SHEFFIELD HOMELESS HOSPITAL DISCHARGE AND HIGH INTENSITY USER SERVICE (HHDS) REVIEW

Contents

SECTION 1: BACKGROUND

Context:

In 2023, Sheffield Changing Futures in Partnership with Sheffield ICB commissioned a Homeless Hospital Discharge Service (HHDS) Test and Learn Pilot to operate between May 2023 and March 2024. The purpose was to 'test and evidence' the efficacy of the approach in line with NICE guidance, to better support homeless adults at A & E, through secondary pathways and on discharge back into a community setting. The Pilot was subsequently extended for a further 12-month period until March 2025 funded solely by Sheffield Changing Futures. Changing Futures is a grant funded programme form the Ministry of Housing, Communities and Local Government focused on improving systems and services for adults experiencing multiple disadvantage.

The evidence based 'Test and Learn' pilot aimed to improve hospital discharge, reduce high intensity users of A & E and improve communications between colleagues in health care settings, adult social care and community supporting services. This entailed whole pathway reviews within Sheffield Teaching Hospitals and formal contractual conversations to ensure delivery helps inform ongoing planned service improvements.

The funding for the Pilot will cease in March 2025 with the ending of Changing Futures Funding after which it will be for the Sheffield ICB and Sheffield City Council to consider how they wish to proceed within the context of their own strategic and resource priorities.

Staffing Structure:

The Homeless Hospital Discharge Service staffing structure and costs are as follows:

Role	FTE	Key Tasks
Senior Support Planner	0.8	Operational lead, supervision support for navigators, case worker
Navigators	3.0	Case workers
Team Manager	0.2	Service oversight and line management
Admin	0.6	Support to process referrals, collect and analyse data

Provided by Sheffield City Council and funded through Rough Sleeper Initiative funding:

Senior Housing Solutions Officer	0.5	Complete Housing Reduction Act assessments, share information, coordinate with Sheffield City Council to prevent or relieve homelessness

Operating Costs:

Staff Costs	£142,779
Non-Pay	£63,744
Total	£206,523

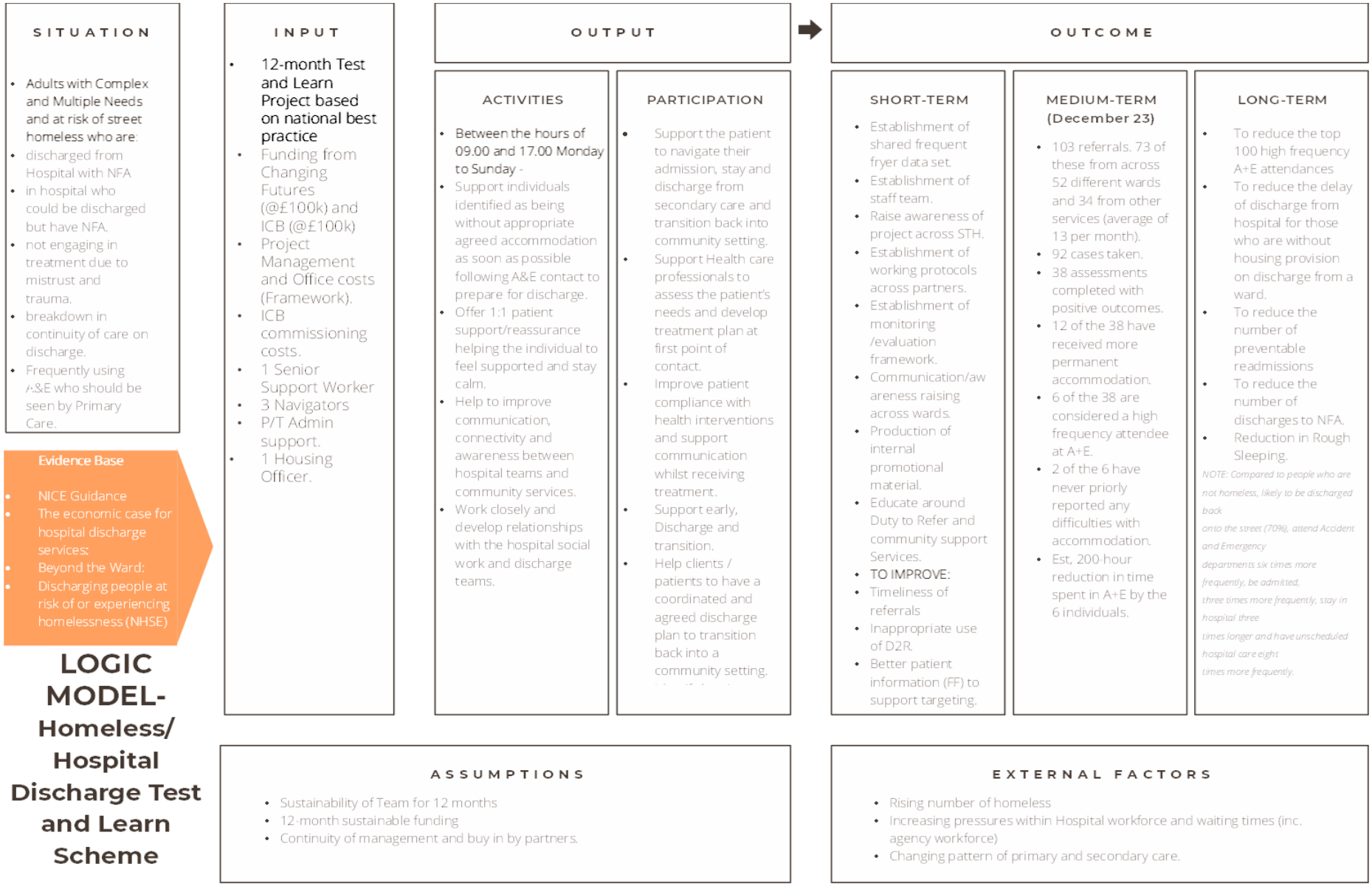
Structure of the Report:

