Healthy London Partnership

Health, housing and social care integration for people experiencing homelessness: needs identified in an inpatient audit

September 2022

Authors:

Theresa Nguyen,
JJ Nadicksbernd,
Theo Jackson,
Caroline Shulman

Supported by and delivering for London's NHS, London Councils, Public Health England and the Mayor of London

About Healthy London Partnership

Healthy London Partnership (HLP) formed in 2015. Our aim is to make London the healthiest global city by working with partners to improve Londoners' health and wellbeing so everyone can live healthier lives.

Our partners are many and include London's NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, Public Health England and London Councils.

All our work is founded on common goals set out in Better Health for London, NHS Five Year Forward View and the Devolution Agreement.

About this document

This document is intended to be used by our partners across health, housing, social care and voluntary community and social enterprises (VCSE). The report aims to show what action can be taken as integrated care partnerships to support timely and safe discharge from hospital and improve out of hospital care (OOHC) for people experiencing homelessness in London.

Acknowledgements

First and foremost, thank you to all the hospital teams involved for their time and participation in providing the information necessary to complete this work.

The authors of this report were substantially supported by multiple partners with the survey design, and implementation: Emma De Zoete, Public Health Specialist with Greater London Authority; Samantha Dorney-Smith, Nursing Fellow with Pathway; and Jane Wilson, Head of System Coordination – Out of Hospital Care with NHS North Central London Clinical Commissioning Group.

We would also like to acknowledge the support provided by Dr Michelle Cornes for her input and the recommendation of using the Bolton methodology, other HLP colleagues including Michael Buggle, Communications Officer; Millie Satow, Project Support Officer; Gill Leng, Strategy Lead; Liza Collins, Deputy Director for Homeless Health; Jemma Gilbert Director of Transformation, Health Inequalities & Inclusion; and Rachel Brennan, National Partnerships Lead with Groundswell UK, in reviewing this document and ensuring its readiness for publication.

Contents

About Healthy London Partnership 2
About this document 2
Acknowledgements 2
Contents 3
Executive summary 5
The audit 5
Key findings 6
Unable to return to previous living situation 6
High level of complex needs 7
Projected accommodation and support needed for a safe discharge 7
Non-UK nationals with restricted or uncertain eligibility for public funds 9
Delayed discharge 9
Unsafe discharges in previous seven days 10
Conclusion 10
What's needed to address the gaps found in this audit? 11
Taking this audit further 12
Introduction 13
Overview 13
Context 16
Methodology 17
Methods 17
Caveats 19
Findings 20
Combined Acute and Mental Health data 20
Acute hospital data 20
Clinical complexity 21
Concerns about cognition or mental capacity 23
Living situation on admission 24
Safeguarding concerns 25
Discharge to assess pathways 25
Delayed discharges 26

Projected summary of need 28
Summary of need (medically fit for discharge) 32
Suboptimal Discharges 32
Mental Health hospital data 33
Living situation on admission 34
Delayed discharges 36
Projected summary of need 36
Summary of need (medically fit for discharge) 37
Suboptimal discharges 37
Unsafe discharges 38
Learnings 39
Summary 40
What's needed to address the gaps found in this audit? 42
Appendix A: Non-UK nationals with restricted eligibility to benefits 44
Appendix B: Rough sleeping cohort data 49
Appendix C: Hospital teams involved 52
Appendix D: Clinical conditions 53
Appendix E: Discharge To Assess (D2A) 57
Appendix F: Summary of need definitions (Acute cohort) 59
Appendix G: Suboptimal discharges (Acute cohort) 64

Executive summary

People experiencing homelessness and multiple disadvantage frequently die young, often from preventable and treatable conditions. They experience significant barriers to accessing health services, so regularly have unmet health and care needs, resulting in high rates of urgent and emergency care.

This report describes the findings of an audit conducted across 19 London hospitals of people experiencing homelessness who were inpatients at one point in time. It was conducted to understand and quantify the needs of people admitted as well as gaps and barriers to safe discharge from hospital.

As highlighted in recent NICE guidance, hospital admission can offer a critical opportunity to provide comprehensive needs assessments and interventions that can significantly improve health and social care access and outcomes. This requires integrated multidisciplinary health and social care services that are trauma-informed, provide person-centred care and recognise the need for long-term wrap-around support. Considering the often-early onset of frailty and multimorbidity, NICE also highlights the need for care packages that are based on needs rather than biological age. The guidance also states that intermediate care should be provided for people experiencing homelessness who have healthcare needs that cannot be managed in the community but do not need inpatient care. This is particularly important considering the bed pressures that hospitals are experiencing.

Reducing inequality is a goal across health, housing and social care. To tackle inequalities, we need to improve visibility and a shared understanding of the barriers and gaps within the system. For strategic planning across sectors, NICE recommends the need for improving data collection and reporting.

The audit

In the absence of data, we undertook a snapshot audit over one week in February 2022 and investigated the health, care, support and accommodation needs of people identified as being homeless who were in hospital at that point in time. Accident and Emergency (A&E) departments were not included.

The audit is of a scale and detail that has not previously been undertaken in hospitals across London. It represents data from 15 Acute, three Mental Health and one Community Healthcare hospital in which there were 150 in-patients identified as being homeless at that one point in time. Homelessness for this report includes individuals not having a home, living in poor or unsafe conditions, sofa surfing, staying in a hostel, night shelter, temporary accommodation, squatting, and rough sleeping. This report focuses on an in-depth analysis of 104 of these inpatients. The depth of information gathered was only possible due to hospital and ‘out of hospital’ inclusion health teams. These specialist teams are often multidisciplinary and aim to support people who are

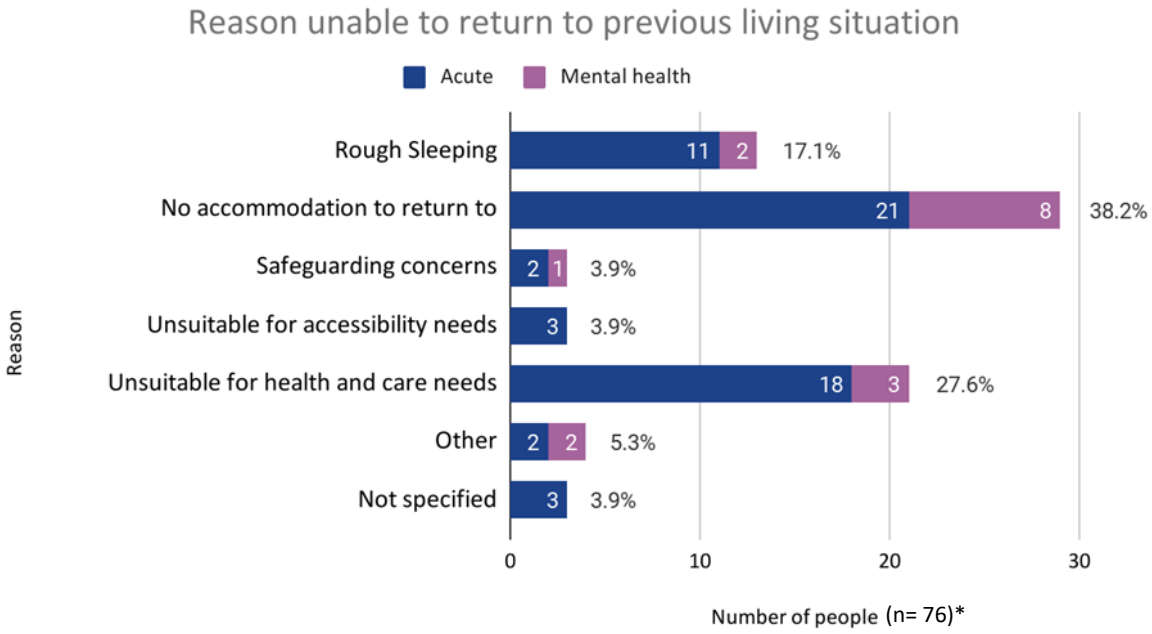
socially excluded, who typically have multiple risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and who are not consistently visible within healthcare datasets.

Key findings

The audit found those experiencing homelessness have high levels of complexity of health and support needs, with the vast majority of people unable to return to their pre-admission living situation. There was a mismatch between the type of projected accommodation and support needed compared to what was available, often resulting in discharges that were suboptimal and/or delayed. Among delayed discharges, there were also people awaiting assessments or decisions from local authority housing and/or adult social care services. For those whose eligibility for public funds was identified as being restricted, the barriers to accessing accommodation and support were even greater with considerable delays in establishing whether they would be supported under the Care Act.

Unable to return to previous living situation

The majority (91.6 per cent) of people were unable to return to their pre-admission living situation for a range of reasons including, rough sleeping, they had no accommodation to return to (due to having been evicted or the host was unwilling to take them back), or the accommodation was unsuitable for their existing and new health and care needs (and would likely result in a suboptimal discharge). See graph below. Those who reportedly could return had been admitted from hostels.

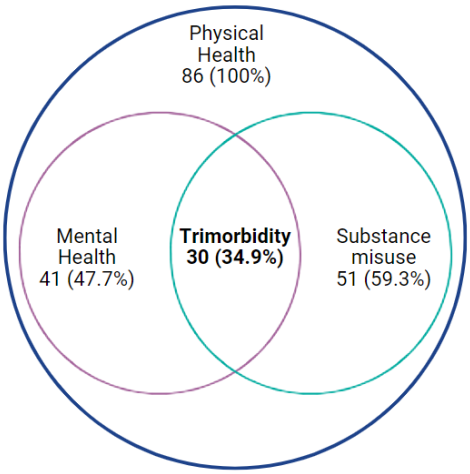


**This question was added at a later date and so responses were not captured from the total cohort.*

High level of complex needs

There were extremely high levels of complexity across the cohort. Out of the 86 individuals in Acute hospitals the following was found.

- Almost two-thirds (64 per cent) had three or more physical health co-morbidities; the highest number being eight.
- A large proportion had mental health and/or substance misuse issues, and over a third (34.9 per cent) had tri-morbidities.
- More than half (54.7 per cent) were believed to have care needs.
- There were concerns about cognitive impairment and/or aspects of mental capacity in 30.2 per cent.
- Significant safeguarding concerns were present in 29 per cent including domestic violence, “cuckooing” and self-neglect.



Out of the 18 individuals in the Mental Health cohort, the following emerged:

- Over one-third (38.9 per cent) had substance misuse issues (dual diagnosis).
- Half of people (50 per cent) had additional physical health conditions (including hypertension, heart disease, vascular dementia, sickle cell anaemia, leg ulcers, kidney stones and chronic musculoskeletal problems).
- Nearly one in six (16.7 per cent) had tri-morbidity.

Projected accommodation and support needed for a safe discharge

The teams were asked to outline what was needed for a safe discharge and most likely to support improved longer-term outcomes. There was a clear need for trauma-informed services that could provide short- or long-term support for a range of physical health, mental health, psychological and addictions needs. Many of these services were not currently available.

- Only one person needed ‘just’ accommodation (low-level accommodation) with access to routine primary care and outpatient services.

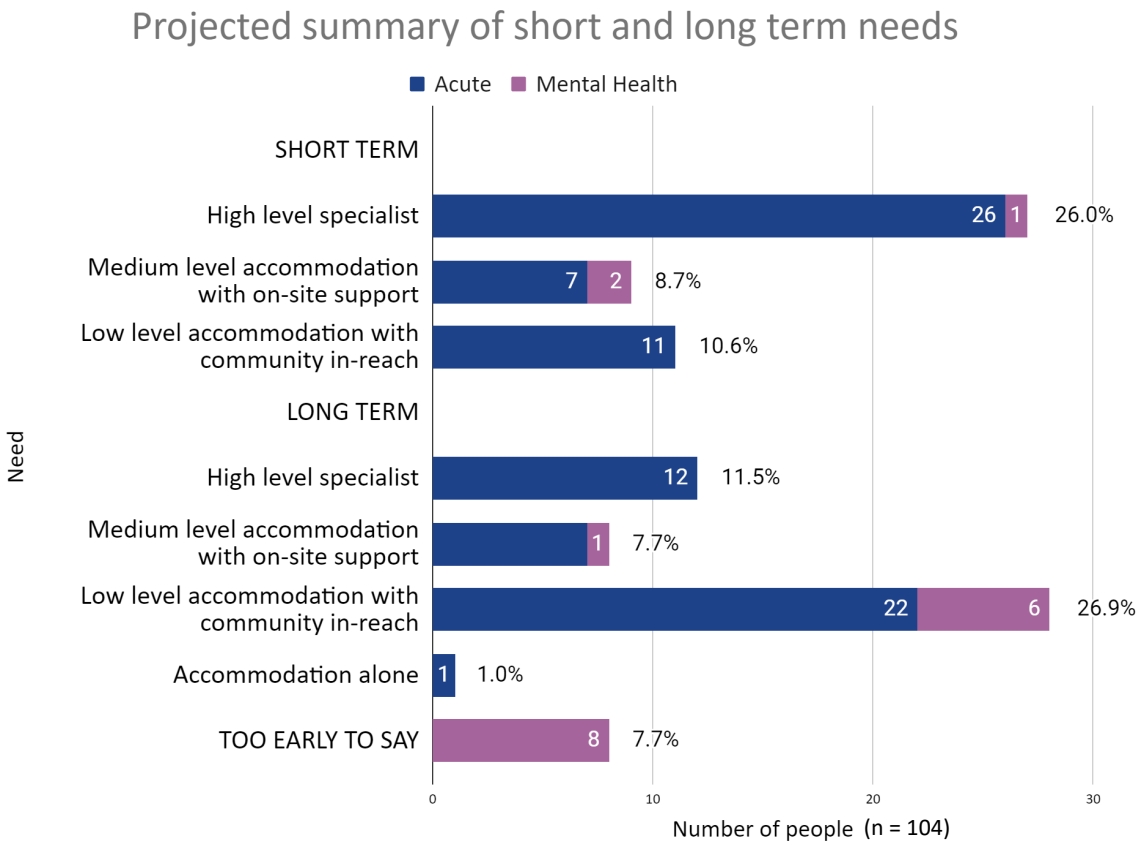
Short-term intermediate care:

- 45.2 per cent were identified as requiring short term intermediate care/step-down initially. This was because they either had needs that would:
    - change with further treatment (for example, following rehabilitation),
    - their needs were not yet fully understood (or they were awaiting further assessment) or
    - more time was needed to explore or resolve immigration issues.
- The intermediate care needs were divided into:
    - high-level, that is, 24-hour health or care staffing (26 per cent),

- medium-level, that is, 24-hour (non-health) staffing with multidisciplinary in-reach (8.7 per cent) or
- low-level, that is, unstaffed accommodation but with in-reach support (10.6 per cent).

Long-term needs:

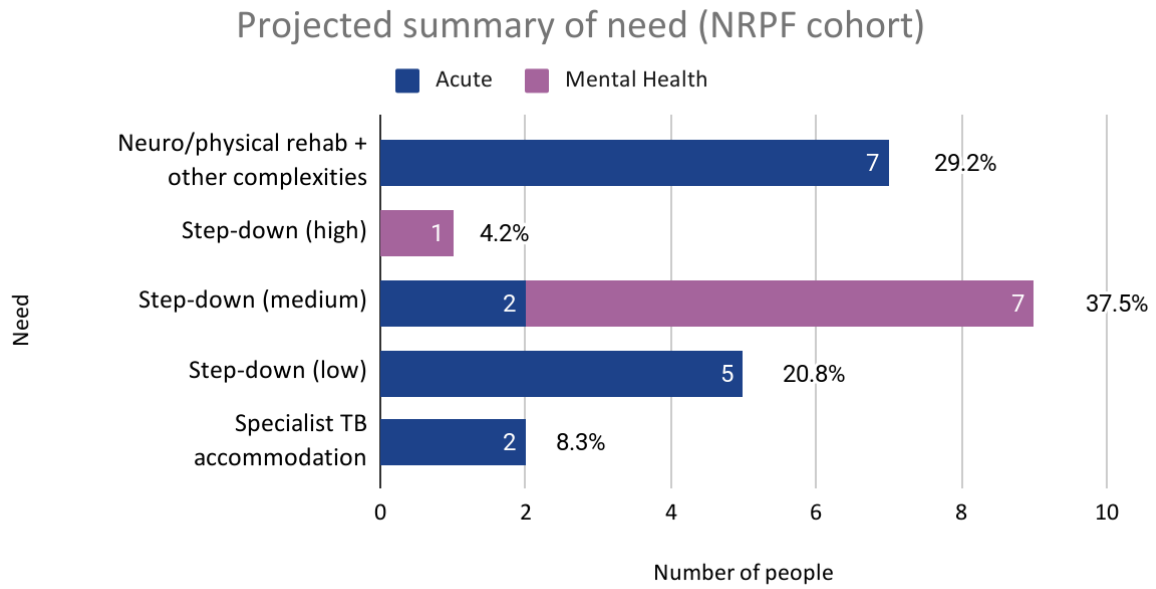
- 46.1 per cent had needs that were unlikely to change in the near future (namely, long-term needs), including:
  - high-level, that is, care home provision (11.5 per cent),
  - medium-level, that is, accommodation with on-site support (7.7 per cent) or
  - lower-level, that is, accommodation with community/in-reach support from a range of services including social care, primary care, homelessness support staff, peer support and voluntary sector organisations (26.9 per cent).



There was more uncertainty around what the most appropriate discharge destination was for teams working within the Mental Health hospitals. However, there was a clear need for placements that could accommodate people with significant mental health needs co-occurring with substance misuse.

