housing Workers or advocacy arrangements are put in place to support patients who are homeless to have their voices heard in discharge planning.
- There is good legal literacy around the 'Hospital Discharge and Community Operating Model '(DHSC, 2022) 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 referral to the transfer of care hub.
- "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 using real-time data about demand and capacity taking a joint approach to shaping the price, flow, quality and shape of the market. While councils remain the lead commissioners and retain their Care Act duties, a joint approach is key to developing step-down facilities, integrated health and social care support and work with the voluntary sector.

Sensitivities for homelessness:

- There is a locally agreed '**Homeless Hospital Discharge Protocol**.' The protocol might recognise, for example, that as part of D2A the local housing authority has the power to implement fast track and integrated systems to expediate the discharge of those who are homeless or living in poor and unsuitable accommodation.
- Delays due to housing and waiting for housing assessments are properly recorded in acute hospital situation reports.
- Partners use a **shared understanding of system flow** to coordinate service delivery (for example, hospitals do not 'signpost' homeless patients to housing unannounced).
- **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.
- **Flow across the system** is smooth, timely, safe and effective. Safeguarding referrals are raised where this does not happen.

High Impact Change Model (HICM): Checklist of sensitivities for homelessness

Change 3: Multi-disciplinary working

Effective discharge and positive outcomes for people are achieved through discharge planning based on joint assessment processes and protocols, shared and agreed responsibilities, and good conversations with, and information for, people and families. Working together with the individual at the centre results in a more timely, safer discharge to the right place for them.

Sensitivities for homelessness:

In hospitals that see 200+ homeless patients per year, ward staff will have access to a specialist multi-disciplinary homeless hospital discharge team offering Patient in-reach (clinical advocacy).
The purpose of clinical advocacy is to:

- To reduce stigma and promote dignity on the ward, for example providing patients who are homeless with toiletries and clean clothes.
- To prevent early self-discharge, for example advising on substitute prescribing for patients with substance misuse issues.
- To improve access to elective (planned follow-up) health care. This is especially important because research suggests one in three homeless patient deaths are due to common conditions such as heart disease and cancer that are amenable to timely healthcare.
- Specialist discharge coordination via the transfer of care hub…
- To provide patients who are homeless with a named point of contact providing expert advice on housing legislation and options and referral onto homelessness service provision.
- To facilitate 'Discharge to Assess' (D2A) or the coordination of a joined-up discharge plan – across all relevant agencies, for example adult social care; drug and alcohol services; mental health.

Change 4: Home First Discharge to Assess

This means people going home as soon as possible after acute treatment. It means always prioritising and, if at all possible, supporting someone to return to their usual place of residence before considering other options, because home is best.

Sensitivities for homelessness:

- Patients discharged on Pathway 1 receive a welfare check on the day of discharge and settle-in support (especially where hotels are being used for discharge).
- Have '**breathing space**' before making decisions about life changes, including new accommodation and support. There are specialist D2A Pathway 2 (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.
- Arrangements are in place for 'trusted assessment'. Patients only have to tell their story once as homeless hospital discharge teams have direct referral rights into specialist 'step-down' intermediate care.
- There is enhanced health care (specialist 'clinical in-reach') to support genuinely integrated care planning in 'housing led' step-down. Pathway 3 and the wider out-of-hospital care system is accessible to people who are homeless where there are more complex health needs.
- 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.
- If support extends beyond 12 weeks local system partners take action to address 'bottle necks' and 'pinch points'.

Other HICM Changes:

Change five: Flexible working patterns – Services are available 24/7.

Change six: 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 seven: Engagement and choice – Having a robust choice protocol, underpinned by a fair and transparent escalation process. 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 eight: Improved discharge to Pathway 3 care homes – Ensure long-term care services are easily accessible to people under 55 years of age, eg where chronic homelessness has led to early ageing/complex health and care needs.

Change nine: Housing – Effective referral processes and alternative pathways for people who cannot go straight home. See also: Improving health and wellbeing through housing: A High Impact Change Model' and could we link to this www.local.gov.uk/publications/improving-health-and-wellbeing-through-housing-high-impact-change-model

D2A Briefing notes 1: Introduction

> Home First Discharge to Assess 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.
>
> (Local Government Association, High Impact Change Model 2020)

In 2019, King's College London and partners published an evidence-based support tool outlining how commissioners and providers could develop specialist out-of-hospital care services for people experiencing homelessness (Cornes et al, 2019). Out-of-hospital care is an umbrella term for a wide range of intermediate care (step-up/step-down) services that facilitate D2A by bridging the gap between hospital and home.

The first support tool was designed to complement the Local Government Association's (LGAs) 'Managing Transfers of Care – A High Impact Change Model' (HICM). The HICM is designed to support local system partners to consider new interventions, designed to improve health and wellbeing, minimise unnecessary hospital stays. It is not a performance management tool but a vehicle for self-improvement. The model is endorsed by government though its inclusion in the Integration and Better Care Fund (BCF) policy guidance. The 2020 HICM identifies nine system changes:

Change one: Early discharge planning

Change two: Monitoring and responding to system demand and capacity

Change three: Multi-disciplinary working

Change four: Home first discharge to assess (D2A)

Change five: Flexible working patterns

Change six: Trusted assessment

Change seven: Engagement and choice (person-centred and strengths-based approaches)

Change eight: Improved discharge to care homes.

Change nine: Housing and related services

In 2020, the HICM was updated to reflect the emerging learning from responding to the COVID-19 pandemic and the national policy shift that put **(Change four) Home First Discharge to Assess (D2A)** centre stage. This refreshed and updated support tool considers how these changes can be made to work effectively for people leaving hospital who are experiencing homelessness. It also describes practical ways in which a NICE guideline for specialist integrated (intermediate care) can be implemented in different local contexts.

In updating the support tool, we draw on the final published report of the National Institute for Health Research (NIHR) evaluation of Improving Care Transfers for Homeless Patients After Leaving Hospital. Evidence from this study informed the development of the new NICE guideline. Additionally, we have incorporated examples of emerging and developing practice based on the early learning from the Department of Health and Social Care's (DHSC's) Out-of- Hospital Care Models (OOHCM) programme for people experiencing homelessness. This provided £16 million investment across 17 test sites to 'roll out' specialist homeless out-of-hospital care services across England. Although the evaluation of this Programme is still ongoing, it has already generated new case studies, further economic evidence and provides a sense of what 'good' looks like in the context of the new hospital discharge operating arrangements.

2: Home First Discharge to Assess (D2A)

Overview

This section gives a brief introduction to the Department of Health and Social Care's (2022) policy guidance on 'Home First Discharge to Assess' (D2A). It also covers the evidence for commissioning specialist out-of-hospital for people who are homeless as part of D2A, and the new NICE guideline.

Prior to the COVID-19 pandemic hospital discharge regulations were set out in the Care Act, 2014 statutory guidance. This set out the responsibilities of the NHS and local authorities to work together to facilitate safe timely discharge. This involved the NHS issuing the local authority with a written notice (Section 2) that an assessment was required with clear timescales set out for the local authority to respond and have care and support in place. Generally, assessments took place before the person left hospital.

Under the Health and Care Act, 2022 s91(1) these statutory regulations are repealed. Instead, NHS trusts must have due regard to any guidance issued by NHS England. The latest 'Hospital discharge and community support guidance' became effective as of 1 April 2022. Home First, D2A are underpinning principles in this latest guidance. Under D2A a period of care is funded to facilitate recovery, rehabilitation and reablement pending a long-term needs assessment being carried out once the person has left hospital.

During the COVID-19 pandemic D2A was mandated by government as the operating model for discharge from NHS acute hospital trusts. (NB Mental health inpatient services are not within the scope of the guidance). Implementation was supported by a national discharge fund of £588 million to help cover some of the costs of increasing capacity in out-of-hospital care. The additional funding was widely welcomed and seen to have a positive impact.

> 'The dedicated, additional funding to support the D2A model during the COVID-19 pandemic delivered value swiftly as 30,000 acute beds were freed up in spring 2020 to support flow through the system'.
>
> (NHS Confederation, 2021)

The National Discharge Fund ended in March 2022. Concerns were raised that this may risk undoing the positive improvements seen during the pandemic by forcing health and social care systems to end the extra capacity created with this dedicated funding (NHS Confederation 2021). According to NHS England The Better Care Fund (BCF) moving forward will be more important than ever as the single joint planning process for health and social care to use pooled resources to deliver better outcomes for people being discharged from hospital. The Better Care Fund is the principle means through which out-of-hospital care is funded in England and it is mandated that integrated care systems must invest in out-of-hospital care for local BCF plans to be approved.

What is Home First Discharge to Assess? (D2A)

D2A is where people who are clinically optimised and do not require an acute hospital bed (but may still require care services) are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Fundamental to D2A is the idea that comprehensive assessment (including assessment under the Care Act, 2014) will take place out-of-hospital. Thus, allowing people time for recovery before making choices about their longer-term care and support.

> 'There should be a range of services commissioned to support people at the point of discharge from hospital that are short-term recovery focussed... No long-term assessments of care needs should be made whilst a person is in a hospital bed. Every individual should have the best possible opportunity to recover before they experience a long-term assessment'.
>
> John Bolton, Developing a capacity and demand model for out-of-hospital care, 2021

The D2A operating model relies on local integrated care systems developing four pathways out-of-hospital:

Pathway 0 – Simple discharge home; no new additional support required to get the person home, or such support constitutes only informal input from support agencies or a continuation of an existing health or social care support package that remained active while the person was in hospital (likely to be a minimum of 50 per cent of people discharged).

Pathway 1 – Able to return home with new, additional or restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home and those with an Intermediate Care service supporting their recovery back to independence (likely to be a minimum of 45 per cent of people discharged).

Pathway 2 – Recovery, rehabilitation, assessment, care planning or short-intensive support in a 24-hour bed-based setting, before returning home (likely to be a maximum of four per cent of people discharged).

Pathway 3 – For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of one per cent of people discharged).

Starting in hospital, the expectation is that where there are new care and support needs, ward staff will refer the patient to a 'transfer of care hub' as soon as possible. Every local health and social care system based around an acute hospital footprint should have a transfer of care hub whereby (physically and / or virtually) all relevant services across sectors (such as health, social care, housing and voluntary sector) are linked together through multi-disciplinary team working (HICM Change three).