This report will not focus on the delivery of the Pilot (though references will be made), as interim evaluation reports and contract monitoring has confirmed that Framework has delivered the Project to a more than satisfactory standard. Rather, it looks at the efficacy or 'theory of change' of the approach to explore three key lines of enquiry:

1. If and how the approach has achieved its anticipated and projected outcomes?
2. If and how the approach can be enhanced or changed to improve potential impact?
3. How it compares with the evidenced outcomes of other approaches with similar objectives?

It is anticipated that exploring these three lines of enquiry we should be able to make some observations to help inform the ICB's (and partners) future commissioning priorities and choices.

The starting point for the Review will be the Logic Model developed for the interim evaluation of the Pilot in January 2024 and reported in the Mental Health and Rough Sleepers Programme (2023-2024) final report (see below). The Logic Model describes in a simplistic way the 'theory of change' as described in the original project brief and against which progress has been monitored and delivery evaluated.


SITUATION
Adults with Complex and Multiple Needs and at risk of street homeless who are:
discharged from Hospital with NFA
in hospital who could be discharged but have NFA.
not engaging in treatment due to mistrust and trauma.
breakdown in continuity of care on discharge.
Frequently using A:&E who should be seen by Primary Care.
Evidence Base
NICE Guidance
The economic case for hospital discharge services:
Beyond the Ward:
Discharging people at risk of or experiencing homelessness (NHSE)
LOGIC MODEL- Homeless/ Hospital Discharge Test and Learn Scheme
INPUT
12-month Test and Learn Project based on national best practice
Funding from Changing Futures (@£100k) and ICB (@£100k)
Project Management and Office costs (Framework).
ICB commissioning costs.
1 Senior Support Worker
3 Navigators
P/T Admin support.
1 Housing Officer.
OUTPUT
ACTIVITIES
Between the hours of 09.00 and 17.00 Monday to Sunday -
Support individuals identified as being without appropriate agreed accommodation as soon as possible following A&E contact to prepare for discharge.
Offer 1:1 patient support/reassurance helping the individual to feel supported and stay calm.
Help to improve communication, connectivity and awareness between hospital teams and community services.
Work closely and develop relationships with the hospital social work and discharge teams.
PARTICIPATION
Support the patient to navigate their admission, stay and discharge from secondary care and transition back into community setting.
Support Health care professionals to assess the patient's needs and develop treatment plan at first point of contact.
Improve patient compliance with health interventions and support communication whilst receiving treatment.
Support early, Discharge and transition.
Help clients / patients to have a coordinated and agreed discharge plan to transition back into a community setting.
OUTCOME
SHORT-TERM
Establishment of shared frequent fryer data set.
Establishment of staff team.
Raise awareness of project across STH.
Establishment of working protocols across partners.
Establishment of monitoring /evaluation framework.
Communication/awareness raising across wards.
Production of internal promotional material.
Educate around Duty to Refer and community support Services.
TO IMPROVE:
Timeliness of referrals
Inappropriate use of D2R.
Better patient information (FF) to support targeting.
MEDIUM-TERM (December 23)
103 referrals. 73 of these from across 52 different wards and 34 from other services (average of 13 per month).
92 cases taken.
38 assessments completed with positive outcomes.
12 of the 38 have received more permanent accommodation.
6 of the 38 are considered a high frequency attendee at A+E.
2 of the 6 have never priorly reported any difficulties with accommodation.
Est, 200-hour reduction in time spent in A+E by the 6 individuals.
LONG-TERM
To reduce the top 100 high frequency A+E attendances
To reduce the delay of discharge from hospital for those who are without housing provision on discharge from a ward.
To reduce the number of preventable readmissions
To reduce the number of discharges to NFA.
Reduction in Rough Sleeping.
NOTE: Compared to people who are not homeless, likely to be discharged back onto the street (70%), attend Accident and Emergency departments six times more frequently, be admitted, three times more frequently, stay in hospital three times longer and have unscheduled hospital care eight times more frequently.
ASSUMPTIONS
Sustainability of Team for 12 months
12-month sustainable funding
Continuity of management and buy in by partners.
EXTERNAL FACTORS
Rising number of homeless
Increasing pressures within Hospital workforce and waiting times (inc. agency workforce)
Changing pattern of primary and secondary care.