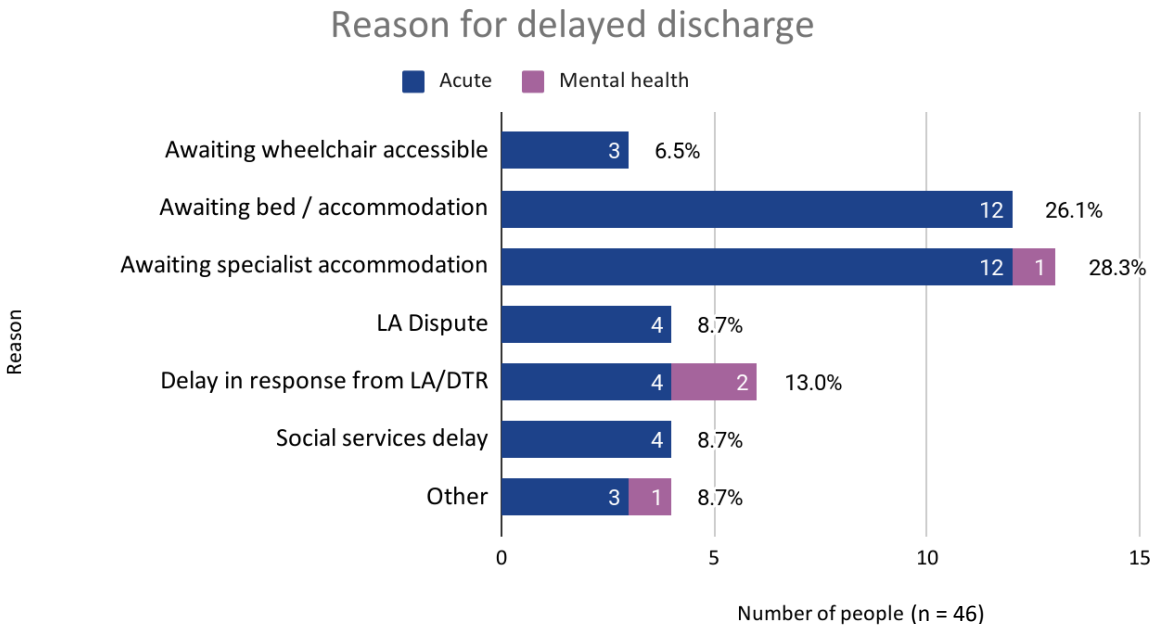
Non-UK nationals with restricted or uncertain eligibility for public funds

There were 24 people who the teams identified as non-UK nationals with restricted eligibility for public funds (16 from the Acute and eight from the Mental Health cohort), and an additional eight from the Acute cohort whose eligibility was uncertain and still being determined. Of these 32 in total, three-quarters were believed to have care needs. The graph below shows the projected summary of need for the 24 people reported to have restricted eligibility or no recourse to public funds (NRPF).



Delayed discharge

Due to a lack of safe and appropriate discharge destinations, 44.2 per cent of the 104 people remained in hospital beyond the time needed for that level of care, in other words, their discharge was delayed. Reasons for delay included awaiting different types of specialist accommodation (for example, neurological rehab for someone with mental health or substance misuse issues), or waiting for assessment, outcome and allocation from local authority housing or adult social care teams. 14 per cent (8) of people delayed were reported to have NRPF.



Unsafe discharges in previous seven days

Additionally, to try and capture the extent of unsafe or unplanned discharges, we asked teams to recall any discharges to the street or discharges they considered unsafe or suboptimal from their inpatient caseload within the previous seven days. The figures are based on the participant's recollection within a specified week and so may not accurately reflect the true number of unsafe discharges within any given week across London. There were:

- 11 unsafe or sub-optimal discharges (which includes three discharges to the street),
- Five self-discharges.

Reasons given for these included pressures for bed availability, challenges dealing with difficult behaviours, lack of options and delays in response from local authority.

Conclusion

People experiencing homelessness often have considerable health, housing and social care needs. Hospital admission is an opportunity to provide holistic assessment to identify what is needed to support recovery. A skilled and multidisciplinary workforce that is familiar with providing person-centred and trauma-informed care, and is trusted amongst this population, can help address these needs to facilitate a safe discharge and access to ongoing support.

Due to lack of available appropriate move-on options, many people are discharged to destinations that are unable to fully meet their needs, to settings that are potentially unsafe, or will remain in hospital while appropriate options are being sought. Once deemed 'medically fit for discharge', many still require ongoing specialist case working, a period of rehabilitation, floating or in-reach/community support and/or

specialist accommodation. Lack of appropriate options is costly to individuals, in that their health and care needs are often not met, but also to the health and care system. Additionally, timescales that local authority housing and adult social care work towards are different from the often highly pressurised situation in hospitals. A slow response to a request for assessments contributes to longer than necessary stays in hospital. This can be particularly problematic for people with complex immigration issues (such as NRPF).

Identifying whether someone is experiencing homelessness early on in the admission process will enable frontline teams to better plan for that person's care and support needs. Improving visibility of this population within NHS data sets will also help inform commissioning decisions based on demands, gaps and needs.

What's needed to address the gaps found in this audit?

This audit demonstrates the gap between NICE guidance for this population, and what's available in practice. It reinforces the value of a focused homelessness partnership, with leadership and strategic oversight for London. It suggests action is needed to secure the following:

- **A shared, robust and up to date understanding of the population's needs and experiences, to inform commissioning and delivery**.
    - Taking opportunities to understand and capture information about an individual's accommodation status (such as hospital staff asking, "have you got a safe place to be discharged to?").
    - Use of the housing status codes, which already exist in NHS service datasets, as part of routine data collection.
- **A consistent and sustained 'service' offer to individuals to facilitate successful transfers of care from hospital to the community, to prevent crisis admissions ('out-of-hospital care') and improve access to appropriate support and better outcomes**. **A service offer that is consistent with the following elements.**
    - Shaped through co-production with people with lived experience.
    - Person-centred and trauma-informed, with multi-disciplinary teams sharing an understanding of the individual's needs, strengths and aspirations, and how to prevent and de-escalate trauma-induced situations.
    - Makes the best and combined use of professionals' knowledge, expertise, and time including:
        - Bringing together health, housing and social care workforces to better understand and value each other
        - The development of shared protocols, which provide a safe framework for action, to:

        - enable more timely identification of, and decisions on, an individual's housing status, health and care needs, eligibility for housing care and support,
        - prevent self-discharge from hospital, including understanding and managing substance misuse needs.
    - Supports the workforce to have access to clinical supervision, reflective practice and training to de-escalate crisis.
    - Offers accommodation options that better reflect the diversity of need and enable personal choice and control, in other words:
        - a range of step-up/step-down intermediate care solutions, and
        - longer-term solutions, particularly for people with complex needs who have a physical disability and mental health and/or substance misuse issues.
    - Makes the most of opportunities to support people in the community, for example, through peripatetic multidisciplinary team (MDT) support and floating support in temporary accommodation and hostels.
    - Reflects the value of trusting relationships in supporting engagement as an essential part of recovery, through the employment of people with lived experience and VCSE partners.
- **To better support people whose eligibility for public funds is restricted or uncertain, there is a need for the following**:
    - Shared understanding across health, social care and housing workforces of the legislation, policy and practice.
    - More timely identification of, and decisions on, an individual's eligibility for support from adult social care.
    - Access to legal support by hospital teams.
    - Use of available resources and escalation procedures (NRPF Network, Home Office), where appropriate.

Taking this audit further

Scoping work is underway to consider how the findings from the audit can be modelled to quantify what is needed sub-regionally and regionally to address the accommodation and service gaps across London. This work will also consider how many bed days could be potentially saved from reducing delayed discharge.

Health, housing and social care integration for people experiencing homelessness: needs identified in an inpatient audit

Introduction

As part of HLP's Out of Hospital Care (OOHC) Project, this audit was designed to identify needs, key challenges and barriers impacting on discharge planning and OOHC for people experiencing homelessness and multiple disadvantage across parts of London, as well as understand the factors that could lead to potentially unsafe or suboptimal discharges. Homelessness for this report includes individuals not having a home, living in poor or unsafe conditions, sofa surfing, staying in a hostel, night shelter, temporary accommodation, squatting, and rough sleeping. The aim of this report is to help inform commissioning decisions across London to improve OOHC and facilitate more partnership working between health, housing and social care partners.

Prior to this audit, a rapid snapshot survey was undertaken in early January 2022, to determine whether there was a need to step up additional pan-London provisions for COVID isolation. While the findings determined that no additional specific COVID isolation provisions were needed at that time, it also highlighted many other issues that were impacting timely and safe discharges from hospital for people experiencing homelessness. There was a wide range of complexity of need, often including a combination of physical health, mental health, addiction, housing and social care factors. These issues were explored in more detail in this audit. Full details of the rapid snapshot survey can be read here.

Overview

People experiencing homelessness and multiple disadvantage are known to face barriers accessing primary care and other support, often presenting at hospitals with complex health and social care problems. They experience some of the worst health and social care outcomes, with an estimated four times the usage of acute hospital services and eight times that of inpatient services when compared to the general population.[1] A hospital admission is an opportunity to support improved assessments, access to care and long-term outcomes.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6752254/#CIT0002

There are many economic and social factors that contribute to homelessness such as poverty, lack of affordable housing, unemployment, trauma, relationship breakdown, exclusion and discrimination. Many of these factors were exacerbated by the pandemic. Adverse child experiences and complex trauma are known to be strongly associated with single homelessness and poor health, and addiction to drugs or alcohol can be both a risk factor for, but also an effect of, homelessness.

Despite being more likely to have physical health, mental health and substance misuse issues, this population experiences significant barriers in accessing the health services they need.[2] They also have been found to develop multi-morbidity around 10-15 years earlier than the general population[3] and have an average life expectancy that is approximately 30 years lower.[4] In a hostel where the majority of residents had a history of rough sleeping, though the average age of residents was 55, frailty scores were equivalent to people in their late 80's. Conditions usually found in older people were present, such as dementia or cognitive impairment, falls, poor mobility, urinary incontinence, and malnutrition. In addition, everyone had multimorbidity with the average number of conditions per person being seven.[5]

For many people with a history of rough sleeping, their complex health and social care needs continue to put them at high risk of premature mortality long after they are supported into accommodation.[6] This demonstrates the need for continued person-centred and trauma-informed care even once people are housed.

In addition to the devastating human cost, the total public sector costs of one person experiencing homelessness are estimated to be up to £38,736 per year in England. In contrast, preventing homelessness for one year is estimated to reduce public expenditure by approximately £10,000 per person.[4] With an estimated over 274,000 people in England recorded as homeless, of whom approximately 62 per cent are in London, this presents an opportunity for significant cost savings.[7]

Access to secure and safe housing is an essential component of preventing homelessness. Without appropriate accommodation, individuals face difficulties with employment, education, their health and wellbeing, and are more likely to be in contact with the criminal justice system. London's housing crisis makes tackling homelessness challenging with one in 10 households on a waiting list for council housing for over five

[2] https://www.bmj.com/content/360/bmj.k902/rr

[3] https://www.pathway.org.uk/wp-content/uploads/2013/05/Homeless-medical-respite-in-the-UK-A-needs-assessment-for-South-London.pdf

[4] https://www.nice.org.uk/guidance/ng214/resources/integrated-health-and-social-care-for-people-experiencing-homelessness-pdf-66143775200965

[5] https://www.emerald.com/insight/content/doi/10.1108/HCS-05-2020-0007/full/html

[6] https://thamesreach.org.uk/wp-content/uploads/2020/01/TST-Executive-Summary.pdf

[7] https://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/homelessness_in_england_2021

years. This is predicted to almost double in the next year due to the impact of COVID-19. Continued investment and commitment to building more affordable housing is needed to support those most disadvantaged.[8]

In England, for a statutory homelessness duty to be owed by the local authority the applicant needs to be: eligible (including being entitled to benefits), unintentionally homeless and fall within a priority group.[9] The 'priority need groups' include households with dependent children or a pregnant woman and people who are vulnerable in some way, for example, due to mental illness or physical disability. However, under the Homelessness Act 2002, local housing authorities must have a strategy for preventing homelessness in their district. The strategy must apply to everyone at risk of homelessness, not just people who may fall within a priority need group. Authorities are also encouraged to take steps to relieve homelessness in cases where someone has been found to be homeless but is not owed a duty to secure accommodation under the homelessness legislation.

People with restricted eligibility or no recourse to public funds (NRPF) are not owed a statutory homelessness duty. However, if they have care and support needs that meet the threshold under the eligibility criteria in the Care Act, they may be entitled to support from adult social care services.[10] Local authorities have the power to provide emergency accommodation pending an assessment and to meet care and support needs even if the person does not reach the eligibility criteria threshold.[10] Recent NICE guidance sets out some key recommendations to improve access to and engagement with health and social care services for people experiencing homelessness. These include funding integrated multidisciplinary health and social care services that are trauma-informed, person-centred and recognise the need for long-term wrap-around support, as well as co-designing and co-delivery of services with experts by experience, improving data collection and reporting, and strategic planning across multiple boroughs to support access to services.[4]

Similar recommendations are mentioned in a new report published by the Local Government Association (LGA) and the Directors of Adult Social Services (ADASS), "*Care and support and homelessness: Top tips on the role of adult social care*". In addition, this report emphasises the importance of working collaboratively and flexibly across the system to deliver timely assessments and early interventions and be able to meet the wide range of needs for this population.[11]

[8] https://www.local.gov.uk/publications/building-post-pandemic-prosperity
[9] https://www.gov.uk/guidance/homelessness-data-notes-and-definitions#statutory-homelessness
[10] https://www.nrpfnetwork.org.uk/information-and-resources/rights-and-entitlements
[11] https://www.local.gov.uk/publications/care-and-support-and-homelessness-top-tips-role-adult-social-care

Context

For many, hospitalisations end with one returning home to family, friends and community services to help with recovery and convalescing. Not only do people experiencing homelessness not have this level of support and care, they also often have complex health and social care needs. Due to a lack of appropriate housing, intermediate care provisions with wrap-around support and support/services for those with NRPF, people experiencing homelessness tend to have longer lengths of stay in hospital. A needs assessment undertaken in South London found that 77.6 per cent of homeless patients experienced a delayed discharge.[3] These delays lead to excess bed days in a health system that is already under pressure and operating at capacity.

For patients that no longer need to be in hospital, delaying discharge increases exposure to risks such as infection, muscle loss and loss of independence.[12] Having appropriate step-down services where people who have care needs, but no longer require the support of acute care, can be transferred for further rehabilitation or assessments (especially in relation to housing and social care) has been shown to help reduce delayed or unsafe discharges, as well as presentations to urgent and emergency care.[13] Clinically led MDTs with housing and resettlement support embedded can also help increase access to planned follow-up care and prevent early self-discharge.[14]

NICE guidance states discharge to the streets should be prevented.[14] A review commissioned by the Department of Health in 2012 reported that more than 70 per cent of homeless people were being discharged back onto the streets.[13] In 2018, it was reported by the Guardian that, across 89 NHS trusts in England, the number of hospital discharges of people with no fixed abode rose by 29.8 per cent from 6,748 in 2014 to 8,758.[15] Poor discharge can lead to worsening physical health, mental health, and social problems, increased use of emergency departments and repeated hospital readmissions. Patients who are homeless in hospital are more than twice as likely to be readmitted to hospital in an emergency compared to those with housing.[16] As well as the significant human cost of this, this 'revolving door' scenario inevitably increases secondary care costs.

This audit was conducted to understand the demand for hospital services, the care and support needs, and help identify the gaps and barriers to safe hospital discharges for those hospitalised and experiencing homelessness. It is acknowledged it took

[12] https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
[13] https://www.gov.uk/government/news/homeless-link-and-st-mungo-s-publish-report-on-hospitals-and-the-homeless
[14] https://www.ncbi.nlm.nih.gov/books/NBK574259/
[15] https://www.theguardian.com/society/2019/mar/13/nhs-data-shows-rise-in-homeless-patients-returning-to-streets
[16] https://www.gov.uk/government/news/fund-to-help-end-cycle-of-homelessness-and-hospital-readmissions

place during a time where additional short-term funding (Protect and Vaccinate) and winter resources (Severe Weather Emergency Protocol) were available to local authorities to provide emergency accommodation. This will likely have impacted the data, which may not reflect the true scale of unmet needs and challenges of this population.

Methodology

The aim of this work was to obtain a view of current hospital caseloads, challenges and barriers to safe discharge, and to identify where there may be gaps in available step-down provisions and/or suboptimal discharges for people experiencing homelessness across London. The objective is for this information to be used to help inform commissioning decisions that will hopefully unblock some of the barriers across the system.

The approach used was an adaptation of what Professor John Bolton[17] used to understand hospital delayed discharges for older people. The premise was that a hospital patient population, at a given hospital, was generally consistent day in and day out and therefore the approach was to capture a count of patients on a given day and their needs. The outcomes from this work supported the creation of the now used Discharge to Assess (D2A) options, using pathways 0-3, to support individuals to be discharged safely from hospital, when appropriate, to receive on-going care and assessments.

Our approach was to also look at one day in time, a hospital's homeless population. In addition to the number of individuals and their needs, the audit took a closer look at the nature of individual complexities to understand the reasons for delayed discharges and gaps in short- and long-term provisions.

Methods

Selected hospital teams working with patients experiencing homelessness were sent an introductory and engagement email approximately three weeks ahead of the audit inviting them to participate. The email explained the purpose of the work, what would be involved and to request nominated team member(s) to take part to represent the team's understanding and assessment of the cases.

Due to limitations of time and resources, not all London hospitals were invited to participate in this audit. However, all hospitals across North Central London (NCL) and North East London (NEL), as well as nine London hospitals with homeless Pathway teams (specialist multidisciplinary teams with a nurse, GP, housing worker, therapist

[17] https://ipc.brookes.ac.uk/files/publications/Some_key_messages_around_hospital_transfers_of_care.pdf

and/or social worker) were approached (a total of 23 hospital teams). In the end, 19 (across 16 different Trusts) agreed to participate (Appendix C). Below is the breakdown:

- Acute hospitals: 15
- Mental Health hospitals: three (including one step-down unit)
- Community Healthcare Trust hospital: one (step-down unit)

Participants nominated a person within their team and agreed to meet virtually at a set day and time over Microsoft Teams with a surveyor, to answer a set of standardised questions. Each session was scheduled for two hours with a nominated surveyor over the period of 21 to 25 February 2022. Where the allocated time was not sufficient to complete the data collection, a follow-up session the following week was encouraged to capture details for the remaining patients. The follow-up session was to retrospectively finish gathering details on the caseload from their allocated interview day the previous week (including patients that had since been discharged). Alternatively, teams were asked to send through any remaining non-identifiable patient details via email.