Hubs should be staffed by a small team, dedicated to ensuring people are discharged from hospital on the right pathways, with the right discharge information, and that they get the right onward care and support (if needed). Decisions about what long-term support package is needed should not be taken on the hospital ward. Case managers in transfer of care hubs should link relevant services to coordinate care and support the individual. The case manager can be from any discipline (such as social care, primary care or therapies) depending on the needs of the individual being supported.

The support offered by the hub should extend beyond the discharge itself. The case manager in partnership with the multi-disciplinary team is expected to work across both hospital and community settings to plan post discharge care, long-term care needs assessments and where appropriate end of life care. Trusted assessment (HICM, Change six) means there is no expectation that people will be assessed by community service providers before leaving hospital, thus facilitating patient flow. Other key D2A practices include:

- the person leaving hospital will have a single point of contact within the hub (earlier guidance stipulated that everyone should have a case manager). This is termed 'safety netting'
- people should not be told to go their GP or A&E if they are concerned about anything. They should only be followed up by a new team once relevant information has been handed over by the hub
- anyone requiring formal care and support to help them recover following hospital discharge should receive an initial safety and welfare check on the day of discharge to ensure basic safety and care needs are met
- every local health and social care system should have a single system coordinator. This system leadership role should address any challenges that impact on patient flow.

Where does homelessness and housing fit in the D2A operating model?

The hospital discharge and community support guidance is clear that the needs of people who are homeless need to be considered as part of D2A and that people who are homeless or at risk of homelessness should not be excluded from short-term post-discharge recovery and support because of their housing status.

- ✓ **People should not be excluded from bed-based intermediate care and rehabilitation facilities on the grounds that they do not have a home address and may 'silt up' the care home. The guidance is also clear that D2A is for all adults not just those over 65.**

Homelessness or risk of homelessness should be identified on admission by A&E and ward staff and a referral made to the local housing authority under the Homelessness Reduction Act, 2017 ('duty to refer').

- ✓ **The statutory 'duty to refer' should be embedded as part of the D2A process. It should not be viewed as a parallel, separate 'homeless pathway'.**

One of the most frequently asked questions is "Which D2A pathway should homeless patients be discharged on?". Patients who are homeless should be referred through the transfer of care hub in the same way as non-homeless patients. All D2A pathways and services locally should be accessible to them. The most appropriate pathway should be allocated and recorded based on needs. Where end of life or frailty is an issue Pathway 3 may be the most appropriate.

- ✓ **Discharges of people who are homeless should not be uniformly recorded as all being 'Pathway 0 discharges'.**

Where there are complex health needs linked to homelessness, inclusion health professionals (GPs and nurses with a 'specialist interest' for homelessness) co-located at the hospital may be best placed to act as the 'case manager' on behalf of the transfer of care hub.

Housing officers should be seen as part of the multi-disciplinary team working through the transfer of care hub. They can case manage the 'duty to refer' process on behalf of ward staff in addition to other 'settle-in' and care coordination activities such as registering the person with a General Practitioner (GP).

Finally, the guidance notes that the local housing authority has the power to implement fast track and integrated systems to expediate the discharge of those living in poor and unsuitable accommodation.

The need to commission specialist out-of-hospital care services

For D2A to be successful, each of the discharge pathways (0-3) must encompass enough capacity across range of different services typologies, ranging from bedded facilities in care homes and community hospitals (Pathways 2/3), to local authority reablement services and 'welfare checks' by the community and voluntary sector (Pathways 0/1). The aim is that discharge coordinators in the transfer of care hubs will have a menu of readily available placements thus ensuring patient flow.

> 'D2A will not work at its best if services are solely commissioned from existing services where they were not established for that purpose (for example 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'.
>
> (Reducing delays in hospital transfers of care, 2018)

The Hospital Discharge and Community Support Guidance states that when commissioning out-of-hospital care the support needs of specific populations (including people who are homeless) should be considered. This includes determining the type of specialist rehabilitation services needed for people with complex conditions and ensuring appropriate social work provision and other specialist support is in place for people in complex, abusive or neglectful relationships.

The evidence for developing specialist out-of-hospital care services for people who are homeless is strong. Between 2015 and 2021 researchers at King's College London and partners undertook an NIHR funded evaluation looking at the differences between 'specialist' versus 'standard' hospital discharge arrangements. Overall, there was strong evidence to support the commissioning of specialist homeless services as this was consistently more effective and cost-effective than standard care (see box one).

Box one: Key findings from the evaluation of specialist out-of-hospital care

Methods

- A synthesis of the hospital discharge and intermediate care literature.
- In-depth fieldwork in 6 sites across England, exploring hospital discharge practices in areas with and without homeless hospital discharge (HHD) schemes.
- Interviews with 77 commissioners, managers and practitioners in health, housing and social care.
- 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 attendance.

Key findings

- NHS Trusts with specialist homeless hospital discharge teams had lower rates of Delayed Transfers of Care linked to 'Housing' than standard care.
- Employing a range of different economic modelling techniques, specialist out-of-hospital care arrangements were consistently more effective and cost-effective than standard care.
- Employing a range of different economic modelling techniques, out-of-hospital care models that encompassed a homeless hospital discharge team **PLUS** direct access to a specialist step-down service were more effective and cost-effective than other models
- Data linkage with Hospital Episode Statistics showed that homeless hospital discharge teams with direct access to specialist step-down services were associated with a reduction in subsequent hospital use, with an **18 per cent reduction in A&E visits** (this was compared to models without step-down).
- Advocacy provided by 'clinically-led' homeless hospital discharge teams increased access to planned (elective) follow-up care. This is an especially important outcome as 1 in 3 deaths of people in the evaluation cohort* were due to common conditions (eg heart disease) which are amenable to timely health care.

Which model of specialist out-of-hospital care is most effective?

In terms of the different models of out-of-hospital care, the study demonstrated that the best outcomes for patients were achieved where hospitals had access to a specialist multi-disciplinary homeless hospital discharge team (comprising inclusion health GPs and nurses). Plus direct access to a specialist step-down service (either residential and/or non-residential). A key finding was:

> 'While we have highlighted the importance of 'clinically-led' homeless teams in increasing access to planned (elective) health care, it is also important to note just how effective and cost-effective are unprofessional housing led step-down services. Most likely this is reflecting the value of good quality 'floating support' in bridging the gap between the hospital and the community… 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'.
>
> (Transforming out-of-hospital care for people who are homeless Support Tool, 2019)

NICE Guideline

These NIHR and other evaluation findings have since been taken on board by NICE within the development of a new guideline for integrated care for people who are homeless.

> 'Evidence from several economic studies suggested that [specialist intermediate care] is cost effective and potentially cost saving. The committee agreed that providing such services would help avoid hospital admissions and ensure safe and timely discharge. Intermediate care can also prevent or shorten expensive inpatient care and provide appropriate care and support to people in need of more intense support than would otherwise be provided in the community'.

The NICE guideline highlights the importance of developing specialist intermediate care locally as it represents value for money.

> 'Intermediate care, including step-down and step-up care, would represent a change in practice because this service is currently rare for people experiencing homelessness. This would need some funding but there is evidence that intermediate care represents value for money'.

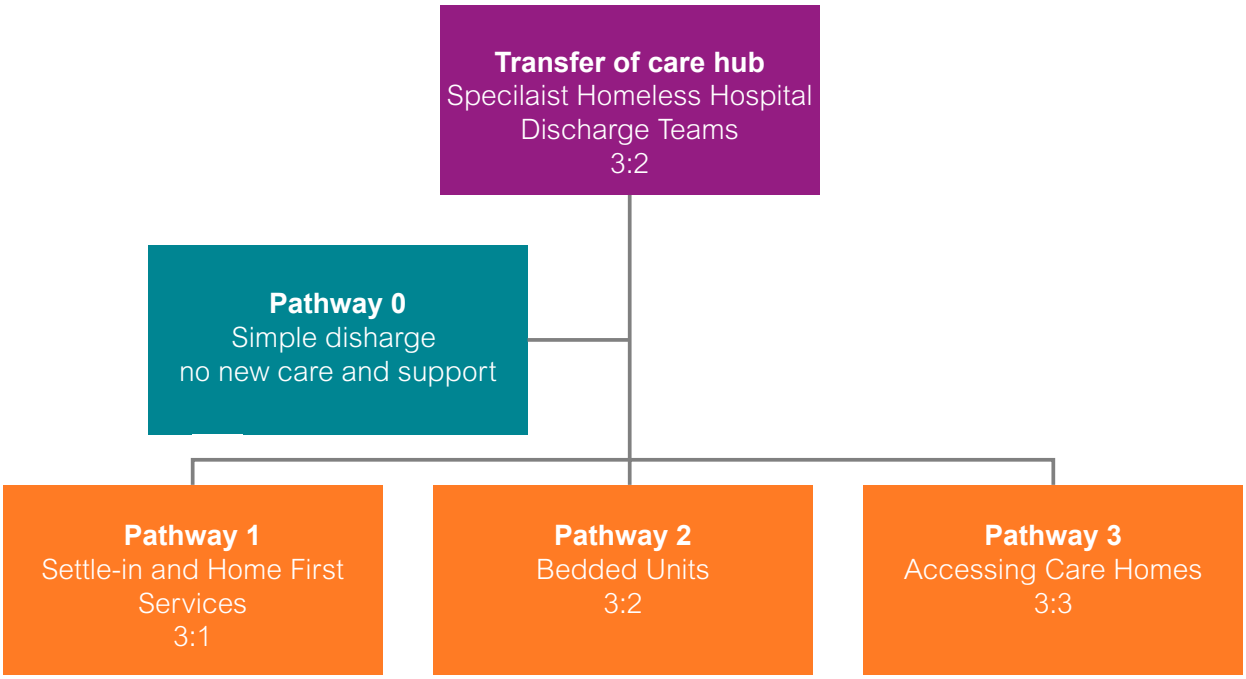
3: Integrating specialist homelessness resources into D2A pathways

Overview

This section draws on the learning from well-established specialist intermediate care services for people who are homeless (reported in our earlier support tool) and new and emerging practices from 17 test sites taking part in the DHSC's Out-of-Hospital Care Models Programme. First, we present case study examples of individual service models that are operational across each of the D2A Pathways (0-3). We then present an insight into how (individual) out-of-hospital services can be integrated as a single operating model, with examples from an urban and rural area.