For this Report we are primarily focussing on the Situation and Outcome columns and re-examining the Evidence Base, Assumptions and External Factors to ensure that they are still true for the Pilot.

Information Sources:

To inform this Review we will be exploring four sources of information:

1. National best practice and appropriate evaluation reports (extracted from Mental Health and Rough Sleepers Programme Final 2023-24, Changing Futures Outcome Report July 24 and Hull Pathway Evaluation Report January 24).
2. Activity data recorded by Framework for the current provision (inc. projections if possible)
3. Qualitative discussions with Project Staff and relevant partners (15th and 16th October)
4. Two Expert Panel sessions held on 2nd and 4th December 2024
5. The views of the Review Steering Group (Changing Futures, Sheffield ICB and Framework)

Review Team:

The Review Team consisted of Vince Roberts, Mental Health and Street Homeless (Phase 2) Project Manager and Molly Dooley, Changing Futures Commissioning Officer.

SECTION 2: EVIDENCE BASE

The relevant section from the **NICE Guidance[1] is 1.8, transitions between different settings**. The guidance focuses on the importance of having Homeless Multi-Disciplinary Teams or leads supporting people through the transitions from one setting to another such as the street, hostels, Housing First and other supported housing, hospital, mental health services, social care, residential or community drug and alcohol treatment, and custody. They recommend providing time sensitive, intensive support which includes:

- having a key practitioner coordinating care
- building a relationship of trust
- providing links to services in the community
- gradually lowering the intensity of support, as appropriate.

The guidance recommends that Clinical teams, working with hospital discharge teams and specialist homelessness multidisciplinary teams, where available, should have procedures to minimise self-discharge **and** prevent discharge to the street. If self-discharge or discharge to the street happens, review the circumstances, and implement learning.

Pathway needs assessment data[2] shows that people experiencing homelessness are more likely to have emergency inpatient admissions, as opposed to elective, than the

Pathway needs assessment data shows that compared to people who are not homeless, those experiencing homelessness are likely to be discharged back onto the street (70%), attend Accident and Emergency (A&E) departments six times more frequently, be admitted three times more frequently, stay in hospital three times longer and have unscheduled hospital care eight times more frequently.

[1] Integrated health and social care for people experiencing homelessness, NICE guideline Published: 16 March 2022
[2] "Always at the bottom of the pile": The Homeless and Inclusion Health Barometer 2024

general population. Similarly, to A&E attendances, HHNA data shows physical health problems or conditions (37.3%), mental health problems/ conditions (13.4%) and self-harm/attempted suicide (13.4%) as the most common reasons for admission amongst people experiencing homelessness. The report leans towards prioritising the importance of approaches that aid effective discharge and references the work of Pathway in supporting nine Pathway hospital teams across England through their structured support offer – the Pathway Partnership Programme.