At the time of the meeting, the surveyor shared their screen with the standardised audit questions from Survey Monkey open. Before starting, it was made clear to each team that the information being collected was dependent on the caseload for that day only. At the end of the survey, participants were asked about any unsafe or street discharges within the previous seven days. Teams were also requested not to share any patient identifiable information. If patient identifiable information was shared, it was not captured.

The surveyor asked the questions and typed in participants' answers live in Survey Monkey. To ensure that the hospital and patient details remained confidential, each hospital team was assigned a hospital code and teams were requested to assign a code for each patient.

The following number of cases were identified:

- Total: 150
    - Acute: 114
    - Mental Health: 33
    - Community Healthcare Trust hospital or step-down unit: three

However, due to limitations outlined below, the majority of this analysis focuses on:

- Total: 104
    - Acute: 86
    - Mental Health: 18

The 46 patient details that have not been included in the analysis include the following:

- 26 Acute patients from one particular team that had a total of 33 inpatients on their caseload and limited time available to complete the survey due to pressures of work
- 15 Mental Health patients where there was a lack of access to the necessary records from the respective team
- Two patients whose details had been provided but were already discharged
- Three patients who were residing in step-down units at the time of audit

The data collected from Mental Health hospitals were separated for analysis and are, unless stated otherwise, presented separately in the findings. In addition, because of the complexities and known challenges around service access and provision for people with NRPF and people experiencing rough sleeping, additional subgroup analyses were undertaken for these cohorts and discussed below in Appendix A and Appendix B, respectively.

Caveats

- This audit did not include people accessing Accident and Emergency (A&E) departments.
- After completing a couple of surveys, additional questions were added and so, for some questions there are less respondents. Where applicable, this is noted in the report. See survey questions here.
- While it was recommended to teams to nominate individuals who had access to the total team caseload details, it is recognised that not all members would be familiar with each patient and there may be gaps in the data for this reason. Some teams were newly established and did not have streamlined processes in place or full access to their hospital's patient record system at the time of audit.
- Discharge To Assess (D2A) options were developed for teams working in Acute Trusts and were not developed for Mental Health services. Though asked within the survey, any responses to the D2A-related questions from Mental Health Trust teams were not included in the analysis.

Findings

Findings presented include demographic information, clinical presentations, housing, health and care needs for discharge, as well as barriers to timely and safe discharge.

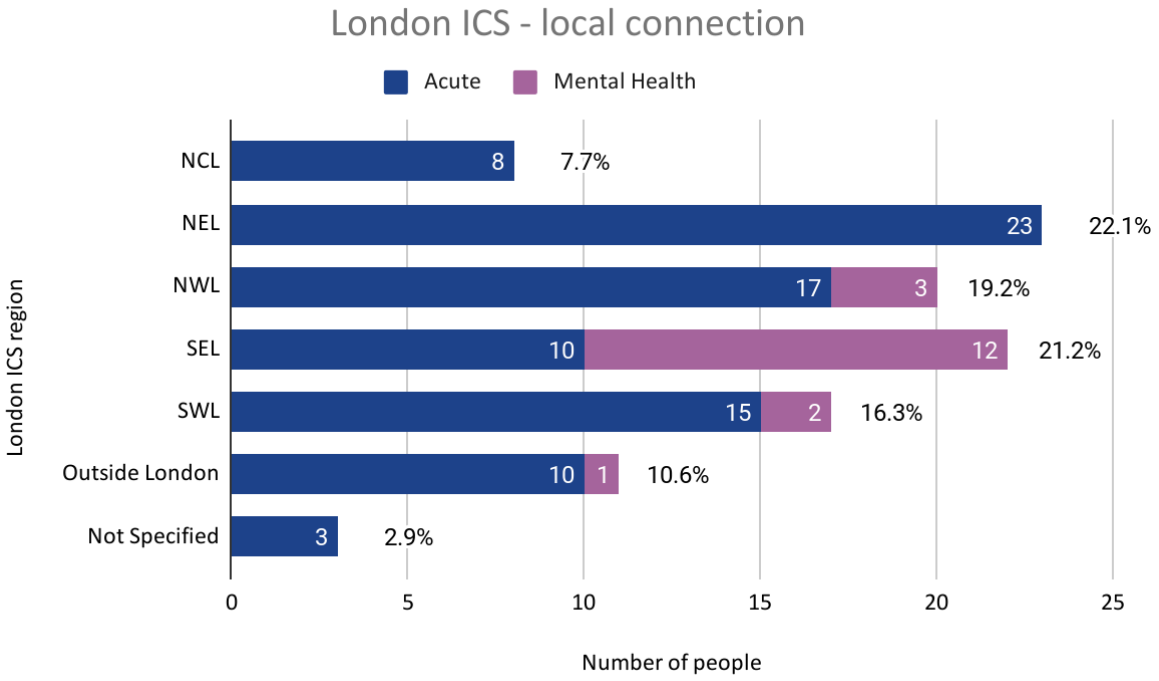
Combined Acute and Mental Health data

The following presents the findings of 104 patients with 86 from Acute and 18 from Mental Health hospitals. Of these:

- 80 (76.9 per cent) were male and 24 (23.1 per cent) were female,
- at least 16 (15.4 per cent) were CHAIN verified,
- 24 (23.1 per cent) were reported to be non-UK nationals with restricted eligibility for public funds and there was an additional 8 whose eligibility was still being determined.

Looking across the London Integrated Care Systems (ICSs), the following is a breakdown of the total cohort by local connection on admission (Graph 1).

Graph 1



Recognising the significant differences between Acute and Mental Health hospitalisations, we present them separately. The next section focuses on the more detailed cases from the Acute hospitals.

Acute hospital data

This audit captured information from 15 of 31 standard Acute hospitals in London. It provides detailed findings on 86 individuals, of which the majority were male, and the most common age range was 45 to 54 years (see Table 1). The average length of stay was 38.3 days (ranging from one to 265 days using the date of admission up to the

date of audit). There were three individuals that were not classified as 'single homeless' (because they had a family or spouse who also had housing needs) but were included in the analysis as they had been mentioned as part of the team's caseload.

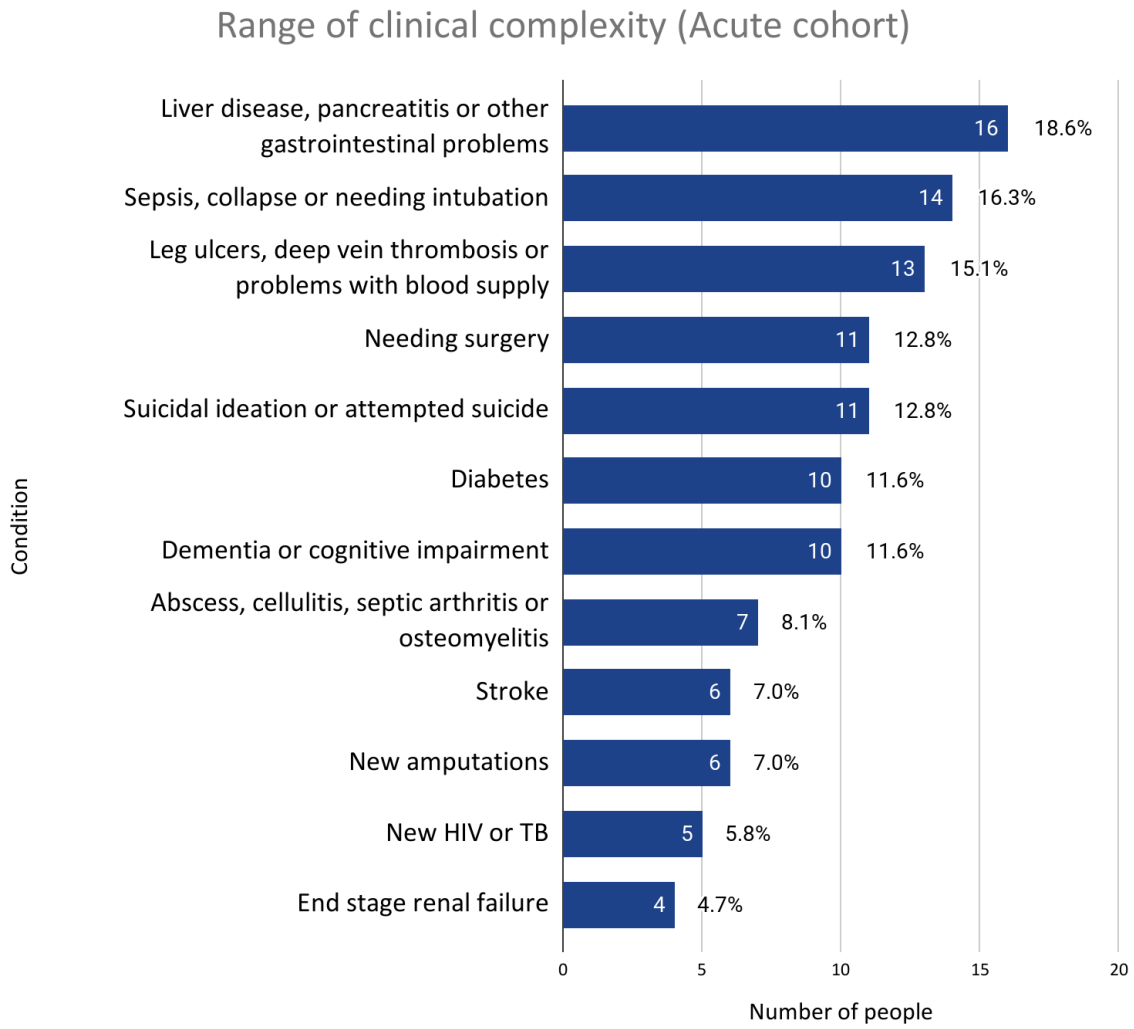
Table 1

Age	Female	Male	Total
25-34	1	4	5
35-44	7	15	22
45-54	7	20	27
55-64	2	16	18
65+	2	12	14
Total	**19 (22.1 per cent)**	**67 (77.9 per cent)**	**86**

Clinical complexity

The level of complexity for many of these cases was considerable. Almost two-thirds (63.9 per cent) had three or more different clinical issues related to their admission, including 17.4 per cent who had between five and eight. The average number of conditions per person was three. Some of the major clinical complexities are summarised below in Graph 2 (in order of most common).

Graph 2

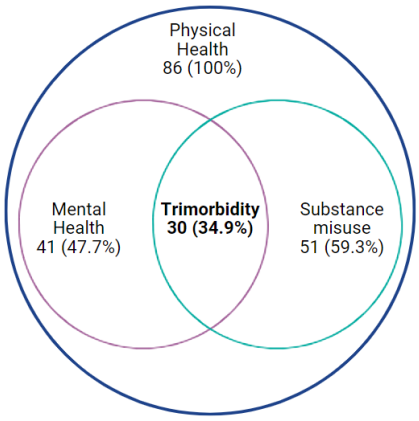


It was also reported that 47 (54.7 per cent) people were believed to have care needs. The full breakdown of the different conditions can be found in Appendix D .

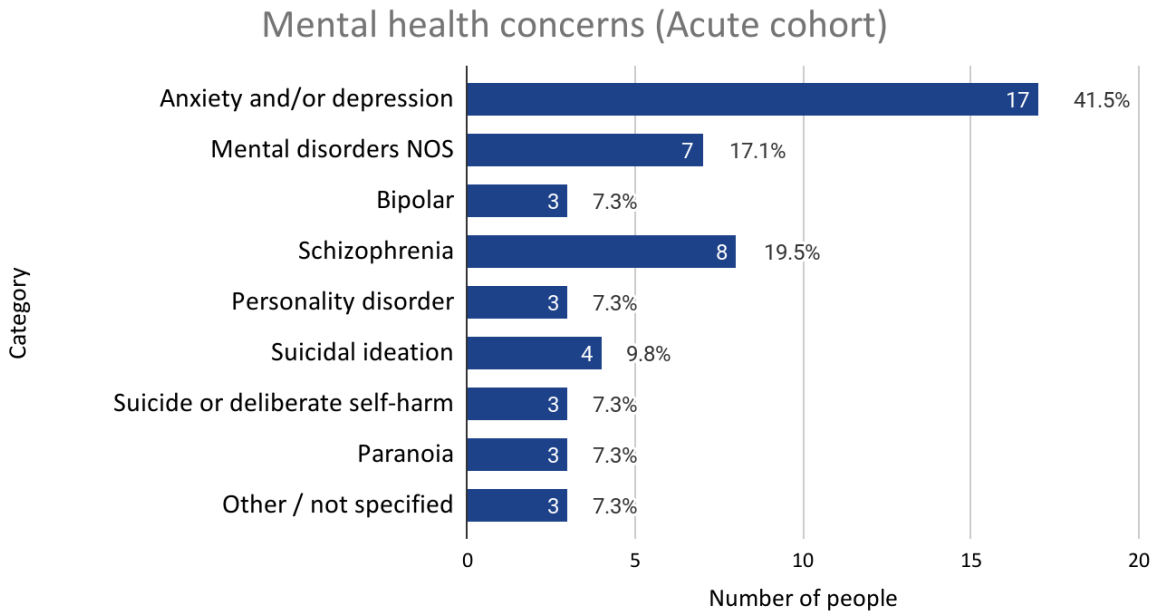
Within this cohort, 47.7 per cent also had mental health difficulties and 59.3 per cent had substance misuse issues (see Figure 1). Over a third (34.9 per cent) had tri-morbidity.

The wide range of mental health needs within the Acute cohort are highlighted in Graph 3, of which the categories are not exclusive. 'Other' includes Korsakoff's Syndrome, post-traumatic stress disorder and those not specified. There was at least one person who had three different mental health needs identified.

Figure 1



Graph 3

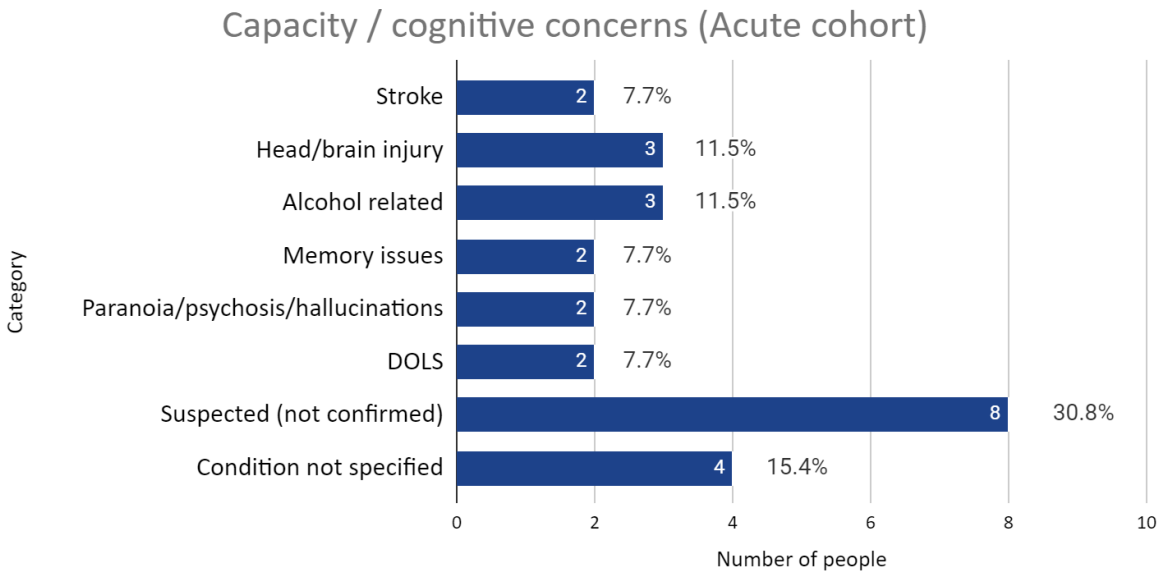


Concerns about cognition or mental capacity

There were concerns around cognitive impairment or fluctuating mental capacity for 26 (30.2 per cent) people, though for 30.8 per cent of these, they were not confirmed (not recorded in the medical records) but suspected by the team. The primary explanations given for the cognitive impairment or concerns around mental capacity are summarised in Graph 4.

Of these 26, 19 (73.1 per cent) were deemed to have substance misuse issues and 15 (57.5 per cent) had mental health difficulties.

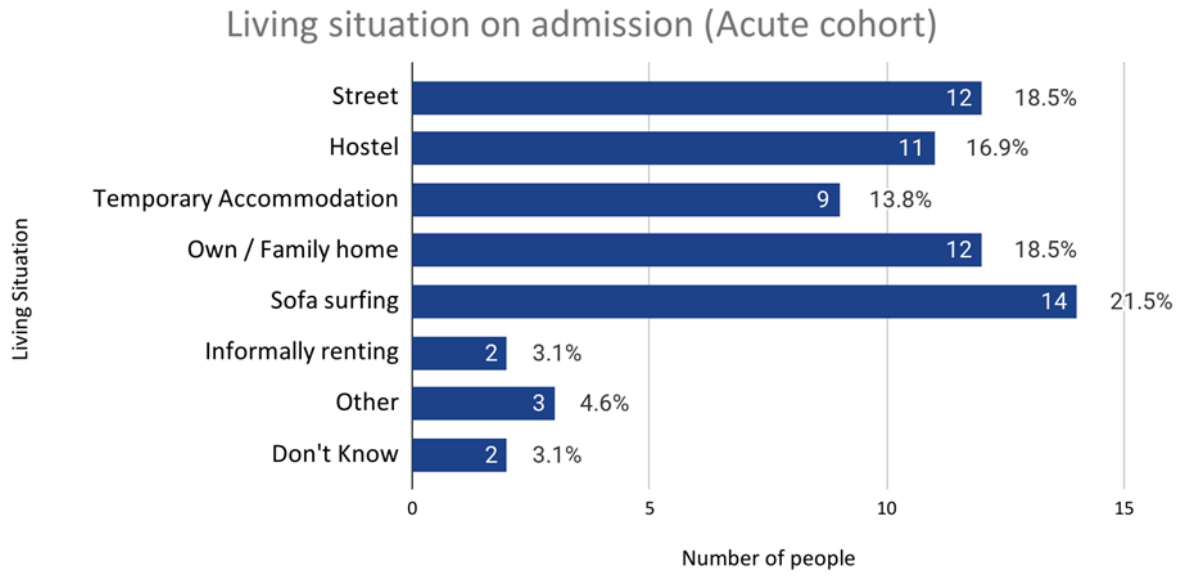
Graph 4



Living situation on admission

The question relating to living situation on admission was added at a later date and so, information was only captured for 65 people out of 86. See Graph 5 for the breakdown of where individuals were living on admission. 'Other' includes those who were living in a car, were squatting or had an address upon admission but the team were unable to verify the person's rights to the property.