The case studies are organised to reflect the D2A Model shown in Figure one below. We also draw attention to some of the early challenges reported at stakeholder events organised by the LGA and evaluators and how these can be overcome. Throughout we highlight the importance of embedding and sensitising the nine High Impact Changes to meet the needs of people experiencing homelessness.

Figure one: D2A model



Specialist homeless hospital discharge teams

HICM Change 3: 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

Hospital based homeless healthcare teams are often multi-disciplinary and 'clinically-led' by a GP or nurse (with a 'special interest' in homelessness). Additionally, they often employ housing link workers and peer navigators (people with lived experience of homelessness). Some teams also include social workers and occupational therapists. They are often called Pathway Homeless Teams by virtue of their links with the Pathway Charity. It is recommended by Pathway that homeless teams are developed in hospitals that see more than 200 homeless patients per year.

The teams offer a range of services to homeless patients, including primary care or patient 'in-reach' (clinical advocacy), discharge coordination and (more recently) continuity of clinical support into intermediate care. The primary aim of the homeless hospital discharge team is to maximise the benefits of a hospital stay and to use this as a window of opportunity for change.

> "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)

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:

> ‘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.’
>
> (Towards system leadership – defining the role and potential of nurses working in homeless hospital discharge, Pathway)

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 may intervene to deescalate the situation through more appropriate clinical management (for example 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.

✓ **In terms of improving patient outcomes, our NIHR research showed that ‘clinical advocacy’ increased access to planned follow-up care as compared to standard care (counted as higher numbers of elective readmissions). This is an especially important consideration given that many people who are homeless have complex health needs and die of common conditions that could potentially be avoided with more timely access to health care (Referenced in box two).**

Specialist discharge coordination: Homeless healthcare teams also contribute to discharge planning and can offer case management on behalf of the transfer of care hub. 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. Housing workers in the homeless health team may also take on responsibility for the considerable administrative burden that can be associated with making an approach to housing (‘duty to refer’) and maximising income (for example sorting out access to benefits or helping people ascertain ID or to establish a local connection). Because homeless health teams are often 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.

> "Now that we have a [homeless team] 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…"
>
> (Ward Manager)

Box two: The morbidity and mortality profile of users of specialist out-of-hospital care

Method: Data Linkage – details about OOHC **3,222** scheme users 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 attendance. Key findings were as follows:

- As compared to the general population, homeless people have extreme levels of co-morbidity. **Eight per cent** of the cohort had five or more co-morbid conditions compared with **five per cent** for the comparator group.
- In the OOHC group, **600** patients died between 1 November 2013 and **30** November 2016. Males made up **78 per cent** of deaths.
- The median age of death was **52** for the OOHC group and **72** for the comparator group (people living in the most deprived areas of England).
- The top three underlying causes of death in the OOHC group were external causes of death (such as drugs, alcohol and suicide) (**22 per cent**), cancer (**19 per cent**) and digestive disease (**19 per cent**).
- When age and sex are accounted for, the underlying causes of death for the OOHC 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 OOHC schemes are identifying and engaging with an excluded population at extreme risk of death.

Extending the role of the homeless hospital discharge team: Under the new D2A operating model, hotel accommodation can be used (and funded by the NHS) as an additional method to the usual discharge routes. Use of hotel accommodation should only be used as a short-term measure (days rather than weeks) for the specific purpose of reducing length of stay for people in hospital and ensuring that they are discharged when they no longer meet the criteria to reside in hospital. Hotel beds can be used for patients who are homeless and those who have no recourse to public funds. Increasingly, hospital based homeless teams are expected to continue discharge planning as people move into hotels and oversee the arrangements for their safe onward transfer of patients. The case study below (box three) illustrates how this can reduce length of stay and prevent a delayed discharge.

Box three: Discharge planning in hotel accommodation

Ms A (age 27), was admitted to hospital with cellulitis in January 2022. She had a housing association flat until late 2020, when it was boarded up by police due to cuckooing. Since then, she had been sofa-surfing at her mum's and living in drug houses with her boyfriend.

While in hospital, concerns were raised by community professionals around domestic abuse from her boyfriend. The Hospital Homeless Team (HTT) made an inpatient safeguarding referral. They also linked Ms A with her social worker who had been unable to support Ms A previously due to poor engagement. HHT then organised a joint ward visit to explore discharge options. HHT completed a holistic housing needs assessment with Ms A on the ward and carried out the 'duty to refer' to the local housing authority.

When Ms A was deemed by the consultant to be medically optimised (no longer met the criteria to reside) she still required more time to gather evidence to support her application to the local housing authority (ID, bank statements etc.). At this point, the HHT transferred Ms A to a hotel.

Once in the hotel, the HHT called Ms A every day. They provided a supermarket voucher, new clothes, phone and toiletries. They assisted her in obtaining and submitting the evidence needed for her homeless application and also supported Ms A to make a housing benefit claim. Prior to admission, Ms A was using crack cocaine and heroin. HHT liaised with the Addiction Care Team, signposted to local substances misuse services and encouraged Ms A to access her methadone script.

After one week in the hotel, the local council provided temporary accommodation. HHT booked transport from the hotel to the accommodation and arranged for on-going support.

(OOHCM Programme – South-East London test site)

Homeless Hospital Discharge Team – Implementation challenges

Recruitment and Retention: The DHSC's out-of-hospital care models programme has enabled the development of many new and expanded homeless hospital discharge teams across England. Recruitment of staff has been difficult in many areas due to a shortage of applicants with inclusion health skills and experience. However, the main challenge for both new and existing teams is the expectation contained within the D2A policy that support will continue after an individual's exit from the acute setting and having the required resource in place to meet this demand. Most teams already have very high caseloads which means that it is difficult to put this requirement into practice.

Lack of Integration: Some of the DHSC test sites have reported that transfer of care hubs are refusing to accept referrals where the patient is identified as homeless, expecting hospital-based homeless teams to continue to take full responsibility for managing their discharge. The danger is that maintaining separate 'homeless' discharge pathways may perpetuate access problems to care and support services. For example, reports continue of non-specialist residential intermediate care facilities refusing to accept people for a period of bed-based rehabilitation where they have no confirmed address to return to.

Burnout and compassion fatigue: High caseloads coupled with the emotionally challenging nature of the work also means that there is potential for 'burn out' and poor staff retention to emerge as significant issue. In some hospitals, advocating for people who are homeless amid the intense pressures to 'free-up' beds can result in a poor working culture. High levels of stress can lead to poor physical and mental health for staff, and risks them becoming unable to provide the effective care they would want to provide due to compassion fatigue.

Compassion Circles: When developing out-of-hospital care services, it is therefore important to consider staff wellbeing and how it can be supported. Working in a trauma-informed way in the area of homelessness means acknowledging the potential impact of trauma on everyone involved, including staff. As part of the OOHCM Programme, there has been discussion with teams about the best ways to support them and protect and optimise their health and wellbeing at work. A structured framework for staff consisting of three components; Compassion Circles; training; and reflective practice, has been proposed. Whilst the benefits to staff of training and reflective practice are well documented in the NHS, Compassion Circles are a relatively new model, first developed with staff working in mental health services. The aim of the Compassion Circle model is to provide staff with a safe space in order to promote open conversation, listening skills and increase the connection staff have with each other, through increased understanding and compassion for oneself and others. Compassion Circles have already been successfully adopted alongside Schwartz Rounds across non-inclusion health teams in the NHS in Wales and learning will be drawn from this. Compassion Circles were adopted and promoted as a means of supporting staff by NHS England during the heat of the Covid pandemic. The approach has been evolved in to other, shorter forms of compassionate practices.

Homeless hospital discharge teams in Bradford and Brighton report that they have regular access to a psychologist to facilitate reflective practice and staff support and have expressed interest in incorporating the Compassion Circle model as part of regular practice. More details about Compassion Circles and guidance on how to develop them and the associated models of Compassionate Practice can be found on the Compassion Practice's website.

When developing discharge services, it is important that commissioners understand the numbers of homeless patients being admitted to hospital (and presenting at A&E) and ensuring that Homeless Hospital Discharge Teams have enough capacity to cope with the demand. Where teams lack capacity, the challenging and emotionally stressful nature of the work can quickly lead to burnout and staff retention issues. Commissioners should regularly review demand and capacity during service delivery, and that this includes understanding the complexity of needs as well as numbers of patients being admitted.

Pathway 1 – 'Take home and settle-in' support

Reablement teams are the mainstay of Home First for older people leaving hospital on pathway 1. Reablement ("doing with, not for"), 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 and social and leisure activities. Resettlement in homeless service provision is a close cousin of reablement, but tends to focus more on inclusion outcomes, such as establishing and maintaining a habitable home environment (securing benefits/financial security), preventing social isolation and supporting people to take part in education, employment and other community activities. Support for 'physical reablement' and personal care (for example helping someone to wash and dress) requires services to be registered with the Care Quality Commission (CQC) and often falls outside the remit of homeless and housing related services.

The hospital discharge and community support guidance states that anyone requiring formal care and support to help them recover following hospital discharge should receive an initial safety and welfare check on the day of discharge to ensure basic safety and care needs are met and allow time for fuller assessments to take place as the person settles in their environment. This should be coordinated through the transfer of care hub.

There is evidence in England that both Age UK and the British Red Cross, as well as other smaller more locally based voluntary organisations, run excellent 'take home and settle-in' services for older people. While most systems commission only a small volume of low-level post-hospital support from the voluntary and community sector this could be expanded to reduce some of the pressure on the community-based domiciliary services for both NHS and local authority:

> ‘Evidence shows how the voluntary sector can offer a realistic alternative for many people to domiciliary care reablement and producing similar outcomes. Commissioning services from the voluntary sector not only can improve outcomes for people but also offers them a richer range of services that can help them not only with their recovery but also to regain important social links in their community.’
>
> (Developing a capacity and demand model for out-of-hospital care, 2021)

’Take home and settle-in support’ is especially important for homeless patients leaving hospital. In our NIHR research, we observed that one of the riskiest points in the transfer process was immediately after the person leaves hospital. Very often, people may be moving into temporary accommodation which they will not have had opportunity to view. It may be in an area with which they are not familiar, they may not have the financial means or executive capacity to find their way to the property and the accommodation may come with little in the way of basic necessities such as bed covers, towels and curtains.