Beyond the Ward: Exploring the Implementation of the Duty to Refer in Hospital Settings[3], looks in detail at how the Duty to Refer (DtR) has been implemented nationally and makes several recommendations for improvement at a system and local level much of which focuses on releasing expertise from Housing/Homeless Support Services to support discharge processes and the need for early identification of risk. The recommendations over-lap with the NICE Guidance and talks in detail about the importance of using the DtR to prevent discharge to the streets and that advice, guidance and training should be provided within appropriate Hospital settings.

The Homelessness Reduction Act 2017 reformed England's homelessness legislation for the first time in 40 years. It aimed to embed a more preventative approach to homelessness. As part of this legislation, a Duty to Refer (DtR) was introduced, which places a duty on various public bodies to refer service users who they identify as at risk of or experiencing homelessness to the relevant local authority.

The Pathway Partnership Programme[4] Pathway's experience has shown that multidisciplinary teams are most effective in addressing the multiple health issues homeless people face. National evaluations have shown that integrating housing and clinical staff into the team led to 'better outcomes and more positive working practice' and recommends this as one of the key 'components of effective models for future replication.'

Pathway teams have been shown to be cost-effective. In today's NHS, the drive for financial savings seems to compete for priority with improving patient care. A randomised controlled trial showed that a Pathway team is cost effective, and improves people's health and housing status, confirming that a little bit of help puts life on a better pathway.

The economic case for hospital discharge services for people experiencing homelessness in England[5]: An in-depth analysis with different service configurations providing specialist care provides the economic case for dedicated and bespoke hospital discharge schemes. This analysis, reports on a study investigating the cost-effectiveness of three different 'in patient care coordination and discharge planning' configurations for adults experiencing homelessness who are discharged from hospitals in England.

They looked at three models of care:

- The first configuration provided a clinical and housing in-reach service during acute care and discharge coordination but with no 'step-down' care.

[3] Beyond-The-Ward.pdf (pathway.org.uk)
[4] How our teams are reimagining healthcare – Pathway
[5] The economic case for hospital discharge services for people experiencing homelessness in England: An in-depth analysis with different service configurations providing specialist care - Tinelli - 2022 - Health & Social Care in the Community - Wiley Online Library

- The second configuration provided clinical and housing in-reach, discharge coordination and 'step-down' intermediate care.
- The third configuration consisted of housing support workers providing in-reach and discharge coordination as well as step-down care.

They provided evidence that Specialist homeless hospital discharge schemes are potentially more effective and cost-effective than 'standard care'. Homeless hospital discharge schemes providing access to specialist intermediate care (step-down beds) appear more cost-effective than schemes with no access to intermediate care.

SECTION 3: QUALATITIVE INTERVIEWS

As part of the review we conducted a series of interviews with stakeholders who either work within or alongside the HHDS including:

- 2 x Hospital Discharge Navigators
- 1 x manager from the HHDS
- 2 x hospital based social care practitioners and 1 x Team Manager within the Sheffield City Council Home First Team based in Sheffield Teaching Hospitals
- 1 x social worker within the Sheffield City Council Hospital First Contact Team
- 1 x acute medicine and infectious diseases consultant from Sheffield Teaching Hospital
- 1 x Team Leader from the Alcohol Treatment Team based in Sheffield Teaching Hospital

The interviews have identified several key themes in relation to the experience of working with the Homeless Hospital Discharge Service. These are summarised below.

The critical role in Discharge and Housing Support:

The HHDS has displayed a vital role in facilitating safe hospital discharge for patients facing housing challenges and severe multiple disadvantage (SMD).

The service is bridging gaps between hospital and community, ensuring, wherever possible, that patients do not return to rough sleeping or unsuitable accommodation after discharge. In cases where NFA discharge is unavoidable, HHDS navigators can provide support within the community to continually advocate for accommodation and link into primary care for continued medical treatment whilst NFA.

One interviewee stated that on a particularly complex case, where ward staff were planning to discharge NFA to Howden House, HHDS were able to intervene and ensure that the patient was well linked into community services on discharge and support the Alcohol Treatment Team to remain in contact with the individual for treatment post discharge. Prior to the pilot, that patient would likely have been discharged NFA and not seen again until next presenting at A&E in crisis.