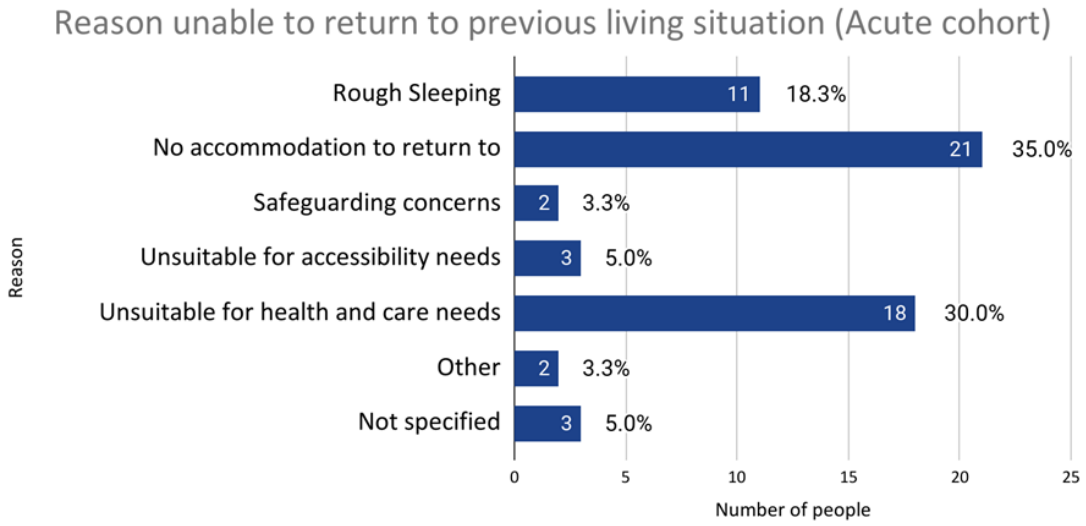
Graph 5



The majority (60, 92.3 per cent) were unable to return to their previous living situation following discharge. The main reasons why, presented in Graph 6, were because they had been rough sleeping (18.3 per cent); it was not suitable for their needs (physical health, tri-morbidity and mental health substance misuse issues; 30 per cent); or because they had no safe accommodation to return to (for example, if they had been sofa surfing and couldn't return, they were living in a car, they had been told by the host they could not return or they were evicted; 35 per cent). Within the last category there was one person who had an address upon admission but said they were unable to return to it and the team were unable to verify the person's rights to the accommodation. It is not clear if these changes in living situation occurred before or during admission. It is assumed that for the majority, it either precipitated the admission (such as mental health crisis) or was precipitated by the admission.

A small number (3.3 per cent) were unable to return because they had safeguarding concerns around domestic violence or other reasons (3.3 per cent) such lack of funds and issues with ordinary residence.

Graph 6

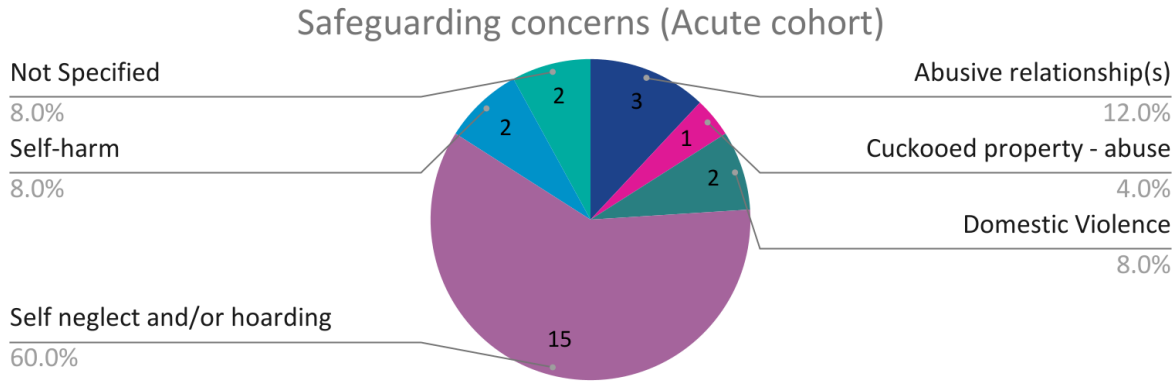


The five people that were deemed able to return to their previous living situation had been staying in a hostel prior to admission.

Safeguarding concerns

The teams noted safeguarding concerns for 25 (29.1 per cent) people. A breakdown of the themes is shared below in Chart 1.

Chart 1



Discharge to assess pathways

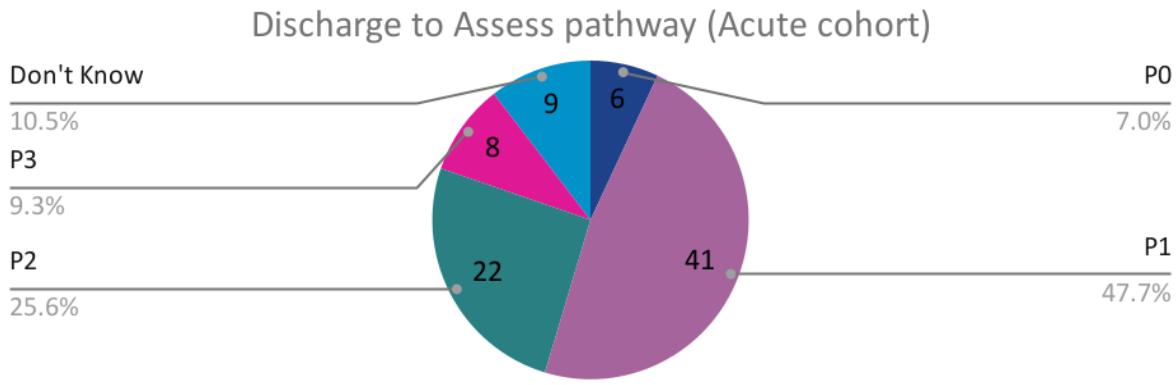
While the definitions for the Discharge to Assess pathways were provided in the survey (Appendix E), many of the teams were not familiar with the terminology and/or interpreted the definitions differently. Chart 2 shows the responses selected.

Few (seven per cent) people were reportedly able to be discharged to a destination without needing new active support from health and social care services (P0).

There were 47.7 per cent who needed a hotel or temporary accommodation setting for further assessment and active support for any health concerns (P1). This includes those who had NRPF. The remaining (34.9 per cent) required short-term intermediate

care or rehabilitation with 24-hour support (P2) or a care-home-like setting with 24-hour on-site nursing and care support (P3). These people would have likely benefited from short-term intermediate care or rehabilitation provision, such as the Mildmay Mission Hospital (referred to as “the Mildmay”), once medically fit for discharge. Some people were waiting for availability from the Mildmay whereas some of the teams voiced that they had avoided making referrals to them, despite the individual’s eligibility, due to the waiting list and anticipated delays with their homeless step-down beds.

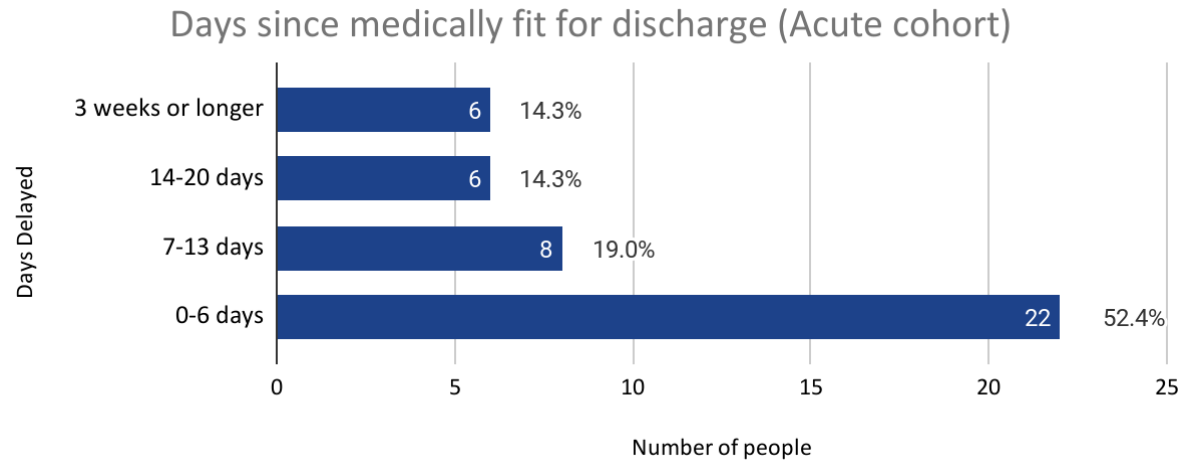
Chart 2



Delayed discharges

Of the cohort, 42 (48.8 per cent) were deemed medically fit for discharge, that is, no longer needing to be in an Acute hospital bed. However, many of these had very complex needs and so could not be discharged due to lack of an onward safe destination. At the time of the audit, 12 (28.6 per cent) had been in hospital two weeks or longer after being deemed medically fit for discharge (see Graph 7). As the audit was only of people who were currently inpatients, there was no discharge date available, and the number of days delayed was calculated using the date deemed medically fit for discharge up until the date of the audit.

Graph 7



Case study 1: Delayed discharge

Male aged between 55-64 years who was admitted following a stroke. He has a history of diabetes but had not seen a doctor in the last two years and also has issues with substance misuse (both drugs and alcohol). As a complication of his stroke, he now has poor mobility, incontinence and cognitive impairment.

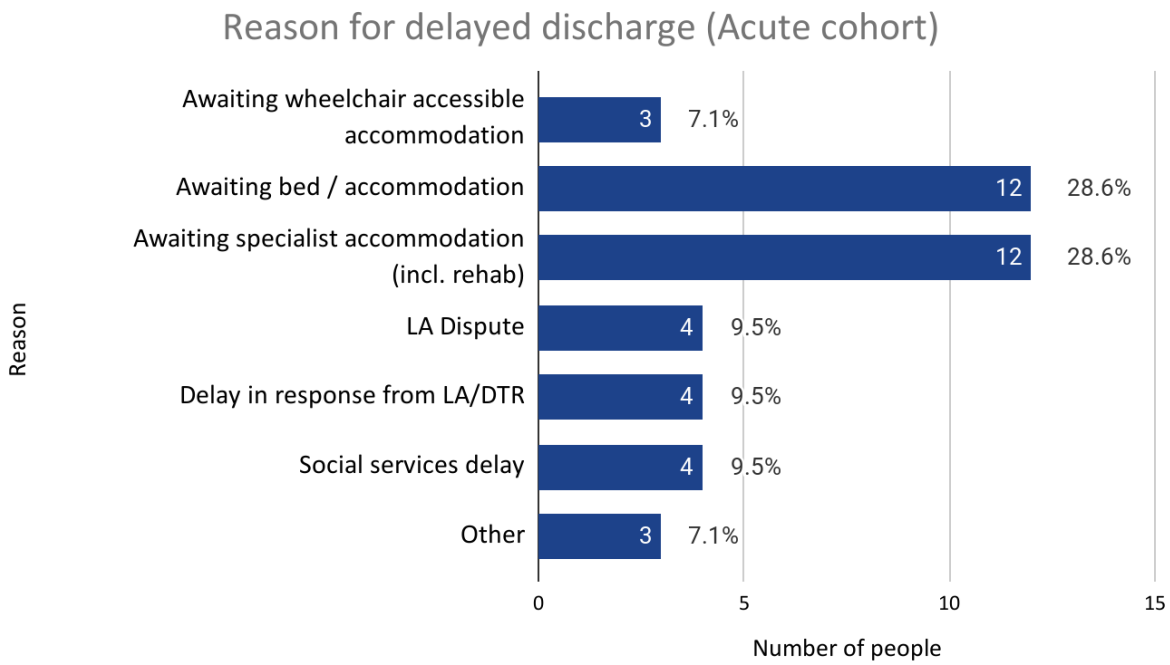
The man had been rough sleeping prior to admission. Previous safeguarding concerns had been raised relating to self-neglect and a lack of insight.

Following his stroke, he was identified as needing a period of physical rehabilitation (with therapists and carers) with wheelchair accessibility and substance misuse support. However, due to a lack of available options, he was going to be placed in temporary accommodation with a four times daily package of care instead.

At the time of the survey he had been medically fit for discharge for three weeks but was unable to be discharged due to a dispute around which local authority would take responsibility for his accommodation. When the survey team connected back with the hospital team to see where the patient ended up, it was discovered he was out of borough, which led to further disputes between adult social care in the placing and receiving boroughs.

The reasons for delayed discharge are captured below in Graph 8. As can be seen, most remained in hospital due a lack of available appropriate accommodation (such as wheelchair or specialist accommodation). There were also some local authority delays including disputes around local connection or ordinary residence. The social services delays were a result of people awaiting assessments (two of which were for people with NRPF). ‘Other’ reasons include safeguarding concerns, COVID infection and those not specified.

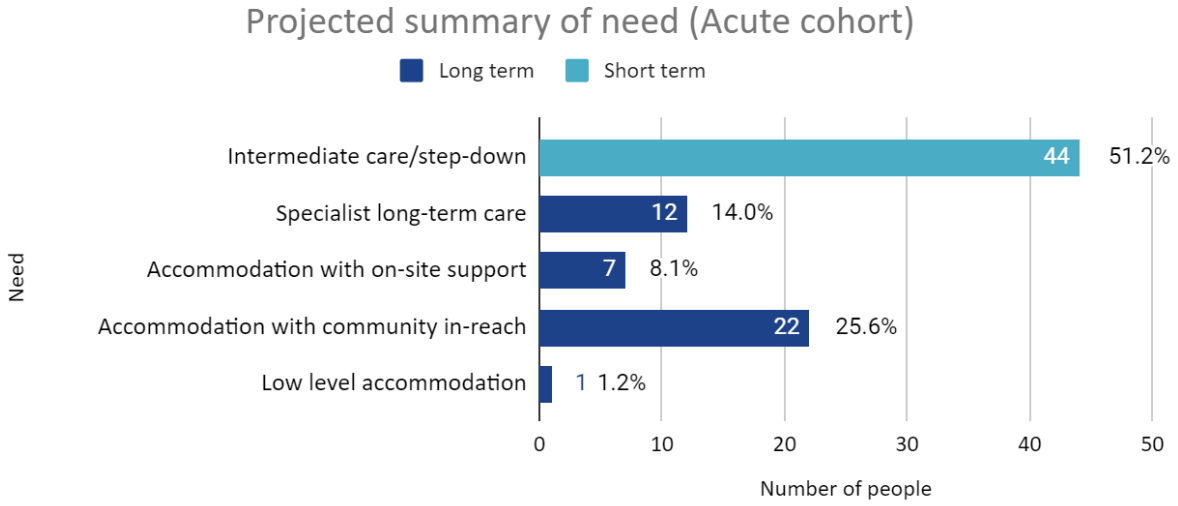
Graph 8



Projected summary of need

We asked the hospital teams to outline what was needed for a safe appropriate discharge and most likely to support improved longer-term outcomes for their patients. The majority of the 86 individuals captured in this audit needed more than accommodation alone following their hospital stay. Only one person (1.2 per cent) required accommodation alone with access to routine primary care and outpatient services. A summary can be found in Graph 9 where needs have been categorised into short-term intermediate care/step-down and longer-term options. These categories are explained and detailed further below and in Appendix F.

Graph 9



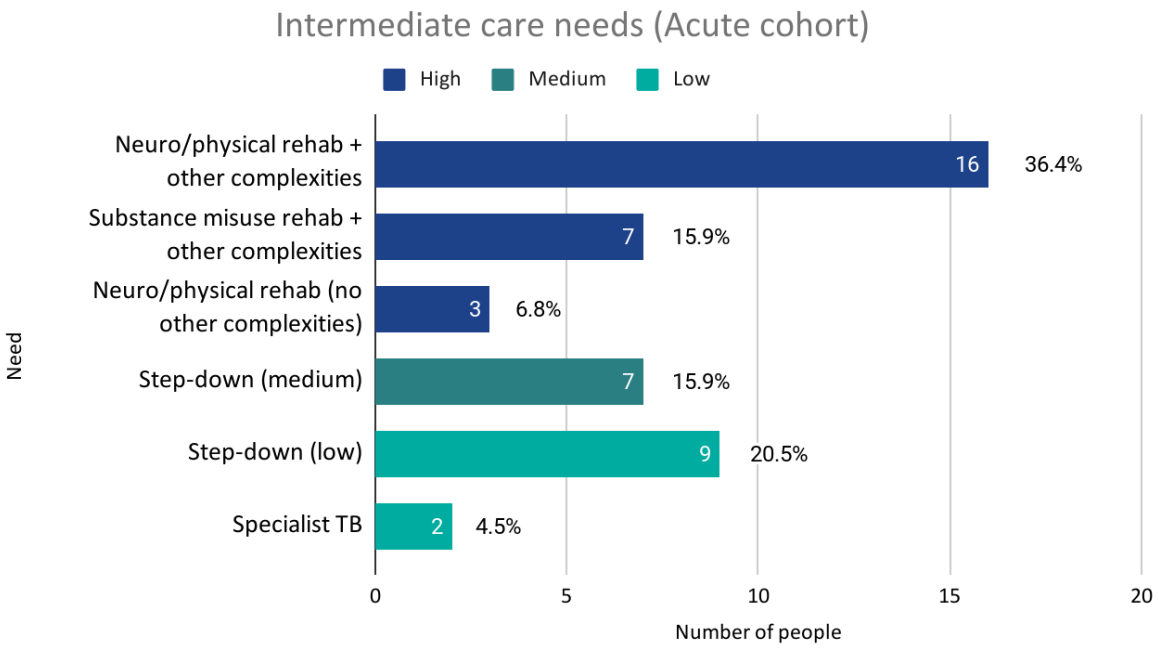
Short-term intermediate care needs

More than half (51.2 per cent) required short-term intermediate care/step-down. This was because they either had needs that would change with further treatment (for example, rehabilitation), their needs were not yet fully understood (or they were awaiting further assessment), or more time was needed to explore or resolve immigration issues. The 16 people in Acute care who were considered to have restricted eligibility for public funds and the eight whose eligibility was uncertain, are all included in this short-term intermediate care need category. The intermediate care needs were divided into:

- high-level: requiring rehab with 24-hour clinical staffing,
- medium-level: needing 24-hour staffing, not necessarily clinical but with multidisciplinary in-reach, or
- low-level: accommodation such as a hotel that is not specifically staffed for people who can manage with in-reach support only but cannot be housed yet due to need for further assessments, such as to establish immigration status. (This also included accommodation for two people with active tuberculosis, without additional high level support needs.)