In addition to the logistical challenges which go with trying to set up a new home straight after leaving the hospital, 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, it can risk undoing the huge health and wellbeing benefits of a hospital stay (rest, care, kindness, treatment, emotional support, good food, detox for alcohol or getting off heroin and onto methadone).

Nearly all of the test sites in the DHSC’s ‘out-of-hospital care models programme’ include some Pathway 1 ‘take home and settle-in’ support. As noted in the previous chapter this has been shown to be highly cost-effective. We include two examples of different service models below.

Example one: British Red Cross specialist homeless settle-in service

In the Southeast London test site, the British Red Cross have been commissioned to deliver a specialist ‘take home and settle-in service to support homeless patients leaving Kings College London Hospital, University Hospital Lewisham, Princess Royal Bromley, Queen Elizabeth Woolwich and Guys and St Thomas’ and Kings College Hospital. The Red Cross team includes a service manager, an administrator and seven full time equivalent service coordinators. The service is operational seven days a week between the hours of 9-5pm. The team works as part of the wider multi-disciplinary team attached to the (‘clinically-led’) homeless hospital discharge teams. The discharge teams maintain oversight of the discharge plan and support and advise the settle-in workers. There is a weekly multi-disciplinary team meeting. The aim is to work with people for between 3-6 weeks. The average case load is around seven people per worker. Around 40 per cent service users are rough sleeping on admission to hospital.

The Red Cross team play an especially important role where people are moving into hotels and other dispersed temporary accommodation and where the risk of social isolation and self-neglect is high. The overall aim of the service is to ensure patients settle into a safe environment by offering timely help and practical assistance. Box four and five below present a summary of activities and a case study.

Box four: Activities provided as part of 'take home and settle-in' support

Needs assessment

- Individual needs assessment for independent living services support. It does not include assessment for health or social care needs.
- Asset-based needs assessments inform activity, support planning and risk assessment.

Goal setting and support planning

- The co-production of person-centred goals and help service users to identify what really matters to them in terms of maintaining their safety and confidence living at home. It does not include goals for health or social care support (eg rehabilitation).

Welfare checks

- Telephone or visit to check wellbeing and risks in terms of maintaining safety and confidence living independently at home. To ensure basic sustenance arrangements are met through the provision of food bank vouchers, mobile phones, clothing, bedding, kitchen items, transport etc. For those moving into TA, welcome packs are available including essential home items (bedding, pots, pans) and toiletries.

Community transport

- Some taxi provision can be provided under the basic sustenance budget (£5000), however this pot is finite so other options will be explored, ie – hospital transport.

Practical support

- Support with shopping, key cutting, arranging GP and outpatient appointments, collecting prescriptions and medical equipment, checking home safety (eg, arranging pest control, water and gas, fire sensor working) prior to discharge.

Emotional support

- To provide person-centred emotional and practical support in the immediate 48 – 72 hours post-discharge, Listening and befriending (kindness) and potentially coaching (identifying triggers and coping strategies).

Navigation support

- Connecting service users to other services or voluntary or statutory agencies who can meet their needs.
- Connecting service users with community groups in line with social connection goals.
- Supporting service user to access other services and community groups.
- Escorting service users to appointments.

Box five: 'Take home and settle-in' support case study

Mr A is a 67-year-old UK national of Black/African descent and was admitted to Hospital on 30 April 2022 with a suspected stroke. Mr A separated from his wife in January 2022 and had become homeless. The Stroke Team declared Mr A medically fit for discharge on 10 May 2022. He was placed in emergency hotel accommodation by the homeless team on the same day he no longer met the criteria to reside.

The British Red Cross first met Mr A on his second day in emergency hotel accommodation. As board and lodgings were provided, the British Red Cross liaised with hotel staff to ensure Mr A's diabetes was considered in the preparation of his meals. The hotel agreed to remove fruit juice and sugary desserts from his menu with Mr A's consent. Mr A also required a few personal items whilst at the hotel including toothpaste, shower gel, a sponge and bottled water. The British Red Cross funded a £50 cash voucher for Mr A to purchase these.

Following the 'duty to refer' made while Mr A was in hospital, he was assessed by the local housing authority over the telephone and moved from the hotel into temporary accommodation (a bedsit) on 1/6/22. On visiting Mr A in his temporary accommodation, Mr A informed the British Red Cross that he only had £4.95 in his bank account as he had not been receiving his sick pay for two months. Mr A decided that he would like to retire. The British Red Cross supported with drafting his letter of resignation as well as requesting his P60 and backdated sick pay from his employer. The British Red Cross then assisted Mr A in applying for pension credit. A hardship grant was applied for from a local charity to help Mr A in the interim and was successful.

Mr A was then supported by the council to move into accommodation within the private rental sector under the deposit guarantee scheme. He moved in on 20 June 2022. The accommodation was a ground floor studio flat with private entrance and an outdoor space. Mr A expressed that he was happy in the new accommodation but that his mobility issues were continuing to cause some difficulties including whilst showering and going to the toilet. The British Red Cross contacted the Occupational Therapy team and made a referral for a home assessment for Mr A. The British Red Cross was made aware that this assessment could take some time as there was a backlog of applications. In the meantime, the British Red Cross secured a toilet seat raiser from their Mobility Aids department. As Mr A was new to the area, the British Red Cross signposted him a number of organisations and charities. Mr A registered himself at a new GP surgery and was collecting all required medications independently. His brother and niece both visited around once per week and this helped to settle Mr A into the area.

Example two – Salford Homes for Home First

In Salford, a local housing association made available eight self-contained properties dispersed across the City for people leaving hospital. The aim is to create a homely environment in which to observe people's ability to live independently before finding them a permanent home or alternative care placement. The properties include a fully accessible adapted bungalow, with wheelchair accessible ramps and wet room facilities. Settle-in and longer-term resettlement support is then provided through the local council's Rough Sleeping Outreach Team, where two team members take on responsibility for people leaving hospital. A similar model has also developed in Cambridge and Peterborough. Here the local authority (generic) reablement team provide the mainstay of support.

Pathway 1 implementation challenges: Providing someone with fully accessible self-contained accommodation has many advantages over hotel accommodation especially where people are being moved frequently and where the expectation is that they will be out of their rooms during the day (as is the case in some areas). However, it can be very difficult to identify suitable properties especially those that are fully adapted and accessible. As a result, homes for Home First models can support only a small number of people at any one time with implications for 'patient flow'.

A second issue is that the shortage of good quality longer-term housing related support. Very often, 'settle-in' workers are supporting people with very complex needs and are offering a fuller resettlement type service that extends far beyond settling someone in.

Pathway 2 services – Specialist (bedded) intermediate care and step-down houses

Pathway 2 caters for a wide range of needs and complexities in 'bed-based' settings. Specialist homeless and other housing related provision includes:

- The Mildmay Mission hospital in London, has 24-hour clinical staffing on site. It offers 14 'step down' beds in addition to beds for COVID care and HIV patients. It works on a pan-London basis. Currently, this is the only 'medical respite' service in England. It is more expensive than other models as beds are costed at palliative care rates, reflecting the ability to cater for end-of-life care and very complex health conditions.
- Services delivered in fully accessible care home type environments that are not Care Quality Commission (CQC) registered. Registration with the CQC is required where 'personal care' is provided. Services offering independent living and housing related support do not require registration). Examples include the Bradford Respite and Intermediate Care Support Service (BRICSS) and Little Cosgarne in St Austell Cornwall. A key objective of the DHSC's out-of-hospital care models programme was to roll out the BRICCS model nationally. However, difficulties finding the right type of properties (especially in London) mean that few new services have been developed. Where suitable properties were found, local opposition to opening a 'homeless service' was also sometimes an issue which could block development.

- Services delivered in independent living units that are not CQC registered. Examples include Summerhill a 42-bed facility in Birmingham. In Leeds, step-down beds are located in three transitional mental health units. The step-down beds are funded and staffed separately to the mental health beds.
- Residential 'step down' houses with a small number of beds (typically three to five) usually with support workers on site during working hours. Oxford has two step-down houses, supporting people leaving the acute hospital and one supporting people leaving the mental health hospital. The main drawback of this model is that properties often do not meet the needs of people with disabilities.
- 'Health beds' in mainstream homeless hostels. These are often commissioned by local authorities (LAs) and/or Integrated Care Boards (ICBs) and allocated for use by people leaving hospital. At St Patrick's in Brighton the step-down beds are staffed by a different team to the main hostel and additional funding has been given to the local inclusion health service to provide in-reach. The main drawback with this model is that mainstream hostels can sometime struggle to deliver an environment conducive to convalescence and recovery, especially for people who have undergone a detox for alcohol or started on opiate replacement while in hospital.

Typologies three to five sit on the boundaries of Pathway 1 and 2 as they cater for people who, if they were not homeless, could most likely be supported in their own homes through the provision of short-term reablement/resettlement support. NHSE makes the important point:

> '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 Guidance

✓ **The level of disability and frailty (early ageing) among homeless patients leaving hospital is often underestimated. Step-down facilities need to be fully adapted and accessible to meet the needs of those who most need them. For an example of 'what good looks like' take a virtual tour of Little Cosgarne in St Austell, Cornwall**

Example one – Bradford Respite and Intermediate Care Support Service (BRICSS)

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. BRICCS offers 17 places with 13 beds in a former care home and four 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 (for example 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 Better Care Fund (BCF). The BCF pays for support staff and manager, who are on duty seven 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. The Bradford Pathway Homeless Team comprises a team manager (a band seven nurse), a nurse, a housing worker/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 seven 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 DHSC's Office of the Chief Analyst: '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 of the patient's health, housing and social care needs commences. 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 snapshot at the point of discharge. These 'snapshots' can be unreliable given that people are 'not themselves' when in hospital and in crises or unwell. This opportunity for comprehensiveness and person-centred care is at the heart of the 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:** As noted earlier reablement, falls outside of the skill set of the housing support worker role and requires a referral into the support provided by (adult social care) reablement teams. For those who need reablement, local reablement teams visit 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' (for example 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.
- **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 services to have clear protocols around the management of patient choice such as those in place for acute care.
- **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 BRICCS the anticipated timeframe is between eight and 12 weeks primarily because of the need for home finding alongside more traditional reablement and rehabilitation activities. Even despite this extended timeframe, it is often the case that people stay 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. To maintain continuity post BRICSS, the Pathway Team is host to a monthly multidisciplinary meeting that brings together the 'multiple and complex needs community' (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.

Example two – Summerhill House Birmingham

Summerhill House in Birmingham is an independent living facility for people who are homeless. It also supports people who have other housing issues, such as those who cannot return home due to hoarding and self-neglect and whose property may require a 'deep clean.' Summerhill offers accommodation in studio flats, ensuite rooms and bedrooms with shared facilities. All the accommodation is fully accessible – and includes five bariatric pods (accommodation that is specially converted for people weighing over 25 stone). All the accommodation suitable for wheelchairs and citizens who require wet rooms, adapted kitchens and wider doorways. Summerhill maintains a strict regime about use of drugs and alcohol on the premise. Citizens whose uncontrolled addiction is problematic are moved to other services for more enhanced, focused support and rarely back to the street.

Summerhill receives around 40-50 referrals per month from the local hospitals and has 40 units of (step-up/step-down) accommodation on a single site. This is noteworthy for the fact that is one of the few specialist homeless Pathway 2 services nationally that appear to have scaled sufficiently to ensure capacity meets demand. For example, it offers more Pathway 2 beds than is currently available across the whole of London where there is much higher demand.

No Recourse to Public Funds (NRPF)

If people have a social care/health need that requires accommodation to be provided (eg need for medication to be stored in fridge), then there are a range of options available to look at what is possible for the citizen and in some cases, this includes the accommodation being funded by Birmingham City Council (under the provisions of the Care Act, 2014). For example, in cases where it is not possible to claim housing benefit, people with NRPF and care and support needs are accommodated at Summerhill. This is, however, problematic for move on, but there is a recognition that care needs cannot always be met without the provision of accommodation being in place. The No Recourse to Public Funds Network produces resources and guidance around NRFP and social care.

Patient flow

HICM Change 2: Develop systems using real-time data about demand and capacity taking a joint approach to shaping the price, flow, quality and shape of the market. While councils remain the lead commissioners and retain their Care Act duties, a joint approach is key to developing stepdown facilities, integrated health and social care support and work with the voluntary sector.

The overarching goal of Summerhill is to promote independence. Support workers are on site (during working hours with security staff out of hours). Support is reablement focussed (doing things with rather than for people). In addition to support from the onsite support workers, many of the residents also receive reablement and personal care from a CQC registered domiciliary care provider. In-reach by the reablement

team is managed and delivered through the Early Intervention Community Team (EICT) which also affords residents with access to therapists and social workers.

The end goal (point at which the citizen is ready to transfer from short to longer-term care) is when a full multi-disciplinary assessment of need has been completed. This can be a joint assessment between Summerhill and the EICT. The goal of the assessment is to identify the best housing option and what type and level of longer-term care and support is needed to sustain this. These assessments afford time for recovery and observations (eg of executive capacity and ability to carry out activities of daily living). As a result, length of stay can vary greatly. There are no strict rules about length of stay – just a focus on understanding the needs of the person. Across the test sites taking part in the DHSC's programme the average length of stay for services on Pathway 2 is 15 weeks, in Summerhill House it is currently just under 11 weeks. In this test site, robust mechanisms are also in place to maintain patient flow at Summerhill and to prevent the facility from becoming silted-up. These are:

- live patient tracker – a live database accessible to workers across health, housing and adult social care which tracks patient progress through the hospital stay, into D2A and into the community
- weekly virtual multi-disciplinary team meetings for all professionals/workers involved with Summerhill residents
- protocols in place with the housing authority for the prioritisation of citizens in D2A which can include the review of housing applications, completion of homeless applications and support for citizens gaining long term accommodation
- each Summerhill citizen has a dedicated housing officer that keeps focus on their long-term housing goals.

Sustainability

Since its inception in April 2020, this service has been able to demonstrate £8 million of savings for the NHS and was recently recommissioned through the Better Care Fund for a seven-year period at a cost of £1.4 million. The cost per bed per week is £244 plus care costs. If housing benefit charged, the cost would be £259.

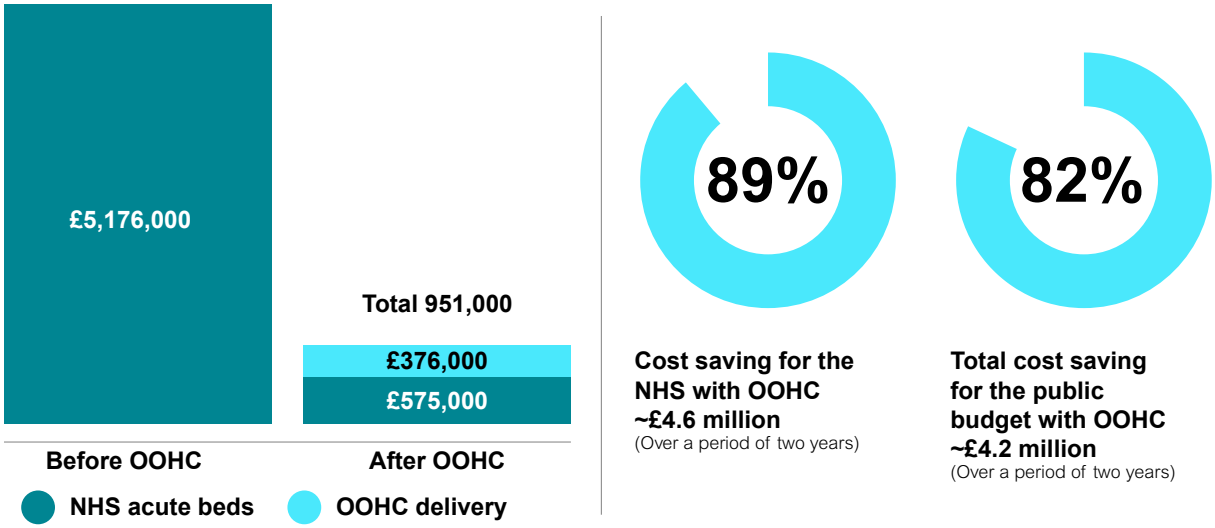
Example three – Oxford Mental Health Step-down House

In Oxford, there was already a long-established five bed step-down house for people who were homeless, but it was recognised that more capacity was required. The Out-of-Hospital Care Models (OOHCM) funding was used to rent an additional three bed house. However, it proved impossible to find a property that could be adapted to meet the needs of patients with disabilities. The house was underutilised for a while because the majority of those leaving the acute hospital had mobility issues. A decision was thus taken to refocus the second step-down house to support the most complex discharges from the local mental health hospital. It was reported that around 14-18 people were delayed every week on local mental health wards due to housing and homelessness issues. Many of the delays were longstanding "lasting years not days".

The second step-down house provided access to three support workers (on site during the day) and a range multi-disciplinary inclusion health focussed support including a clinical psychologist, a community based mental health worker and a social worker. Because of the complexity if the cases, the second house allows for a longer stay than the 14 days aimed for at the first house. Time in step-down not only gives the service user breathing space and time to recover, but also enables other services to come together collaboratively and to have the confidence to try out new ways of working together (see box six). Delayed transfers have been significantly reduced as a result of these developments. Currently, it is rare for more than two people to be delayed (compared with 18 delayed per week before OOHC).

Implementing hospital in-reach and step-down has reduced this cohort's bed days dramatically (89 per cent). The overall cost saving to the NHS after the introduction of OOHC is in the region of £657,000 (when comparing two years before OOHC vs. two years after OOHC). See figure two below.

Figure two: Cost comparison before OOHC (April 2018 – March 2020) versus after OOHC (April 2020 – March 2022)



We considered 126 bed days delayed per week (before OOHC, April 2018 – March 2020) vs. 14 bed days delayed per week (after OOHC, April 2020 – March 2022). Unit costs for the NHS costs per bed day for acute services (£395) were sourced from: Nick O'Shea (2021). Mental health and housing. The feasibility of calculating an investment case. London: Centre for Mental Health. Discount rate applied 3.5 per cent (£ at 2022 value).

Box six: Home First and for complex mental health issues

Mr J was previously residing in supported accommodation (block of flats) due to long and enduring mental health issues. There was a fire at his property, putting Mr J and other residents at risk of death. Mr J was alleged to be the perpetrator of arson – police investigated but no charges were brought.

Mr J's flat was severely damaged and uninhabitable. He was sectioned and admitted to hospital. Forensics and other mental health professionals deemed that Mr J was not suffering from an acute episode and was deemed fit for discharge.

Mr J's landlord served legal notice to vacate on grounds of probable arson. This put Mr J at risk of homelessness. A Housing Officer from the OOHCM team advised medical professionals that Mr J had a tenancy and that the landlord had to provide alternative accommodation (until tenancy ended in law). The landlord refused to accept Mr J back due to perceived risk of arson. Complicating matters, the local authority had concerns re his placement in interim accommodation on grounds of arson risk.

Conflict ensued between the hospital and local authority. The OOHCM project manager intervened and brokered discussion between parties – it was agreed that if Mr J could show that he could maintain a stay in stepdown with appropriate support, then the local authority would offer temp accommodation.

Step down accepted this referral, and the potential arson risk. Mr J was supported by the Step down team – life skills, finances, social connections; clinical psychologist – mental health. He was also supported by the Health Home Treatment (HHT) team who took charge of medications management.

Mr J did well in the Step-down house – worked well with the team and was helpful with other guests. He seemed to grow in confidence and also began to take his medication which had been a significant issue in the past.

On the basis of this good progress, the local authority identified a detached property (to minimise risk of fire to others) but insisted on Mr J having an ongoing package of care confirmed before commencing the tenancy. Health brokerage had difficulty sourcing a care package (due to a lack of providers) and Mr J became stuck in the step-down house. The OOHCM Team intervened between parties and identified that what the local authority housing department meant by 'care package' could be met by continued support from the HTT. OOHCM Project Manager brokered a meeting and it was agreed that Mr J could move into the property with HTT support for meds with continued resettlement support from the embedded mental health workers.