The range of needs for all 44 people are outlined in Graph 10.

Graph 10



Case study 2: Intermediate care neuro/physical rehabilitation

Female aged 45-54 years admitted due to head injury and multiple fractures following a fall from the second floor. She has a history of schizophrenia, epilepsy, heart issues and substance misuse.

Prior to admission, she was living in a hotel. Following this injury she requires neuro/physical rehabilitation with additional adult social care and mental health support.

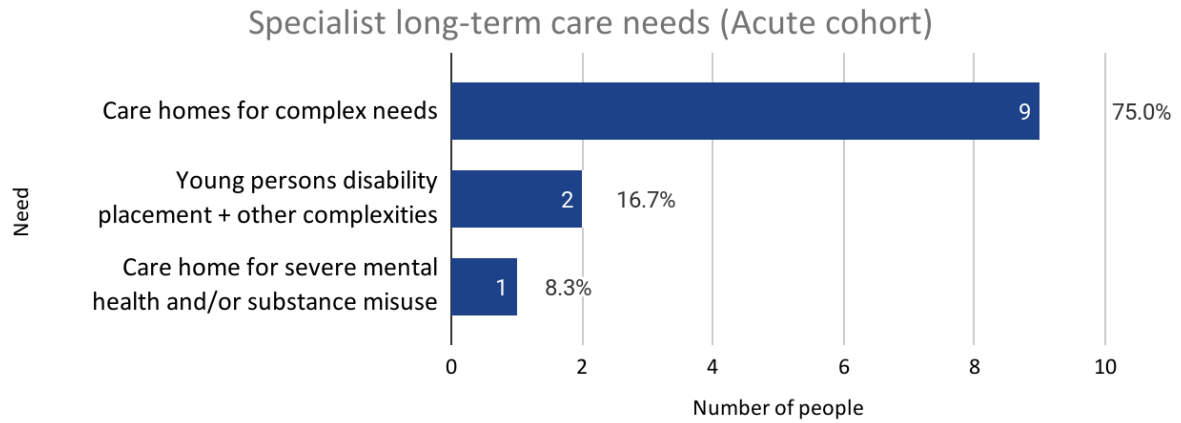
Long-term needs

The rest of the Acute cohort had needs that were considered longer-term, in other words, needs that were less likely to change in the near future. These have been divided into those needing residential care (equivalent of a care home), those needing accommodation with onsite (non-clinical) support and those needing accommodation with some community in-reach or floating support.

Residential care home

There were 14 per cent who required specialist long-term care. This includes those with dementia, those that required palliative care and young people with a disability, who all also had issues with mental health and/or substance misuse. A breakdown is shown in Graph 11.

Graph 11



Case study 3: Specialist long-term care

Male aged 55-64 years was admitted due to a head injury following a fall. He has a history of substance misuse (alcohol and drugs), aggressive behaviour, schizophrenia and diagnosed Korsakoff Syndrome (alcohol related dementia). For the 2 years prior to this admission he had been staying in a hostel where there had been safeguarding concerns raised around self neglect and cognition.

He needs a specialist care home for dementia with additional substance misuse and mental health support.

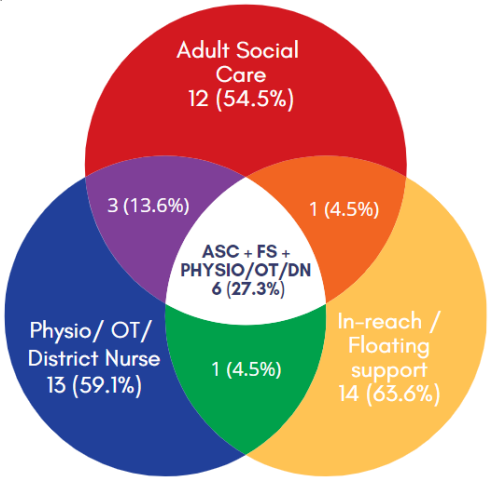
Accommodation with onsite support / supported accommodation

There were 8.1 per cent of people who required accommodation with on-site support (supported accommodation) for their physical, mental health and/or substance misuse issues. Examples include warden controlled mental health accommodation, certain hostels or specialist substance misuse supported accommodation with access to adult social services, a physiotherapist, occupational therapist and/or district nurse.

Accommodation with community in-reach

Around a quarter of people (22, 25.6 per cent) needed accommodation with a range of different forms of community in-reach or support such as adult social care (ASC) and/or access to a physiotherapist, occupational therapist (OT) and/or district nurse (DN). In addition, for this accommodation to be sustained, 63.6 per cent of these were believed to require some form of ongoing in-reach/floating support (FS) to facilitate continued engagement with primary care, or around mental health or addictions. This in-reach support may be from inclusion or mental health practitioners or a range of people including homelessness support staff, peer support and voluntary sector organisations. See Figure 2 for an illustration of these support needs.

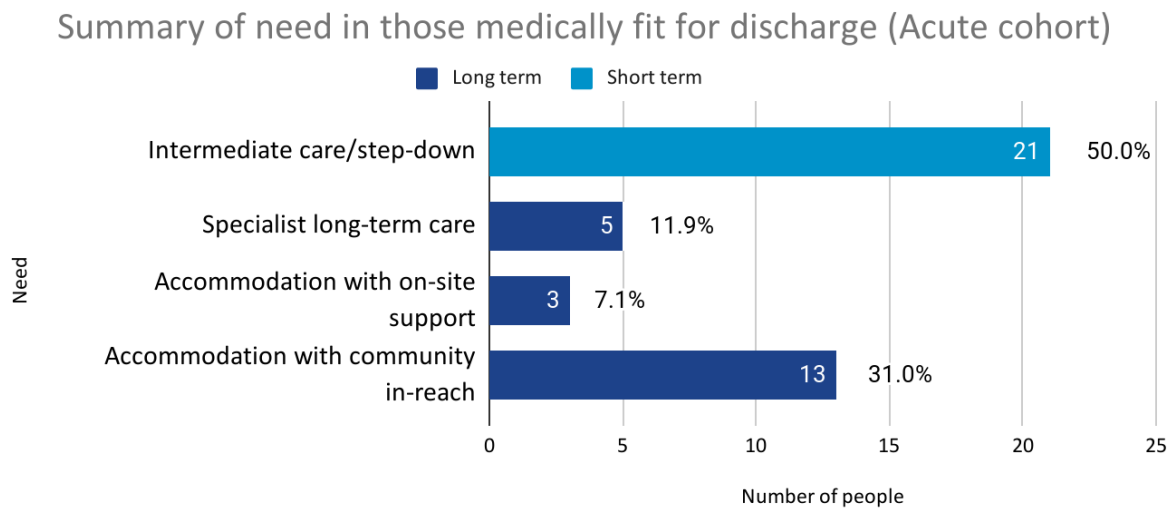
Figure 2



Summary of need (medically fit for discharge)

More specifically, all those medically fit for discharge (42 people) needed accommodation or rehabilitation with additional in-reach/floating or on-site support. See Graph 12.

Graph 12



Suboptimal Discharges

From the team's perspective, at least 21 (24.4 per cent) patients were likely (or planned) to be discharged to a destination unable to meet their needs. Most frequently (38.1 per cent) this was due to the complexity of the case and lack of appropriate available options, for example, the need for specialist care facilities that combine physical or neurological rehabilitation with substance misuse and/or mental health support. For these cases, it was felt that the likely discharge location and support would not meet all the complex needs of the patient.

There were an additional five patients (23.8 per cent) who were anticipated to have a suboptimal discharge as they were likely to be placed into temporary accommodation without adequate wrap-around support for their mental health and/or substance misuse issues.

Case study 4: Suboptimal discharge

Female aged 35-44 years was admitted due to sepsis with a necrotic lung lesion. She had been rough sleeping prior to admission and had a history of substance misuse (on methadone), chronic obstructive pulmonary disorder, malnutrition and depression. There were also safeguarding concerns around self-neglect and repeated prison stays.

It was believed she was at high risk of deterioration and death if she returned to rough sleeping. Her likely discharge destination was a hostel, which hadn't worked for her in the past and which was felt would not meet her needs. The team felt that for a chance of recovery, she needed a more 'therapeutic environment' with intensive wraparound, person-centred and trauma-informed support.

Three people (13.6 per cent) were likely to be suboptimal discharges as teams were uncertain about whether the person would receive a housing placement or accommodation that was accessible or suitable for a family. An additional four people had uncertainties regarding their placement and access to support as they had been reported as having NRPF. This is further detailed in Appendix G .One patient was identified as requiring discharge to accommodation with a package of care but declined the support.

Mental Health hospital data

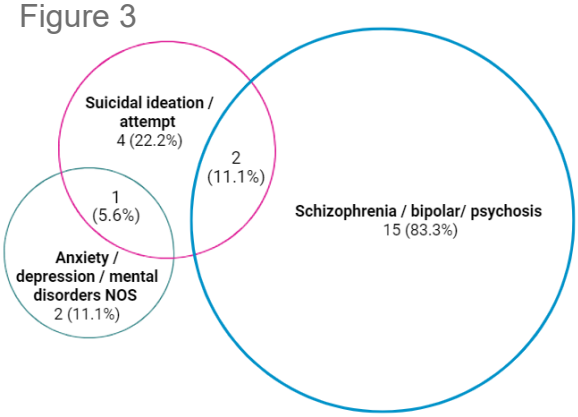
There were three Mental Health hospitals included in this audit (one of which was a step-down unit). Due to the limited amount of information provided, the focus of this analysis will be on data from one hospital with a caseload of 18 people. Of the 18 people, the majority (72.2 per cent) were male, and the most common age range was between 35 and 44 years (See Table 2).

Table 2

Age	Female	Male	Total
18-24	1	Nil	1
25-34	1	2	3
35-44	2	5	7
45-54	Nil	3	3
55-64	1	2	3
65+	Nil	1	1
Total	**5 (27.8 per cent)**	**13 (72.2 per cent)**	**18**

The average length of stay was 51.3 days (ranging from three to 205 from the date of admission to the date of audit). Almost half (eight, 44.8 per cent) reportedly had NRPF. A third were confirmed not to be CHAIN verified, while the status for the remaining were unknown. The primary reason(s) for admission are shown in Figure 3.

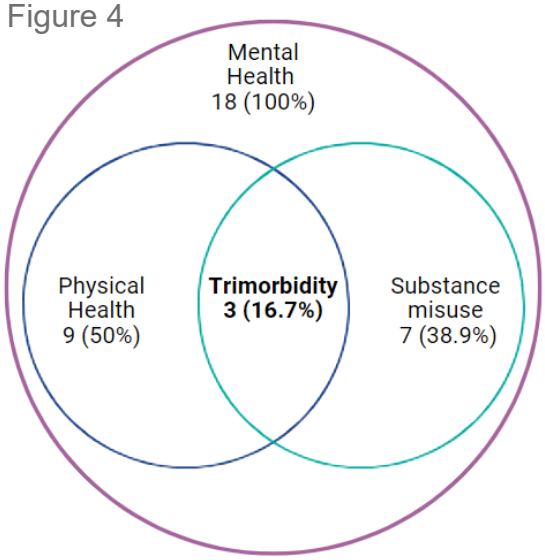
Figure 3



Eight people (44 per cent) were being held under a section of the Mental Health Act (four under section three,[18] three under section two[19] and one under section 37.[20]

Figure 4 illustrates the frequency of physical health, substance misuse and tri-morbidity within this cohort. Over one-third (38.9 per cent) had substance misuse issues (dual diagnosis) and half had additional physical health conditions (including hypertension, heart disease, sickle cell anaemia, vascular dementia, leg ulcers, kidney stones, and chronic musculoskeletal problems). 16.7 per cent had tri-morbidity. Additionally, five (27.8 per cent) had concerns with safeguarding.

Figure 4

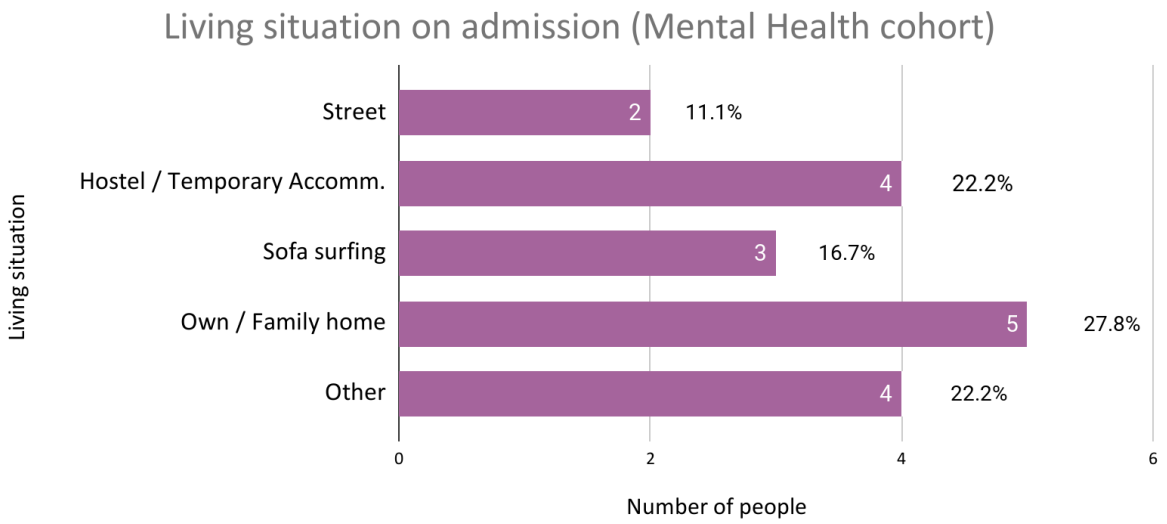


Living situation on admission

The living situation reported on admission is outlined in Graph 13. 'Other' includes informally renting, being in prison and settings that were not specified.

[18] Admitted into hospital and detained for up to 6 months for the purpose of treatment.
[19] Admitted into hospital and detained for up to 28 days for the purpose of an assessment.
[20] Ordered by the court to be admitted into hospital for treatment, as opposed to a custodial sentence.

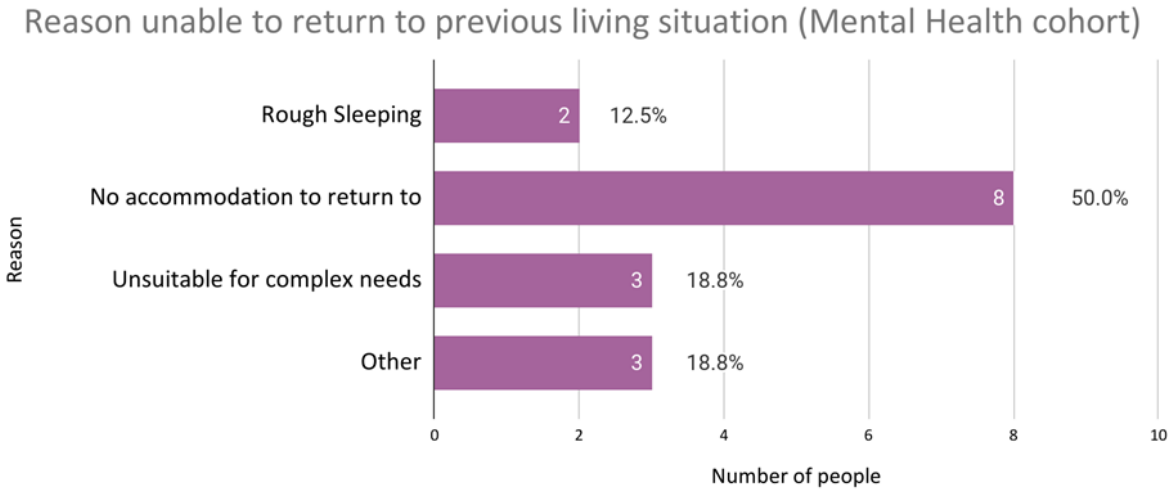
Graph 13



Similar to those within the Acute hospitals, the majority (88.9 per cent) were unable to return to their previous living situation. This was mainly (50 per cent) because they had no accommodation to return to as they had been sofa surfing, previously in prison, or were told they could not return. See Graph 14.

Some people had complex issues with mental health and substance misuse that made their previous living situation unsuitable (18.8 per cent), and others were rough sleeping (12.5 per cent). 'Other' reasons (18.8 per cent) include lack of funds, issues with immigration and safeguarding concerns. It is not clear whether the change in living situation occurred before or during admission, however, it is assumed during if the person had come in from somewhere other than the street.

Graph 14



The two people who were deemed able to return to their previous living situation were either likely to be repatriated or able to return to the temporary accommodation that they had been living in the past two years with support from the local outreach team.

Delayed discharges

Of the 18, there were four (22.2 per cent) people who were deemed medically fit for discharge. At the time of the audit, two of these were delayed up to a week and the other two for longer (one patient was delayed for three weeks or more). As they were still inpatients, discharge date was not known so the number of days delayed was calculated using the date deemed medically fit for discharge and the date of audit.

The reasons for delay included:

- one awaiting appropriate bed or accommodation, including specialist mental health, and accommodation with substance misuse in-reach services or those able to support someone with a previous history of arson,
- two awaiting a response from the local authority following a duty to refer submission, and
- one awaiting repatriation.