Step down flexed their boundaries (accepting risk); health flexed their support (extending the length of time the HTT could stay involved) leading to very positive outcome for someone who otherwise could have remained in hospital indefinitely.

OOHCM – Oxford Test Site

Pathway 2 – Implementation challenges

The main challenges for Pathway 2 specialist stepdown services is where there is a lack of move-on options. This relates to both the shortages of housing and access to Care Act 2014, assessments and long-term care and support. In some services, length of stay was averaging eight months plus rather than the target timescale of six-eight weeks. Where delays occur, it is important that these are quantified and closely monitored (see HICM change two) by the single system coordinator.

A further challenge is recruitment and retention. Some residential services in the OOHCM test sites were experiencing severe staffing shortages. Where this occurs, there is a danger the people are 'warehoused' and do not receive active support for recovery and resettlement.

✓ **To address the recruitment and retention challenges one service provider in Cornwall offers all new recruits a two-week trial. If they decide to take the post, they are offered this on a permanent basis as short term contracts were thought to exacerbate issues in already tight labour market.**

Developing a single system

In this final section we present two examples of how Integrated Care Systems (ICSs) can develop specialist out of hospital care services as part of a 'single system'. In many areas, out-of-hospital care provision for people who are homeless is often limited to a single (one-size-fits-all) service. In the examples below, we see how a range of specialist services can be developed to meet different recovery needs across D2A Pathways and how these are being integrated with non-specialist services. We also highlight the importance of single system coordination for maintaining oversight and addressing any blockages/safeguarding issues that arise. For example, Pathway 3 services are long-term placements in care homes for which there is currently no specialist provision. Ensuring care homes are accessible to homeless patients is an important consideration in developing the single system.

System example one – North Central London Integrated Care System

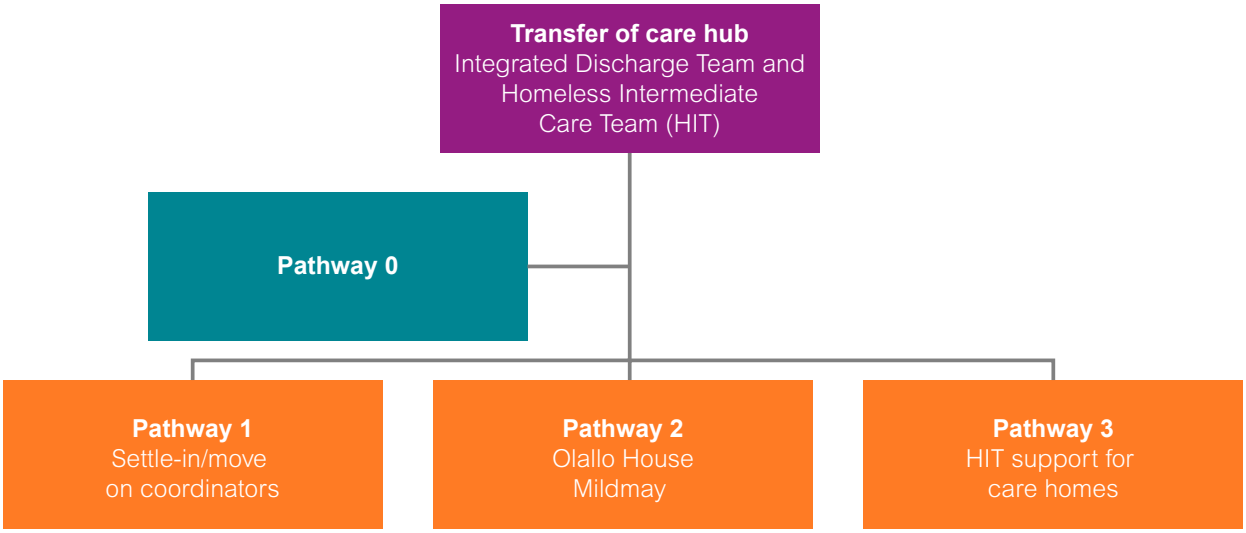
In North Central London (NCL), the Integrated Care System (ICS) operates across five boroughs and leads on the development of a 'single system' for out-of-hospital care. The overall strategic objective is to develop a Discharge to Assess (D2A) model that meets the needs of all adults. The aim is not to develop a separate 'homeless pathway' but to ensure people who are homeless can benefit from the full range of resources and expertise that is available across the ICS.

Prior to receiving £1 million DHSC/OOHC funding, (generic) D2A services were already well established across the five constituent boroughs including over 210 stepdown beds. However, admissions data linked to patients who were homeless indicated that a lack of clinical support and navigation shortly after leaving hospital

was leading to a high number of readmissions and poor health outcomes.

The delivery model for specialist D2A in NCL has a number of constituent components that are coordinated by programme manager (shown in figure three below).

Figure three: North Central London D2A Integrated Care System



Homeless intermediate care team – The homeless hospital discharge team based at University College London Hospital (UCLH) has been remodelled into a homeless intermediate care team. This is thought to better reflect the requirements of D2A and the need to refocus support out of hospital. The Homeless Intermediate Care Team comprises a clinical operations manager, a clinical specialist for outreach/prevention, two senior staff nurses, a podiatrist and a health care administrator. The team works across University College Hospital (UCLH), Royal Free Hospital and Whittington Health Hospital which have the high numbers of homeless patients admitted. All patients begin their D2A journey via a referral to the Transfer of Care Integrated Discharge Team. The transfer of care hub / integrated discharge team consults a wide range of professionals involved in out-of-hospital care and arranges for the person to be discharged on the most suitable D2A Pathway (0-3).

Strong effective leadership by the integrated discharge team managers across the ICS ensures safe practice for all patients in which “discharge to the street” is not an option. Where this occurs, it is recognised as a safeguarding concern. Patients will be delayed rather than discharged unsafely.

Once discharged, the Homeless Intermediate Care Team will then follow-up all homeless patients (regardless of any local connection issues) on the same day they are discharged and will case manage their recovery, coordinating a comprehensive assessment of their health, care and support needs. The activities undertaken by the team are shown in box seven below. Support is provided until longer term services are in place and working well, ideally for around six weeks.

Box seven: Activities carried out by the homeless intermediate care team

1. Assessments

- Care Act assessment
- housing
- OT/PT/therapy
- malnutrition – Malnutrition Universal Screening Team (MUST).

2. Care planning and delivery

- wound care
- mental health
- coordination role
- team to follow where best for the patient – street / hostel / D2A P2 health bed.

3. Rehabilitation

- therapies
- substance misuse / detox
- digital inclusion / support.

4. Liaison, integration, coordination

- adult social care
- psychiatric liaison teams
- community pharmacy
- primary care including GP registration where required
- substance misuse team
- move on coordinators
- Integrated Discharge Teams (IDTs)
- advocacy for patients so that Care Act assessments and other assessments are fair eg getting relevant information and professionals together
- care navigation is 80 per cent of the work – getting people access the services – assertive model.

Inclusion criteria

- homeless, rough sleepers and those at risk of rough sleeping including those with NRPF
- work with patients referred via Integrated Discharge Team at UCLH and other sites
- Adults >18years old

Exclusion criteria

- <18years old

Pathway 1 – a linked team of 'move on, coordinators manage the housing dimension of the intermediate care plan including following-up the 'duty to refer'. Each borough has its own coordinator who also provide some basic settle-in support. Both teams have access to personalisation funding to provide for basic items such as toiletries and mobile phones.

Pathway 2 – another use of the DHSC funding has been to provide resources for the spot purchase of specialist step-down beds to ensure patients have a place to recover. This includes bed spaces at two facilities that offer respite type services (Olallo House and Mildmay). Funds have also been used to adapt of temporary accommodation so that it is accessible to people with disabilities. The homeless intermediate care teams maintain case management responsibility for the patient in temporary accommodation and in the spot purchased beds.

Pathway 3 – importantly, while the homeless intermediate care team holds its own case load, it also works to improve the accessibility of (generic) D2A services. So, for example, if a homeless patient requires placement in a Pathway 2 or 3 ('therapy led') rehabilitation bed, the team will support staff around any drug and alcohol issues and how to work in trauma informed ways to address any challenging behaviour.

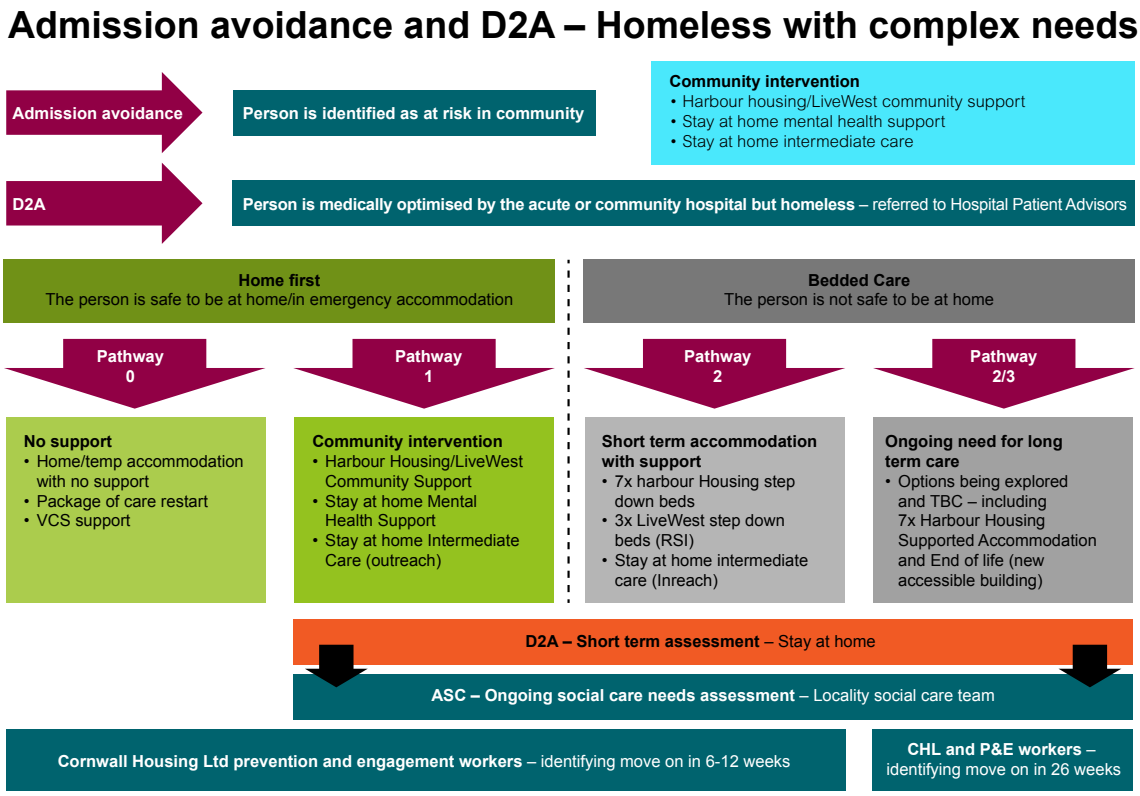
Single system coordination – a programme manager plays a key role in ensuring that these specialist resources are fully integrated as part of the wider D2A operating model and with longer-term care and support services. Where any 'patient flow' or safeguarding issues arise the programme manager intervenes to implement 'single system coordination' (a negotiated solution to the problem based on principles of learn, develop, improve). This provides key intelligence for strategic planning and ensures that front-line staff do not get bogged down in day-to-day 'battles' which can damage working relationships and lead to high levels of stress and 'burn out'.

Impact – since becoming operational in June 2022, the team has quickly established itself as a key component of the hospital D2A operating model. Clinical staff have caseloads of around eight to nine and support staff between five to six. A high number of patients are rough sleeping on admission. Average length of time supported by the HIT is 38 days (just under the six-week target for intermediate care). To date, only one patient has returned to rough sleeping after leaving hospital. Based on an initial cohort of 51 patients rates of readmission to hospital are 4 per cent and A&E visits (while supported by scheme) 16 per cent. Although not strictly comparable, these figures look promising based on an earlier 2017 linkage report for NCL where figures were 20 per cent and 18 per cent respectively.

System example two – Central Cornwall D2A out-of-hospital single care system

The main challenge for the Central Cornwall test site was not only ensuring out-of-hospital care could meet a range of recovery needs, but also ensuring coverage across a large rural geographical area. This achieved by working with a range of service providers. The Central Cornwall D2A System is shown in Figure four below. To the best of our knowledge, it is the only area to have developed a specialist homeless CQC registered domiciliary care reablement team. The single system encompasses:

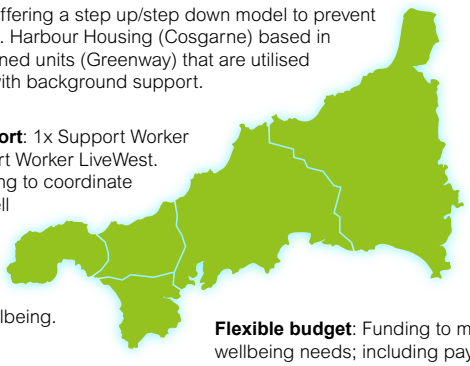
Figure four: Cornwall D2A single care system



Discharge pathway: Additional 1x FTE Homeless Patient Adviser in the Integrated Safeguarding Service at Cornwall Partnership NHS Foundation Trust (CFT) & Royal Cornwall Hospital Trust (RCHT) – coordinate discharge for homeless patients across the hospital network

Temporary accommodation: Offering a step up/step down model to prevent admission or delayed discharge. Harbour Housing (Cosgarne) based in St Austell identified 7 self-contained units (Greenway) that are utilised as temporary accommodation with background support.

Intermediate community support: 1x Support Worker Harbour Housing and 1x Support Worker LiveWest. Key Worker/navigator role helping to coordinate access to other agencies, as well as delivering social support (non-CQC regulated activities) to help people develop independent living skills and self-manage health and wellbeing.



Intermediate community care: 70 hours per week of intermediate care delivered by Stay at Home (Chaos Group) providing an inreach and outreach model (CQC regulated activities). This may include but is not limited to personal care and administration / supervision of medication. An additional 7 accessible units, for people with mobility needs (Little Cosgarne), to commence December 2021.

Flexible budget: Funding to meet personalised health and wellbeing needs; including paying for transport, basic daily living necessities, purchasing a mobile phone/other device, purchasing bespoke support.

Author: Martha Reed, Cornwall Council

Housing in-reach into the transfer of care hub: Working across all hospital sites (acute general and mental health and community), there are two homeless patient advisors' led by an experienced team leader. This specialist in-reach team sits within the integrated safeguarding services. The team coordinates the discharge of all homeless patients across the hospital network. As is the case for other patient groups, the expectation is that people who are homeless will leave hospital within 24 hours of being medically optimised. The homeless patients advisors will have been working with people since the point of their admission and will have built good relationships with them. They will have referred the patient to the housing authority ('duty to refer') as soon as they are known to be homeless and will make a recommendation to the single discharge coordinator in the transfer of care hub as to which D2A Pathway they should be discharged on.

Pathway 1 – Settle-in and resettlement: patients identified as meeting the criteria for D2A Pathway 1 can be discharged to temporary accommodation (including hotel accommodation) with the support of two teams of outreach workers (covering different areas of central Cornwall). The teams help people settle-in after a stay in hospital and provide a range of practical tenancy sustainment and other support.

Pathway 2 – for those patients who have more complex care and support needs and who require 'bedded' support under D2A Pathway 2, there are two stepdown units. Greenaways provides 10 units of accommodation in a large house (rooms have bathroom and kitchen facilities. And as touched upon above, a new facility, Little Cosgarne that is fully accessible and has an additional seven ensuite rooms each with their own wet rooms. Stepdown accommodation provides onsite support 24/7.

Pathway 1/Pathway 2 specialist CQC registered homeless reablement team: to support people who have personal care needs and those who need help with activities of daily living, Cornwall council has commissioned a team of specialist CQC registered domiciliary care (reablement) workers. The carers receive specialist training in drug and alcohol misuse (including self-neglect) and trauma informed ways of working. Training on how to administer Naloxone is required for all those working in specialist out of hospital care in Cornwall. The care team has been commissioned on a 'block contract' to provide 70 hours per week to those on D2A Pathways 1 and also on Pathway 2.

The need to integrate specialist domiciliary care as part the Cornwall system was recognised for two reasons. Firstly, a November 2020 snapshot of those waiting for a care package to be arranged by adult social care revealed that over 40 people with multiple and complex needs linked to homelessness had been waiting in for over 50 days requiring just over 500 hours of care per week. This was thought to contribute to increased admissions to hospital and delayed transfers of care. Secondly, 27 care packages were "handed back" over a six-month period in 2020 in circumstances where the person was known to have multiple and complex needs. This was thought to reflect the need for workforce development in the domiciliary care sector to challenge stigma and raise awareness of trauma informed approaches.

Economic impact: To explore the economic impact of the Cornwall model a small project team was convened and facilitated with LGA support. This included the test site project manager and stakeholders from the hospital and the community providers. The economist from the evaluation team joined and supported the group and advised on the methodology. The group met via Microsoft Teams on four occasions.

First, the team selected a single case (Mr KA) that was thought to be representative of the cohort that were using the step-down house. It was acknowledged in selecting this particular case there was some bias towards a 'good outcome' and recognition that other cases may incur much higher 'post intervention' costs where for example, the person may have been readmitted to hospital (from the step-down house) for a lengthy stay. Once the case was selected, the key worker who had worked closely with the person got in touch, explained the process and secured their written consent for the case study to be carried out. The person was actively involved so that they felt part of the process and could share their story.

In the next step, the economist provided the project team with a template on how to count and cost service and resource use (This is available to share contact M.Tinelli@lse.ac.uk). This looked at health services and also wider public services such as criminal justice. This process also helped the economist to plan for the evaluation itself, as regards the full range of services that would need to be included. For example, the evaluation team had not though about neighbourhood policing.

Data collection then looked at services and resources that were used by Mr KA in the 12 months prior to entering the step-down house and then in the 12 months after he left the stepdown house. The team worked individually and together to complete the relevant sections looking back at their own case notes to build as full and reliable picture as possible. Information on Mr KA's self-rated health was also available as he had completed the OOHCM audit EQ-5D questionnaire on entry to the service and 12 weeks later.

Once the template was completed and reviewed by the group, this information was handed to the economist who undertook the analysis. The aim of the analysis was to understand the full costs of service provision for Mr KA without OOHC and the potential saving as well as health outcome improvements when accessing appropriate OOHC. This approach also enabled the team to look at the potential benefits in terms of shifting costs from urgent / emergency to supporting a system that focusses on recovery and prevention. Information on use of resources were sourced from audit data from stakeholders and costed using published tariffs (Curtis and Burns, 2020) and previous studies (Please, 2015; Flatau and Zaretzky (2008); Ashton and Hempenstall (2009)). In summary, the team was able to look at what happened to Mr KA without OOHC – the year prior to staying in the stepdown house (2020/21) – and with OOHC, the following year (2021/22).

Without OOHC – total public costs incurred in the year prior to staying at Harbour Housing are £40,400 (see Figure five overleaf)

Prior to engagement with OOHC services, Mr K.A. was in a cycle of frequent A&E admissions because of his complex health conditions, his rough sleeping and self-neglect. This led to a deterioration of his health and wellbeing with no realistic prospect of improvement. Difficulties managing his diabetes led to a below the knee amputation, leading to him becoming a wheel chair user.

In the year prior to entering stepdown, Mr KA visited A&E department seven times, he spent a total of 46 days in hospital (six different emergency hospitalisations) and received one hospital outpatient visit. He was assessed by a social care worker and had two follow up consultations. Two staff from the homeless outreach team visited him 43 times whilst living rough. Community police contacted him at least 60 times for various matters, mainly related to welfare and antisocial behaviour. Overall, he slept rough for 309 nights and, just prior to moving into OOHC he got a place in a hotel for a total of 10 nights.

With OOHC – total public costs incurred after one year at Harbour Housing are £29,200 (see Figure six overleaf)

Once the OOHC provision was in place, the hospital in-reach service were able to quickly move Mr KA from hospital into the step-down house where his ongoing health, care and housing needs could be properly assessed. Mr KA then had access to support work and the new specialist domiciliary social care service. He is also receiving the community health and outpatient care that will help him manage his health and cope with the impact of his amputation.