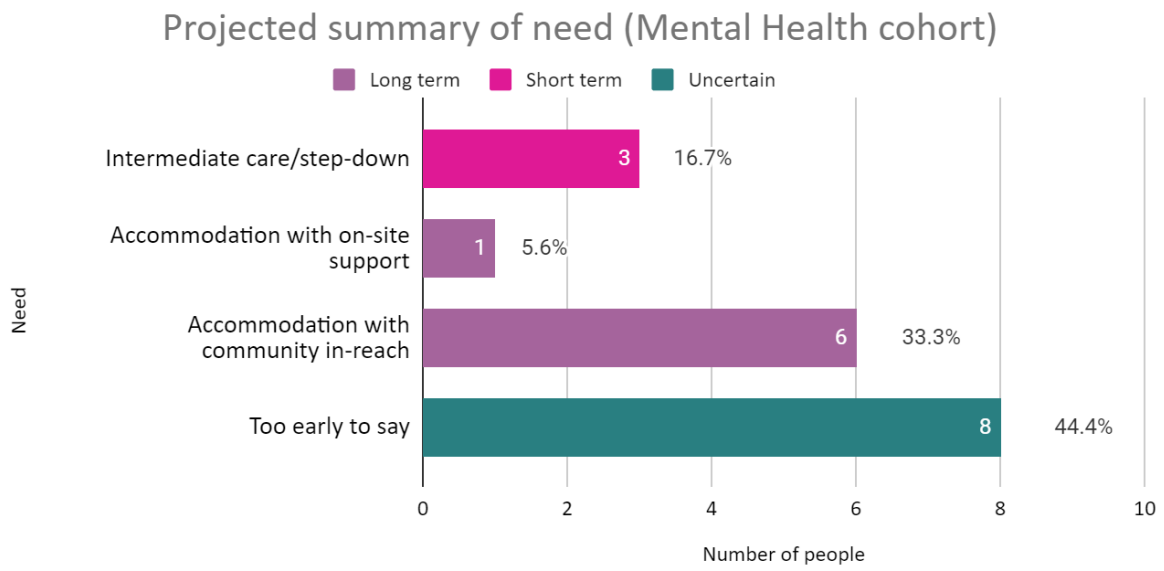
Projected summary of need

We asked the teams to outline what was likely to be needed for a safe discharge, for the 18 patients from the Mental Health cohort (see Graph 15). One point of difference from the Acute patients was that teams expressed more uncertainty over what the most appropriate discharge destination was.

Additionally, while some were identified as needing intermediate care/step-down placements, it is noted that these placements required a more specific focus on accommodating for significant mental health needs than the intermediate care placements required by patients from Acute hospitals. This data highlights the need for treatment options for those with dual diagnosis.

The definitions used for the different summary of need categories were adapted from those used within the Acute cohort and can be found in Appendix F.

Graph 15



Short-term needs

Intermediate care/step-down

All patients in this category (16.7 per cent) were believed to have restricted eligibility for public funds/NRPF and required medium-level support, at a minimum, for immigration and mental health issues. One needed high-level step-down with additional support for substance misuse and cognitive problems.

Long-term needs

Accommodation with onsite support/supported accommodation

One person (5.6 per cent) required self-contained accommodation with on-site support (supported accommodation) for mental health and/or substance misuse issues. They were also listed as needing physiotherapy or occupational therapy support, but reasons are unclear from the data.

Accommodation with community in-reach

A third of patients needed accommodation with support from the community Mental Health team. Half of these had issues with substance misuse, including one who also needed floating support.

Uncertain needs

There were eight patients (44.4 per cent) who the team felt it was “too early to say” regarding what the most appropriate discharge destination would be. Of these, five were reported to have NRPF and quite complex needs, who would benefit from medium-level intermediate care/step-down (to support further immigration work and other issues including substance misuse, physical health or safeguarding, in addition to mental health).

Summary of need (medically fit for discharge)

Of the four people who were medically fit for discharge, two required accommodation with community in-reach support for their mental health and/or substance misuse problems, one required accommodation with on-site support and the remainder needed medium-level, intermediate care/step-down for mental health and immigration issues.

Suboptimal discharges

From the team’s perspective, at least four of the 18 people (22.2 per cent) were likely (or planned) to be discharged to a destination unable to meet their needs.

A breakdown of these cases is summarised in Table 3:

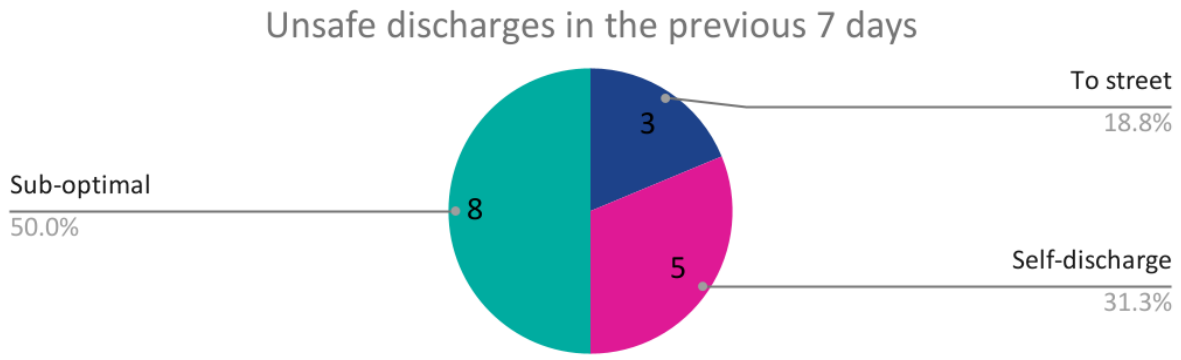
Table 3

Placement need	Likely (or planned) placement	Reason perceived / anticipated suboptimal
Supported accommodation	• uncertain (two)	• NRPF cases, both sectioned. Immigration status causing uncertainty around access to support on discharge.
Appropriate accommodation	• temporary accommodation or supported accommodation (two)	• Longer term accommodation preferred for stability. Both patients had issues with capacity/cognition and substance misuse.

Unsafe discharges

At the end of the survey, both Acute and Mental Health teams were asked to recall any discharges to the street and unsafe or sub-optimal discharges within the previous seven days (not including A&E). Chart 3 below is a summary of the responses. The figures are based on the participant's recollection within a specified week and so, may not accurately reflect the true number of unsafe discharges within any given week across London.

Chart 3



Where further details were provided, the following was identified.

- Due to acute hospital pressures, people were being discharged to the street with advice to contact the relevant local authority or homelessness centre.
- One person was forced out of hospital onto the street due to their challenging behaviour.
- Of the five self-discharges, four of these were to the street due to delays in response from the local authority, lack of trust with the system or their accommodation was threatened with closure. One person self-discharged to be with their family but there were concerns around whether the family could manage their care needs.

- Discharges to suboptimal environments included accommodation where the team had safeguarding and mental health concerns, and one where the patient had previously chosen to sleep rough because they had difficulties using the stairs at the property and had received threats from neighbours.

A general comment made by one of the teams noted that some of these patients were "likely to re-present to hospital due to delays and provision of unsuitable accommodation by the local authority" and that "more accommodation options [were] needed to meet the various care, functional and mental health needs of patients".

Case study 4: Discharge to street

Male aged 55-64 years was admitted due to frostbite and sepsis. Also has a history of alcohol dependency, hypothermia, malnutrition, scurvy and incontinence. There are concerns around cognitive impairment and self-neglect.

Soon after admission he self-discharged and was readmitted into hospital within five days. He was then placed under a Deprivation of Liberty Safeguard (DOLS). However this DOLS was rescinded when his behaviour became challenging (drinking alcohol on the ward). He was evicted from hospital. Prior to this eviction, he was undergoing neurological and therapy assessments while awaiting referral to adult social care.

Fortunately, this man was picked up by ambulance and admitted to a different hospital.

Learnings

Time

The audit sessions took longer than anticipated. An estimated four patients were captured per hour and there were five teams who had caseloads larger than eight. A few of the teams expressed that the survey was long and slightly repetitive, and there was feedback from one of the surveyors who felt "guiltily aware of the pressure they [the teams] are under" but recognised the significance of the information being captured.

At the time of the audit, the acute sector in London was extremely stretched and under pressure due to the pandemic. More notice to teams regarding estimated time and survey requirements would likely help manage expectations and preparations for the audit. Where possible, future surveys should be scheduled at a time during the year where teams may have more capacity or fewer competing priorities.

Access to information

Hospitals that had dedicated homelessness teams seemed to have richer data and a deeper understanding of patient needs.

At least three of the teams were newly established and had difficulties answering some of the survey questions. Despite being notified ahead of the audit session to nominate members who were familiar with the details of (or have access to) each patient on the caseload, there were still gaps in the survey where the information was not known or available. This was mostly due to the relevant person(s) not being present, there being no streamlined process for data collection or difficulties with accessing patient records.

Where teams were anticipated to have difficulties with accessing information, a more detailed conversation around each patient on the caseload, rather than using Survey Monkey, may be more helpful to capture as much information as available, including reasons for any gaps.

It was also noted that access to and familiarity with the CHAIN database was variable.

New connections

It was acknowledged that the audit presented an opportunity for the surveyors to establish working relationships with teams from both the Acute and Mental Health hospitals that did not exist before.

Terminology / definitions

There was some confusion and a lack of awareness regarding Care Act assessments and the terminology used to describe the D2A options. The D2A definitions used in the audit were those suggested by the Department of Health and Social Care and NHS England and Improvement (Appendix E). Despite not being inclusive of mental health, a few of the teams from the Mental Health hospitals provided a response to the D2A-related questions in the survey. Further activities around training to improve awareness and understanding of D2A and Care Act Assessments amongst hospital teams is needed.

Furthermore, teams also seemed to define “supported accommodation” differently with some referring to hostels and others to accommodation with floating or on-site support.

Other data

Arising from a session with one of the teams in NCL, it was found that there were a number of homeless people who had been discharged to a step-down unit, whose cases would have been interesting to explore in more detail. Where the time allowed, the surveyor was able to capture some of the patient information, which was not included in this detailed analysis. Future audits focusing on hospital discharge and OOHC may want to consider other cohorts, such as those residing in specific provisions, discharged to the street or frequent attenders.

Summary

People experiencing homelessness often have quite staggering health, housing and social care needs. A hospital admission is an opportunity to intervene in a critical moment in preventing further deterioration. This audit highlights what is needed for a

safe discharge from hospital and ongoing support in the community to reduce the appalling morbidity and mortality affecting this population. Once deemed 'medically fit for discharge', many people still require ongoing specialist case working, a period of rehabilitation, floating or in-reach/community support and/or specialist accommodation. In fact, very few people in this audit (one) required accommodation alone following their hospital stay.

We identified a range of both long- and short-term accommodations and care needs which we have divided into:

a) intermediate care/step-down of which a range of needs were identified (high, medium and low level) and also
b) longer-term needs (high level residential, supported accommodation with full-time support and accommodation with community in-reach support)

Discharge delays for people experiencing homelessness are often due to having no appropriate or safe accommodation for hospital teams to discharge the person to. Many of the patients captured in this cohort had tri-morbidity or dual diagnosis, for which there are limited services available to provide the specialist support needed. The situation and lack of options is even more complex for those with uncertain or restricted eligibility for public funds. Furthermore, a large proportion of people were assessed as likely to be discharged to accommodation unable to meet their health and care needs, increasing their risk of absconding or being readmitted to hospital.

Perceived slow responses from other agencies was also a key factor in delayed discharges. Teams submitting 'duty to refer' forms expressed frustration in the response times from some local authorities. In addition, there were often significant delays described for people awaiting assessments by adult social care. Disputes around ordinary residence for people who were placed out of borough by housing local authorities but had care needs was another factor. It is recognised that there are significant resourcing and staffing constraints across the system and a lack of available accommodation and care options. Hospitals with a dedicated inclusion health team, who have existing relationships and are more familiar with such processes, are likely to be able to overcome some of these challenges more quickly and enable more timely transfers of care.

For people with uncertain or restricted eligibility for public funds, suitable placement options are limited. Their discharges are often delayed due to awaiting evidence (for example, identification documents or information from the Home Office or benefits agency) or assessments (Human Rights Assessment or Care Act Assessment), which can sometimes take several weeks. This is also the case for those who are likely to be repatriated. Access to immigration and legal advice for this population is important to explore people's rights and options. Hospital teams should be able to refer people to appropriate support.

Many of the discharges to the street and unsafe or suboptimal environments could be prevented with access to appropriate short-term provisions or step-down

accommodation. Having a safe place while awaiting assessments or responses from the local authority, where the person can also receive ongoing support for their health needs, will help prevent rough sleeping and free-up hospital beds. However, we know this can be challenging with some housing providers reluctant to accept referrals that don't have a specified 'exit' plan.

This audit is the first of its kind across London. We are not aware of a similar piece of work that has been completed on an equivalent scale with the same level of detail. The findings reflect the stark complexities within this cohort and highlights the importance of ongoing, routine data collection in providing tailored solutions, especially for vulnerable groups. Capturing details at the time of admission on housing status and whether someone has a safe place to go following their hospital stay, will help identify needs at an early stage, support safe discharge planning and reduce delays.

Scoping work is underway to consider how the findings from the audit can be modelled to quantify what is needed sub-regionally and regionally to address the accommodation and service gaps across London. This work will also consider how many bed days could be potentially saved from reducing delayed discharge.

What's needed to address the gaps found in this audit?

This audit demonstrates the gap between NICE guidance for this population, and what's available in practice. It reinforces the value of a focused homelessness partnership, with leadership and strategic oversight for London. It suggests action is needed to secure the following:

- **A shared, robust and up to date understanding of the population's needs and experiences, to inform commissioning and delivery**.
    - Taking opportunities to understand and capture information about an individual's accommodation status (such as hospital staff asking, "have you got a safe place to be discharged to?").
    - Use of the housing status codes, which already exist in NHS service datasets, as part of routine data collection.
- **A consistent and sustained 'service' offer to individuals to facilitate successful transfers of care from hospital to the community, to prevent crisis admissions ('out-of-hospital care') and improve access to appropriate support and better outcomes**. **A service offer that is consistent with the following elements.**
    - Shaped through co-production with people with lived experience.
    - Person-centred and trauma-informed, with multi-disciplinary teams sharing an understanding of the individual's needs, strengths and aspirations, and how to prevent and de-escalate trauma-induced situations.

- Makes the best and combined use of professionals' knowledge, expertise, and time including:
  - Bringing together health, housing and social care workforces to better understand and value each other
  - The development of shared protocols, which provide a safe framework for action, to:
    - enable more timely identification of, and decisions on, an individual's housing status, health and care needs, eligibility for housing care and support,
    - prevent self-discharge from hospital, including understanding and managing substance misuse needs.
- Supports the workforce to have access to clinical supervision, reflective practice and training to de-escalate crisis.
- Offers accommodation options that better reflect the diversity of need and enable personal choice and control, in other words:
  - a range of step-up/step-down intermediate care solutions, and
  - longer-term solutions, particularly for people with complex needs who have a physical disability and mental health and/or substance misuse issues.
- Makes the most of opportunities to support people in the community, for example, through peripatetic multidisciplinary team (MDT) support and floating support in temporary accommodation and hostels.
- Reflects the value of trusting relationships in supporting engagement as an essential part of recovery, through the employment of people with lived experience and VCSE partners.

- **To better support people whose eligibility for public funds is restricted or uncertain, there is a need for the following**.
  - Shared understanding across health, social care and housing workforces of the legislation, policy and practice.
  - More timely identification of, and decisions on, an individual's eligibility for support from adult social care.
  - Access to legal support by hospital teams.
  - Use of available resources and escalation procedures (NRPF Network, Home Office), where appropriate.

Appendix A: Non-UK nationals with restricted eligibility to benefits

The following are details about 24 people from both the Acute (16) and Mental Health (eight) hospitals who the teams identified as having restricted eligibility or no recourse to public funds (NRPF). The majority were male (20, 83.3 per cent) and almost all (22, 91.7 per cent) were over the age of 34 years (see Table 4).

Table 4

Age	Female	Male	Total
18-24	1	Nil	1
25-34	1	Nil	1
35-44	2	9	11
45-54	Nil	7	7
55-64	Nil	4	4
Total	**4 (16.7 per cent)**	**20 (83.3 per cent)**	**24**

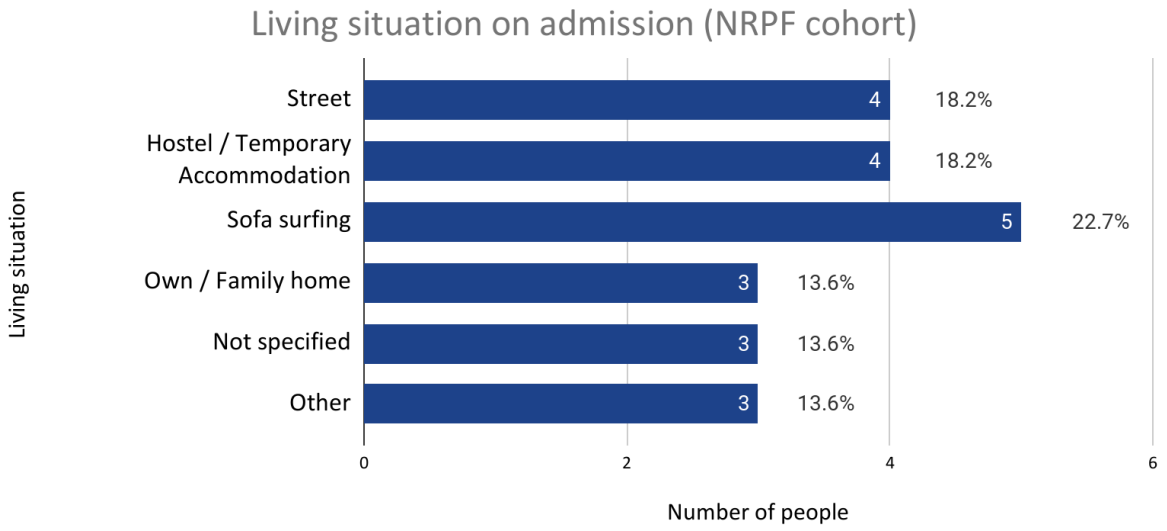
Of the 24, only four were CHAIN verified and the average length of stay was 57.1 days (ranging between one to 204 days from date of admissions to date of audit). Also, just over half (54.2 per cent) had been referred for legal advice due to their status.

Living Situation on Admission

The question relating to living situation on admission was added at a later date and so, information was only captured for 22 people out of 24.

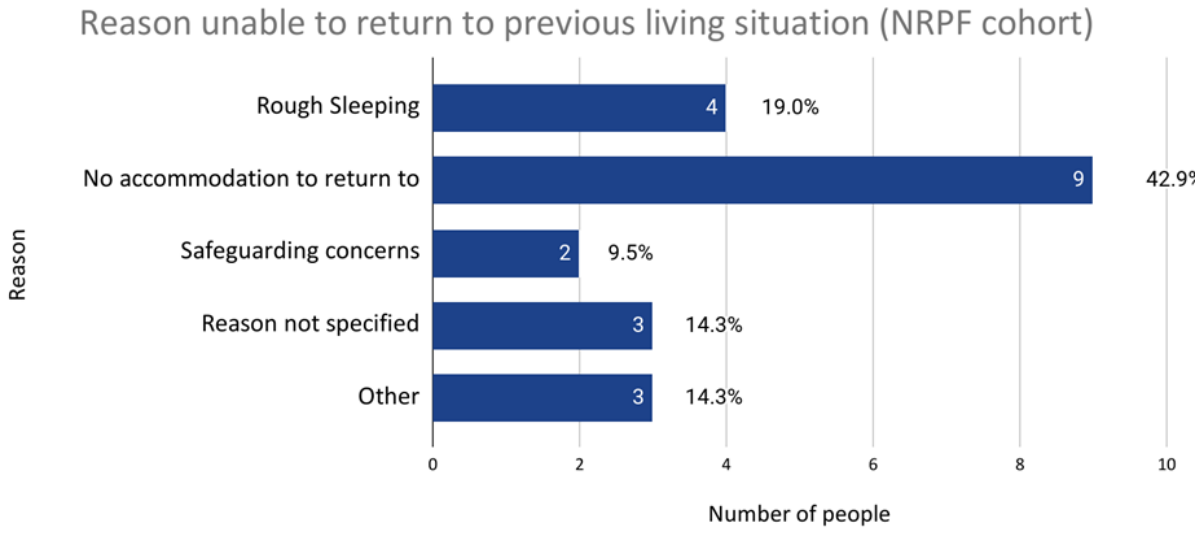
The living situation on admission for those with NRPF is highlighted in Graph 16. Of the four people who were rough sleeping, only one person was confirmed to be CHAIN verified. ‘Other’ living arrangements include informally renting or in prison. This also includes one person who had an address upon admission, but the team were unable to verify the person’s rights to the property.

Graph 16



Of the 22 people, all but one (95.5 per cent) were unable to return to their previous living situation. Reasons are captured in Graph 17. 'Other' reasons include issues with immigration or that the accommodation was unsuitable for their complex needs (tri-morbidity or mental health and/or substance misuse issues).

Graph 17



The one person able to return to their previous living situation was likely to be repatriated.

Clinical Complexity

Of the 24, there were 11 people (45.8 per cent) who had mental health problems noted and 10 (41.7 per cent) who had known issues with substance misuse. Two (8.3 per cent) suffered from tri-morbidity. Additionally, teams felt that half (12, 50 per cent) of this cohort had issues with capacity and/or their cognition.

Care Needs

There were 15 people (62.5 per cent) who reportedly had care needs. Eight out of 15 (53.3 per cent) had been referred to social services for an assessment. Within these, two were rough sleeping prior to admission.

Of the eight people that had been referred to social services for an assessment, almost all (seven, 87.5 per cent) had not had an assessment undertaken by the time of the audit. This includes two of the people who were medically fit for discharge for three weeks or longer. One was awaiting a social services assessment and the other had a referral made but not continued due to awaiting repatriation. For the remaining person that had been referred, according to the audit responder, social services declined to do a Care Act Assessment due to the person's unwillingness to engage with substance misuse services.

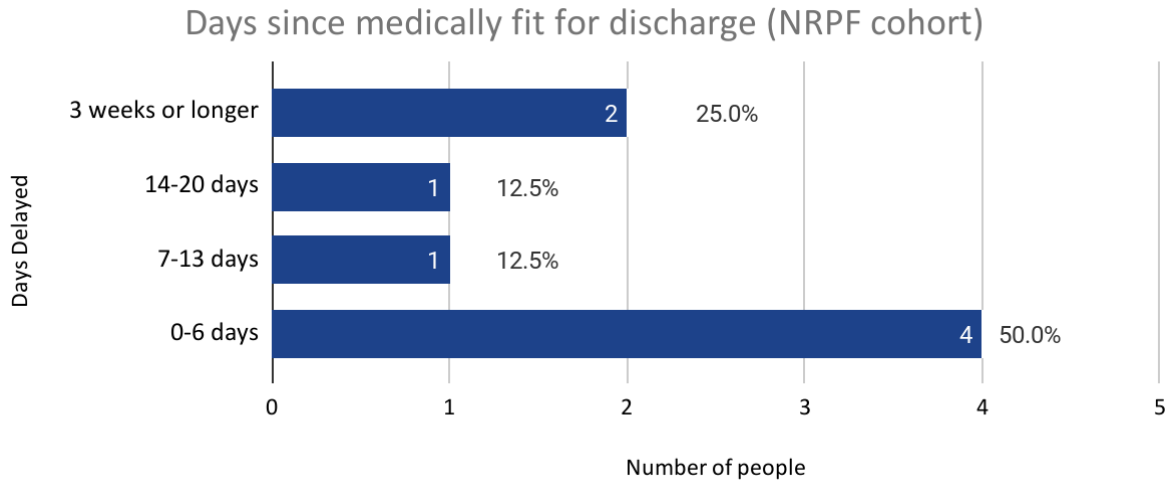
Safeguarding

The team believed five people (20.8 per cent) had safeguarding concerns. These included domestic violence, self-neglect, destitution, as well as those not specified.

Medically Fit For Discharge

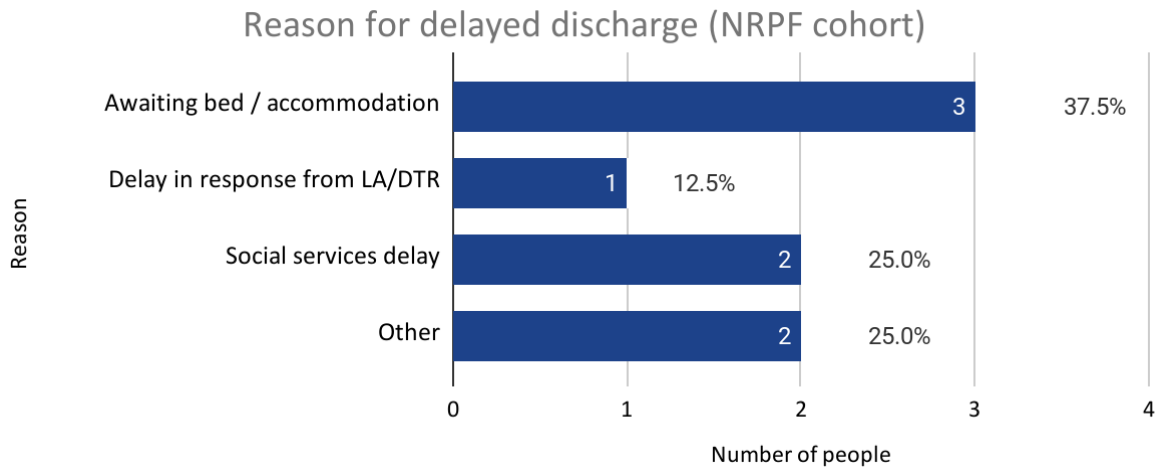
A third (eight, 33.3 per cent) of people were deemed medically fit for discharge at the time of audit. Half (four) of these were delayed by up to a week, while the remaining for longer (see Graph 18). As the audit took place while they were still inpatients, the number of days delayed was calculated using the date deemed medically fit for discharge up until the date of the audit.

Graph 18



The reasons for delayed discharge are outlined in Graph 19. 'Other' reasons include repatriation and those not specified.

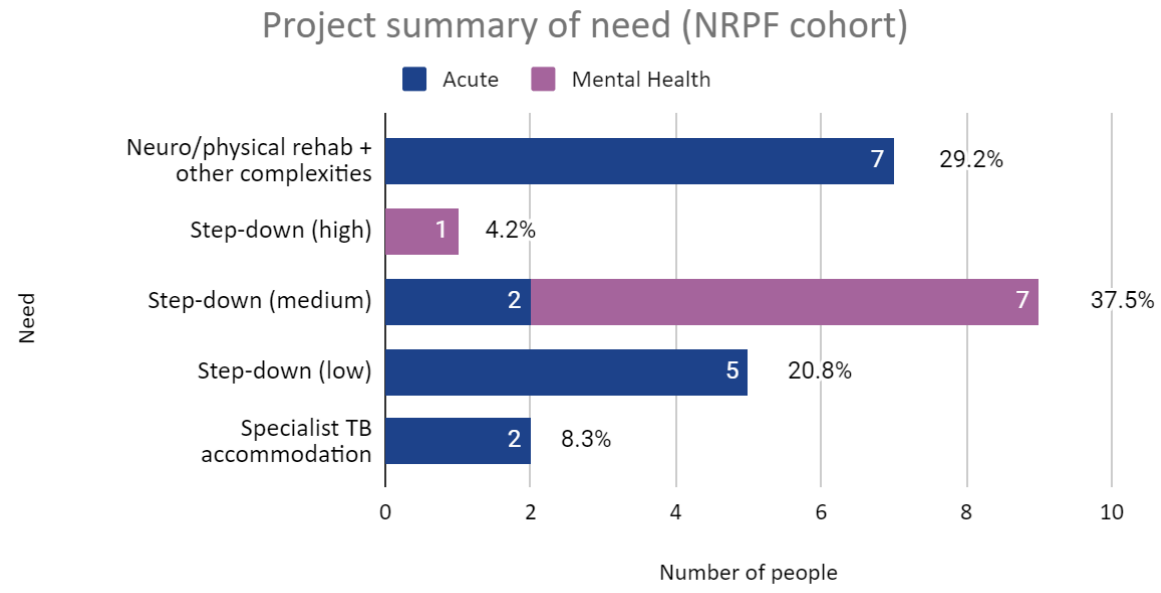
Graph 19



Projected summary of need (total NRPF cohort)

All 24 patients with NRPF were identified as needing intermediate care/step-down placements, 33 per cent of whom needing high-level support. See Graph 20 for a further breakdown. High-level step-down refers to those who have very complex needs with mental health, substance misuse, cognition and/or immigration issues.

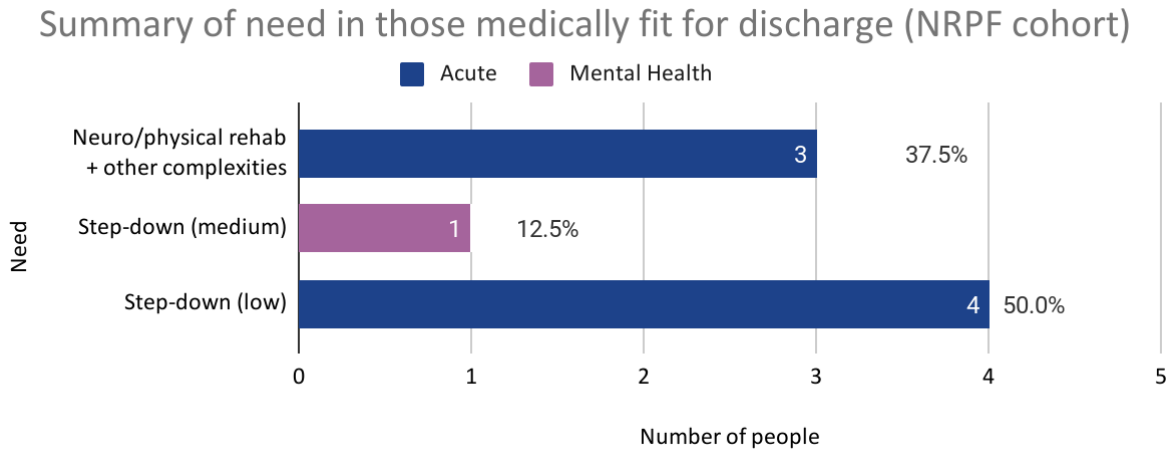
Graph 20



Summary of need in those medically fit for discharge

Of those medically fit for discharge (eight, 33.3 per cent), half (four) required low-level step-down with immigration support. See Graph 21 for further details.

Graph 21



Additionally, there were eight people whose eligibility for public funds was uncertain and teams were awaiting evidence (including, identification documents or information from the Home Office or benefits agency) to try and ascertain the person's status.

Appendix B: Rough sleeping cohort data

We undertook a further subgroup analysis of the 14 people from both Acute and Mental Health cohorts who were note as rough sleeping on admission. The question relating to living situation on admission was added at a later date meaning that information was only captured for a total of 83 people out of the 104 inpatients. Of these, the majority were male and most commonly aged between 35 and 44 years (See Table 5).

Table 5

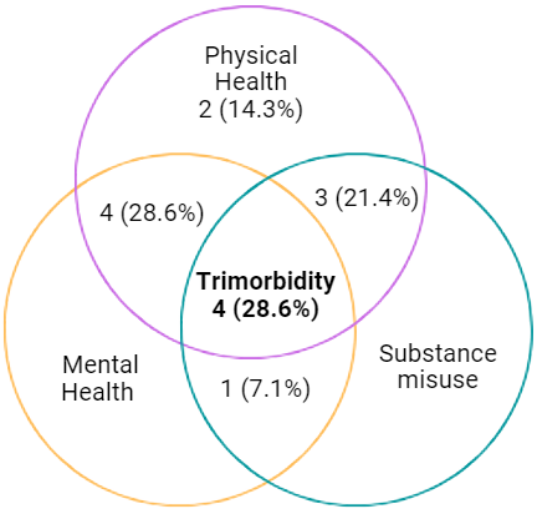
Age	Female	Male	Total
25-34	Nil	1	1
35-44	2	3	5
45-54	Nil	3	3
55-64	Nil	4	4
65+	Nil	1	1
Total	**2 (14.3 per cent)**	**12 (85.7 per cent)**	**14**

The average length of stay was 55.8 days for Acute hospitals (ranging from 4-264) and 76 days for Mental Health hospitals. This was calculated using the date of admission to the date of audit.

Figure 5 illustrates the breakdown between physical health, mental health and substance misuse issues within this cohort. In addition to this, a small number (three, 21.4 per cent) had capacity/cognitive issues and four people (28.6 per cent) had safeguarding concerns around self-neglect or being in an abusive relationship(s).

Just over a third (five, 35.7 per cent) were CHAIN verified while the rest were not (eight, 57.1 per cent) or unknown (one, 7.1 per cent). There were eight people who were believed to have care needs, of which four had been referred for a Care Act Assessment. A further four people (28.6 per cent) were reported to have NRPF.

Figure 5



Primary reason(s) for admission

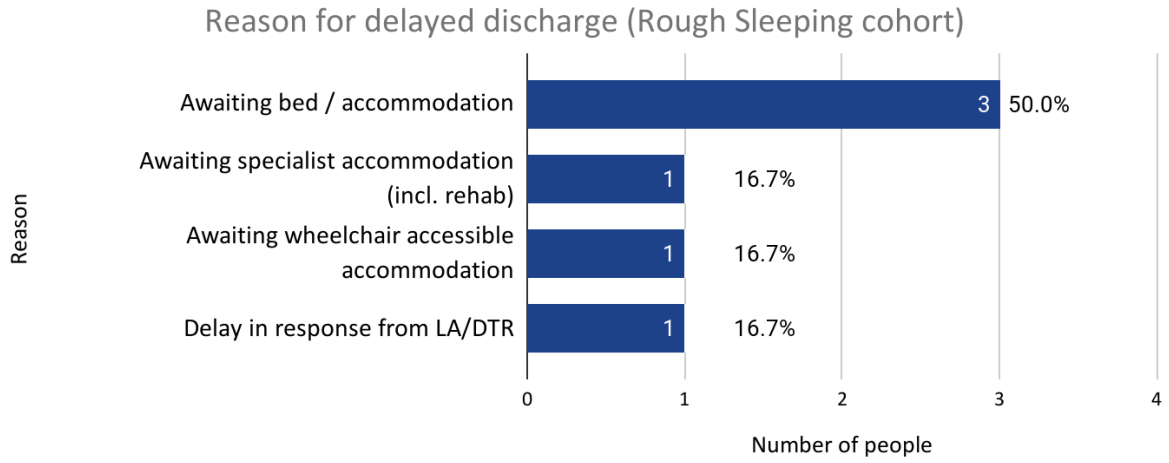
Of the two people from the Mental Health cohort, their main reasons for admission were suicidal ideation or attempted suicide, and psychosis with cognitive impairment. Amongst the Acute cohort, the most common reasons for admission were cardiac arrest and/or collapse (three, 21.4 per cent), and major surgery or trauma (two, 14.3 per cent). Other reasons included sepsis, respiratory issues, alcohol withdrawal, leg ulcer, head injury or assault, stroke, and a bone fracture.

Delayed discharges

Of the 14 people, there were six (42.9 per cent) who were deemed medically fit for discharge. Most of these (four, 66.7 per cent) had been delayed for up to a week, while there was one who had been delayed for three weeks or longer.

The main reasons for delayed discharges are shown in Graph 22.