Based on Mr KA's first 12 weeks at the step-down house and discussion with experts, we assumed that in the first year Mr KA would have a total of three visits to A&E, one planned hospital admission and 24 outpatient visits (with a neurologist, nurse and podiatrist) to manage a range of health issues including diabetes, Crohn's disease, fibromyalgia and nerve damage. Mr KA would have a care package in place and would be engaged with a paid carer (after leaving step-down) who visits him every day. Mr KA would have stopped any contact with community police and would stay in supported accommodation all time to provide somewhere safe and secure to live. He would also have a rough sleeper outreach worker, social worker, homeless patient advisor and occupational therapist who all work together with Mr KA and the staff where he lives to ensure his needs are being met. OOHC delivery included staff time, overheads and other costs per client.

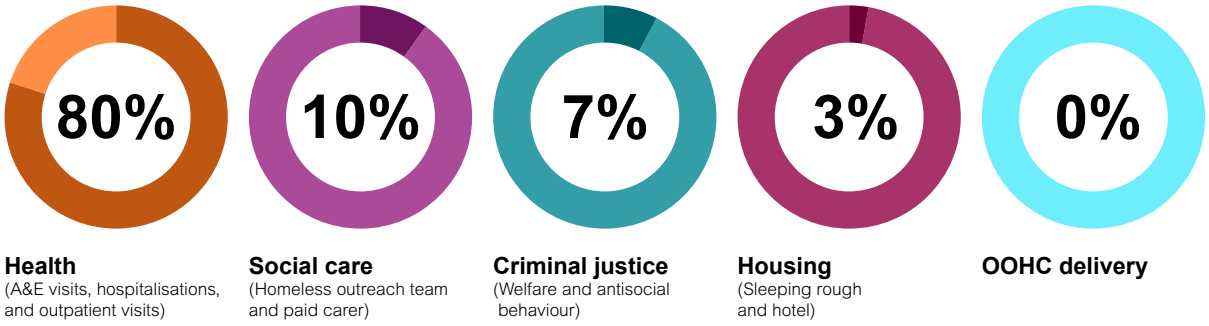
Figure seven (below) shows how the costs were shifted from urgent / emergency care to supporting a system that focusses on recovery and prevention

Figure five: Costs year before D2A services £40,400

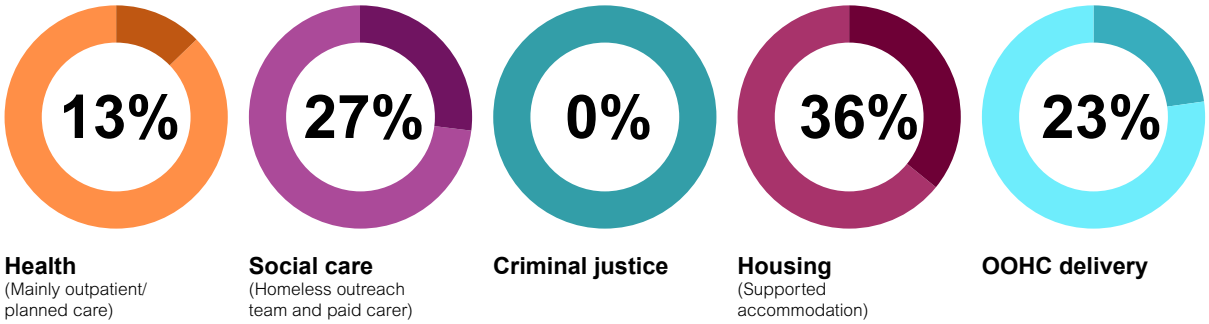
Figure six: Costs year after with D2A services £29,200

Figure seven: Shifting the costs from urgent / emergency care to supporting a system that focusses on recovery and prevention

Without OOHC – 80 per cent of costs incurred in the year prior to staying at Harbour Housing) include A&E visits and hospitalisations. For the other cost items, see the percentage breakdown reported below:



With OOHC – 64 per cent of costs incurred after one year at Harbour Housing include supporting accommodation and social care. For the other cost items, see the percentage breakdown reported below:



Health
(Mainly outpatient/ planned care)

Social care
(Homeless outreach team and paid carer)

Criminal justice

Housing
(Supported accommodation)

OOHC delivery

Box eight: Cornwall model – summary of economic Impact

(1) Overall OOHC costs 28 per cent less compared with before. The total saving on public money invested after one year at Step-down is £11,200.

(2) The costs in the system are shifted to the community and are more preventative and recovery focussed. About £20,100 (50 per cent of total budget) are shifted to housing and social care.

(3) KA health and wellbeing has dramatically improved (4X increase in general health status compared with before – from 20 to 80 on a scale where 0 is the worst imaginable health and 100 the best imaginable health).

4: Summary

- 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.
- The evidence underpinning the HICM is focussed mainly on older people. This support tool draws on research evidence and the DHSC's out of-hospital care models programme to show how specialist services can be developed as part of Home First Discharge to Assess.
- Early evidence from the programme suggests that good progress is being made to draw housing and homelessness resource into D2A Pathways, with many emerging examples of new services and wider system transformation.
- Challenges developing and integrating specialist homeless out-of-hospital care in D2A pathways include:
  - recruitment and retention of staff with inclusion health (homeless) experience and skills
  - ensuring housing and homelessness expertise is valued as part of the multi-disciplinary processes linked to the transfer of care hubs
  - ensuring small enough caseloads to ensure continuity of active care for recovery after discharge (preventing 'warehousing')
  - difficulties in finding properties that can be adapted to meet the needs of people with disabilities linked to frailty and early ageing
  - difficulties accessing move-on accommodation leading to longer lengths of stay in Pathway 2 services
  - difficulties in securing Care Act assessments and longer-term care and support services, also leading to longer lengths of stay in step-down.
- Future sustainability of specialist homeless services is also uncertain. While the Better Care Fund is identified by NHSE as the primary source of funding for mainstream services, it is unclear if this will extend to secure the significant progress that has been made to 'roll out' specialist services.

References

Ashton and Hempenstall (2009). Research into the financial benefits of the Supporting People Programme. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/16136/1274439.pdf [Accessed 3.10.22]

Bolton, J (2018) Reducing delays in hospital transfers of care for older people: Key Messages in planning and commissioning. Oxford: Institute of Public Care. https://ipc.brookes.ac.uk/files/publications/Some_key_messages_around_hospital_transfers_of_care.pdf [Accessed 3.10.22]

Bolton, J. (2022) Developing a capacity and demand model for out-of-hospital care. Learning from supporting seven health and care systems. www.local.gov.uk/publications/developing-capacity-and-demand-model-out-hospital-care [Accessed 3.10.22]

Cornes, M et al (2019) Transforming out-of-hospital care for people who are homeless: support tool and briefing note complimenting the High Impact Change Model. London: KCL. https://kclpure.kcl.ac.uk/portal/en/publications/transforming-out-of-hospital-care-for-people-who-are-homeless-support-tool-for-the-high-impact-change-model(fca232e9-1d6c-44f7-a477-c69963393807).html

[Accessed 3.10.22]

Cornes, M., Aldridge, R., Byng, R., Clark, M., Foster, G., Fuller, J., Hayward, Hewett, N., Kilmister, Manthorpe, J., A., Neale, J., Tinelli, M., and Whiteford, M., (2021) Improving care transfers for homeless patients after hospital discharge: A Realist Evaluation. Health Services and Delivery Research. 9(17). www.journalslibrary.nihr.ac.uk/hsdr/hsdr09170/#/abstract [Accessed 3.10.22]

Curtis, L. & Burns, A. (2020) Unit Costs of Health and Social Care 2020, Personal Social Services Research Unit, University of Kent, Canterbury.

DHSC/HM Government (2022) Hospital Discharge and Community Support: Policy and Operating Model. London: HM Government. www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model [Accessed 2.10.22]

Dorney-Smith, S (2019) Towards system leadership – defining the role and potential of nurses working in homeless hospital discharge. London: Pathway & Burdett Trust for Nursing. www.pathway.org.uk/wp-content/uploads/Burdett-Full-Final-report-Towards-system-leadership-final-for-web.pdf [Accessed 3.10.22]

Flatau, P., & Zaretzky, K. (2008). The Economic Evaluation of Homelessness Programmes. European Journal of Homelessnes, 2, 305–320.

House of Commons Health and Social Care Committee (2021) Workforce burnout and resilience in the NHS & social care. https://committees.parliament.uk/publications/6158/documents/68766/default/ [Accessed 2.10.22].

Legislation.gov.uk. (2017). Homelessness Reduction Act 2017. www.legislation.gov.uk/ukpga/2017/13/pdfs/ukpga_20170013_en.pdf [Accessed 2.10.22].

Local Government Association, Department of Health and Social Care, Association of Directors of Adult Social Care, NHS England and NHS Improvement (2019) High Impact Change Model. Managing Transfers of Care between Hospital and Home. A self-assessment tool for local health and care systems. London: Local Government Association. www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model [Accessed 10.10.19]

Local Government Association and NHS England (2022) Better Care Fund planning requirements.

www.england.nhs.uk/wp-content/uploads/2022/07/B1296-Better-Care-Fund-planning-requirements-2022-23.pdf [Accessed 10.10.19]

NHS Confederation & NHS Providers (2021) Discharge to Assess: the case for permanent funding. www.nhsconfed.org/publications/discharge-assess [Accessed 10.2.22].

NHS England and NHS Improvement, Department of Health and Social Care, Association of Directors of Adult Social Services, Local Government Association, Housing LIN and Care Sector Alliance (2016) Quick Guide: Discharge to Assess. Transforming Urgent and Emergency Care Services in England. London: NHSE Publications Gateway Reference 05871. www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/discharge-to-assess/ [Accessed 10.10.19]

NICE (2022) Integrated health and social care for people experiencing homelessness. NG214. London: NICE www.nice.org.uk/guidance/ng214 [Accessed 10.10.19]

Pleace (2015) At what cost? An estimation of the financial costs of single homelessness in the UK. Crisis London

www.york.ac.uk/media/chp/documents/2015/CostsofHomelessness.pdf [Accessed 10.10.19]

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