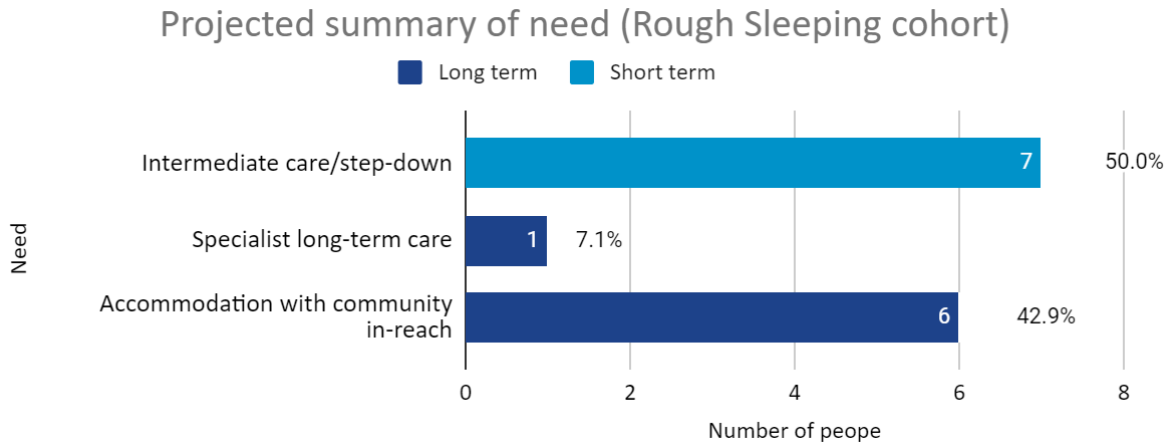
Graph 22



Projected summary of need (total rough sleeping cohort)

The majority of this cohort were identified as needing intermediate care/step-down or accommodation with community in-reach (see Graph 23). The definitions for these categories can be found in Appendix F.

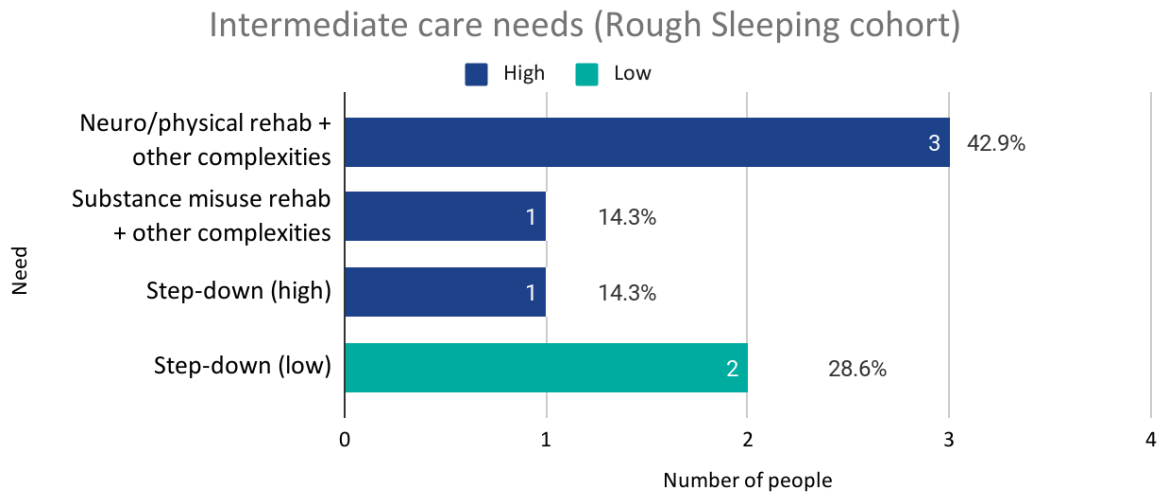
Graph 23



Short-term intermediate care needs

There were seven people (50 per cent) that required intermediate care/step-down for short-term support. This is further broken down in Graph 24. Those that needed low-level step-down mainly required support with immigration issues and additional floating support for mental health or substance misuse. The one person that required high-level step-down had issues with substance misuse, cognitive impairment and immigration status. In the graph, 'other complexities' includes issues with physical health, mental health, substance misuse and/or immigration.

Graph 24



Summary of need (medically fit for discharge)

For the six people who were medically fit for discharge, their summary of need was equally divided amongst intermediate care/step-down and accommodation with community in-reach. Of those that required intermediate care/step-down, two needed physical or neurological rehabilitation with additional support for substance misuse, mental health and/or immigration issues, and the remaining required low-level step-down.

Appendix C: Hospital teams involved

Acute hospitals team(s):

- Whipps Cross Hospital Complex Discharge Team
- Newham Hospital Integrated Discharge Hub
- North Middlesex Hospital Integrated Discharge Team (run by Barnet Enfield and Haringey Mental Health Trust)
- Integrated Discharge Team, Barnet Hospital (run by Central London Community Healthcare NHS Trust)
- Camden Community Access & Integrated Discharge Service, Royal Free Hospital (run by Central and North West London NHS Foundation Trust)
- University College London Hospitals (UCLH) Integrated Discharge Team (run by Whittington Health NHS Trust)
- Whittington Hospital Integrated Discharge team
- The Royal London Hospital Pathway team
- Homerton University Hospital Pathway team
- Imperial College Healthcare NHS Trust Pathway team
- Chelsea and Westminster Hospital Pathway team
- Guy's and St Thomas' Hospital Pathway team
- King's College Hospital Pathway team
- St George's University Hospital Pathway team
- Croydon University Hospital Pathway team

Mental Health hospital team(s):

- South London and Maudsley (SLaM) Pathway team
- Barnet Enfield and Haringey Integrated Discharge and Acute Support Team
- St Pancras Hospital (step-down unit)

Community Healthcare hospital team(s):

- Integrated Discharge Team (run by Central London Community Healthcare NHS Trust), Finchley Memorial Hospital (step-down unit)

Appendix D: Clinical conditions

Clinical Category	Acute cohort (n=86)		Mental Health cohort (n=18)	
	Primary	Secondary	Primary	Secondary
HIV	2	1	0	0
Viral (serum) hepatitis B; history of hepatitis B; Hepatitis C; Hepatitis C treated; Viral (infectious) hepatitis A	0	4	0	0
Tuberculosis (2 MDR)	3	0	0	0
Asthma; chronic obstructive airways disease NOS; bronchitis NOS; pneumonia or influenza NOS	6	8	0	0
Cirrhosis and chronic liver disease; oesophageal varices	3	3	0	0
Gastrointestinal symptoms; pancreatitis	6	4	0	0
Acute myocardial infarction; old myocardial infarction; heart failure; cardiac dysrhythmias; H/O: cardiovascular disease	1	6	1	1
Stroke and cerebrovascular accident unspecified	6	2	0	0

Hypertensive disease	2	6	0	2
Pulmonary embolism; deep vein thrombosis of lower limb; other peripheral vascular disease; venous ulcer of leg/foot ulcers	8	4	0	1
Diabetes mellitus K (includes those with complications – 2 retinal problems)	5	5	0	0
Obesity	0	1	0	1
Renal failure unspecified - renal other including stone; kidney stone	1	2	0	1
End stage renal failure; renal dialysis	4	0	0	0
Other specified disorders of the central nervous system	3	1	0	0
Cognitive impairment; Korsakoffs	5	4	2	0
Epilepsy NOS; Fit	2	5	0	0
Head injury	4	0	0	0
Neoplasms NOS; cancer confirmed; carcinoma, metastatic, NOS; suspected cancer	6	3	0	0

Abscess NOS; cellulitis NOS; septic arthritis or osteomyelitis	7	0	0	0
Fracture of bones NOS	6	1	0	0
Musculoskeletal pain	1	3	0	1
Falls	3	3	0	0
Assault	3	0	0	0
Road traffic and other transport accidents	2	0	0	0
Schizophrenia NOS; psychosis NOS; bipolar affective disorder / schizo affective; drug induced psychosis	1	9	14	0
Anxiety with depression; depressed; mental disorders NOS; mental health crisis; autism	2	15	3	0
Suicidal ideation; attempted suicide	5	6	4	0
Vascular surgery for leg ulcers / embolectomy; foot surgery / debridement or toe amputation	5	1	0	0
Amputation	6	0	0	0

Spinal surgery; trauma surgery; neurosurgery; major trauma; Abdominal surgery	11	0	0	0
Poor mobility	5	6	0	0
Sickle cell disease – crisis; H/O sickle cell disease	2	0	0	0
Sepsis ; palliative care; very sick – awaiting more investigations/needed intubation	8	0	0	0
Cardiac arrest; unconscious on admission (include very sick / collapsed); collapsed	6	0	0	0
Alcohol withdrawal	4	0	0	0
Alcohol withdrawal seizure	3	0	0	0
Malnutrition	1	2	0	0
Mental disorders NOS	1	11	0	0
COVID	5	0	0	0
TOTAL	**154**	**116**	**24**	**7**

Appendix E: Discharge To Assess (D2A)

Pathway 0

a) Discharge to a domestic home. No new active support needed from health and social care once home. Includes people whose home care package is active and unchanged at point of discharge.

b) Discharge to a domestic setting (other place). No new active support needed from health and social care once home. Includes people whose home care package is active and unchanged at point of discharge.

c) Discharge to a hotel or other form of temporary accommodation. No new active support needed from health and social care.

d) Discharge to supported housing (for example, a homeless hostel) where a placement has remained open while the person was in hospital. No new active support needed from health and social care once home.

e) Adults who self-discharge without appropriate housing care and support being in place.

Pathway 1

f) Discharge to a domestic home. Assessment and active support needed from health and social care services for reablement, rehabilitation or end of life care at home. Includes people whose home care package has lapsed during their hospital stay and requires a restart at pre-admission level.

g) Discharge to a domestic setting (other place). Assessment and active support needed from health and social care services for reablement, rehabilitation or end of life care at home. Includes people whose home care package has lapsed during their hospital stay and requires a restart at preadmission level.

h) Discharge to a hotel or other temporary accommodation. Assessment and active support needed from health, housing* and social care. This includes need for short term floating/peripatetic ‘settle in’ support.

i) Patients who have NRPF (no right of recourse to public funds) discharged to hotel accommodation for further assessment of their care and support needs.

Pathway 2

j) Discharge to a care home. For rehabilitation or short-term care in a 24-hour bed-based setting before return home.

k) Discharge to a designated setting. For care and isolation before moving to a care home.

l) Discharge to a hospice. For short term 24-hour bedded support.

m) Discharge to a community rehabilitation bed. For rehabilitation or short-term care in a 24-hour bed-based setting before return home.

n) Discharge to a specialist homeless intermediate care “step-down” bed for assessment and rehabilitation.

Pathway 3

o) Discharge as a new admission to a care home which is likely to be permanent and may include end of life care.

p) Existing care home resident discharged back to care home with the same level of care as that delivered prior to admission to hospital.

q) Existing care home resident discharged back to care home with a need for an increased level of care from that delivered prior to admission to hospital. May include end of life care.

r) Discharge to a designated setting for care and isolation before moving to a care home.

s) Discharge to a specialist homeless medical respite facility that provides onsite 24-hour nursing and care.

Appendix F: Summary of need definitions (Acute cohort)

For each patient in the acute cohort, a 'predicted summary of need' was determined. These summaries describe the needs of the patient with regards to their immediate discharge from hospital, and covers both housing, care and support needs.

In order to assess patients' needs we developed several broad categories, each with its own sub-categories along with a detailed description. The categories were developed from a consideration of the patient needs identified along with an understanding of the different types of services/accommodations available.

Long-term needs

Specialist long-term care (P3)

- Care home for dementia, substance misuse and/or mental health issues
- Care home/palliative care (physical health concerns with substance misuse and/or mental health issues)
- Young person's disability placement plus other complexities such as substance misuse and/or mental health issues
- Severe mental health and/or substance misuse

Patients in this category display extremely complex needs (a combination of physical health, mental health, substance misuse, cognitive concerns and other complexities), to the extent that residential placements with 24-hour support are needed.

There were 12/86 (14 per cent) who were identified in this category. Three were able to return to their previous living situation. This is further broken down below:

Sub-Category	Out of 12	Additional needs/complexities:
Care homes for complex needs	9 (75 per cent)	• One required palliative care home for terminal cancer • Six required care homes for complex needs (varying combinations of care needs due to physical health and capacity issues combined with substance misuse and mental health support needs) • Two required care home for dementia and mental health and/or substance misuse support
Young persons' disability placement and other complexities (including mental health and/or substance misuse)	2 (16.7 per cent)	• Both required specialist care for chronic health conditions and mental health support. One needed a wheelchair accessible placement.

Care home for severe mental health and/or substance misuse issues	1 (8.3 per cent)	• Required a specialist mental health placement that is wheelchair accessible.

Accommodation with on-site support (P2)

- Includes on-site support from adult social care and/or district nurse

Patients in this category require supported living situations (that is, for substance misuse or mental health) which can accommodate a range of complex needs, but without requiring 24-hour care and support. Examples include warden controlled mental health accommodation or specialist substance misuse supported accommodation. Additional in-reach needs (such as support from adult social care or a district nurse) were also identified.

There were seven/86 (8.1 per cent) people who were identified in this category. Each of them required on-site support around mental health and/or substance misuse. One was able to return to their previous living situation. This is further broken down by additional needs below:

- one required support of a district nurse,
- one required adult social care and physiotherapy/occupational therapy,
- one required adult social care, support of a district nurse and floating support,
- one required physiotherapy/occupational therapy and support of a district nurse.

Accommodation with community in-reach (P1)

- Includes in-reach support from adult social care (ASC)
- Floating support for mental health and/or substance misuse issues (MH/SM)
- Community Mental Health services
- Physiotherapist, Occupational Therapist, District Nurse (Physio/OT/DN)
- Homelessness support staff, peer support and voluntary sector organisations

Patients in this category required accommodation placements with a range of different forms of community/in-reach support, outlined above. For each patient, the specific combination of care and support needs were identified.

There were 22/86 (25.6 per cent) who were identified in this category. One was able to return to their previous living situation. This is broken down below:

Support needs (and accommodation)			**Out of 22**	**Additional needs/complexities:**
ASC	**Floating support for MH/SM**	**Physio/ OT/DN**		
x			2 (9.1 per	• one required accessible accommodation

			cent)	
	x		6 (27.3 per cent)	• two required self-contained accommodation
		x	3 (13.6 per cent)	• one needed self-contained accommodation
x	x		1 (4.5 per cent)	• required accessible accommodation
x		x	3 (13.6 per cent)	• one required wheelchair accessible accommodation • two required accessible accommodation
	x	x	1 (4.5 per cent)	
x	x	x	6 (27.3 per cent)	• two required accessible accommodation • three required wheelchair accessible (one self-contained)

This information is summarised below:

Accommodation	Community In-reach services
• four (18.2 per cent) required wheelchair accommodation • six (27.3 per cent) required accessible accommodation • four (18.2 per cent) required self-contained accommodation	• 12 (54.5 per cent) required support from adult social care services • 14 (63.6 per cent) required floating support for mental health and/or SM • 13 (59.1 per cent) required support from a physiotherapist, occupational therapist and/or district nurse

Accommodation with low-level needs (P1)

Patients in this category required accommodation placements, with very few to no additional care and support needs. There was one/86 (1.2 per cent) person identified in this category, whose support needs following discharge included access to routine primary care and outpatient services.

Short-term needs

Intermediate care/step-down

Patients in this category had an identified short-term need for rehabilitation or step-down placements, to facilitate rehabilitation, further assessment, immigration dispute resolution and other complexities (including, mental health and/or substance misuse issues). They exhibit a range of different needs as outlined below.

There were 44/86 people (51.2 per cent) who were identified in this category. This includes the 16 people in acute care who were reported to have NRPF status. Below is a breakdown:

Sub-Category	Out of 44	Definition	Additional needs/complexities:
Neuro/physical rehab + other complexities (P2)	16 (36.4 per cent)	Patients required either neurological or physical health rehabilitation, along with support for other complexities such as mental health, substance misuse and/or immigration issues.	• seven required immigration support • three required wheelchair accessible • five required accessible for mobility issues • seven required neuro rehab and other support • six required physical rehab and other support • three required neuro and physical rehab and other support
Substance misuse rehab + other complexities (P2)	7 (15.9 per cent)	Patients required substance misuse rehab placements, with additional support around physical health and/or mental health and/or immigration issues	• four required adult social care input and accessible accommodation
Neuro/physical rehab (no other complexity) (P2)	3 (6.8 per cent)	Patients required either neuro or physical health rehabilitation with no additional support needs	• two required neuro and physical rehab (one accessible accommodation) • one required physical rehab and wheelchair accessible accommodation

Step-down (medium level) (P2)	7 (15.9 per cent)	Patients required accommodation with 24-hour staffing and additional clinical in-reach for issues around immigration, physical health, mental health, substance misuse and/or social care. This includes those requiring disability accessible accommodation.	● three required immigration support ● two required accessible accommodation ● four required input from adult social care ● four required floating support or support for mental health and/or substance misuse issues ● two required support from a physiotherapist, occupational therapist and/or district nurse
Step-down (low level) (P1)	9 (20.5 per cent)	Patients predominantly required accommodation for further immigration-related assessments, as well as support for their physical health issues.	● All required immigration support ● 4 required floating support for mental health and/or substance misuse ● 1 required support from adult social care and accessible accommodation
Specialist TB accommodation (P1)	2 (4.5 per cent)	Patients needing specialist accommodation because they had tuberculosis, as well as support for their immigration issues.	● All required immigration support

Appendix G: Suboptimal discharges (Acute cohort)

There were 21 patients who the teams felt were likely to be discharged to a destination unable to meet their needs. This is further outlined below. One patient, who was included in this count but whose details were not captured below was offered accommodation with a package of care but declined support.

Placement Need	Likely (or planned) placement	Reason perceived / anticipated suboptimal
Specialist care facilities	• 4 x temporary accommodation / hostel with support from adult social care and/or other organisations • 2 x neuro/physical rehabilitation • 2 x uncertain	• Unlikely to manage complex MH/SM needs • Awaiting social care assessments. Unlikely to get specialist care placement.
Supported accommodation	• 3 x temporary accommodation	
Appropriate accommodation + support	• 2 x temporary accommodation (one out of area)	• Uncertainty around access to physical/MH/SM support. One required independent accommodation.
Appropriate accommodation	• 1 x temporary accommodation • 1 x not ground floor accommodation • 1 x uncertain	• Unsuitable for family • Requires ground floor accommodation • Awaiting housing appointment. Unsure if placement will be found.
NRPF appropriate accommodation	• 4 x with NRPF	• Uncertainty around placement and access to support. One required wheelchair accessible accommodation.