By taking over the housing related issues the HHDS significantly reduces the workload of hospital teams including clinical staff and adult social care, increasing capacity within these severely over stretched services.

Specialised knowledge and expertise:

The HHDS team has in-depth knowledge of housing systems, housing legislation and community resources which hospital staff and social care teams do not possess. This includes immigration, support for people with no recourse to public funds, navigating complex cases

who have been previously declined accommodation, and challenging housing decisions made by the local authority.

Their ability to act quickly to accurately identify the right resources and services is invaluable in discharge planning and continuity of care on discharge. This knowledge and expertise enables the HHDS to effectively advocate for the rights and needs of patients in a way that hospital staff do not feel equipped or experienced enough to do.

The HHDS team also have a great deal of knowledge and expertise around complex case meetings and vulnerable adult risk management meetings and can effectively organise and chair these meetings ensuring involvement from all relevant services in the individuals care and support.

One Consultant stated that this was of 'huge value as most clinicians are not trained and do not know how to organise and facilitate these meetings nor do they have the capacity to do so in their clinical roles.'

Responsiveness and flexibility

Throughout the interviews it was consistently acknowledged and praised that the HHDS are extremely responsive and flexible in their approach to referrals often meeting face to face with people referred and initiating support immediately.

Their ability to be flexible and meet patients where they are and adjusting to their needs is proving to support engagement with treatment for people who were previously service resistant due to past negative experiences and trauma.

CASE STUDY ONE

The HHDS started working with the beneficiary who was a repeat referral, in mid July. Initially there was a pattern of repeated admissions to the Acute Medical Ward via A&E due to repeat overdoses. Admissions for this person were estimated at around 17 in a month. HHDS completed a safeguarding referral due to the severity and regularity of the overdoses.

In getting to know the beneficiary the team were able to identify that he felt lost and unable to see past his homelessness and substance misuse. In completing basic tasks such as supporting the beneficiary to set up his property shop account to enable him to bid on council properties, scanning his passport and ID for his universal credit, accessing food banks, supporting to attend assessments at Howden House and maintaining regular contact, the beneficiary became more hopeful. Seeing the progress he had made, he expressed a desire to continue moving forward to prevent himself from using substances and committing further offences.

After encouragement from the HHDS, the beneficiary was able to reconnect with family. As a result of the progress the beneficiary had made, his family member agreed to help and support him. The council have also raised his priority to band C as a result of the advocacy from the HHDS and they are able to bid on properties for him weekly. The HHDS are also providing food parcels whilst supporting him with a complex Universal Credit claim. With regular contact, the HHDS have seen a significant reduction in the beneficiary accessing A&E, and it is understood that he has not presented at A&E for over 2 months.

Interviewees repeatedly referred to the HHDS teams as applying a 'tenacious', 'persistent' and 'professionally curious' approach to accessing support for the cohort.

Integration with other services

The HHDS team are closely linked with the street outreach team with the manager managing both services. This means that the HHDS navigators already have a great deal of knowledge and useful information on those being referred into the HHDS as well as having positive relationships with those referred helping to quickly engage people with the service.

Note: Important to acknowledge, though not part of the review, was the unanimous praise and admiration expressed for those we talked to about the professionalism, dedication, friendliness, and calmness of the Framework HHDS staff.

The HHDS navigators have worked hard to build good relationships with hospital staff on wards and A&E. This can be evidenced in the increase in referrals over the course of the pilot and the positive feedback in all of the interviews. This has led to better communication and outcomes for beneficiaries of the service.

The HHDS works closely with the Homeless and Health MDT operated by Devonshire Green and Hanover Medical Practice. This ensures that for some patients it was possible to co-ordinate treatment and care following discharge. It was noted that this was much more difficult to achieve for beneficiaries registered with other General Practices who do not take the same trauma informed approach to providing health acre to this cohort.

The HHDS connections with community-based support services such as CAB, community mental health teams, drug and alcohol services and supported accommodation providers, combined with their relationships with hospital staff has led to a better co-ordination of support post discharge and has ensured that patients have access to the resources and support they need.

This was particularly important to clinical staff working within acute medicine and infectious diseases, 'The work HHDS do on the street means there is a chance to keep tabs on the patient and link them in with primary care – often the cohort have previously never accessed primary care.'

Challenges and potential areas of improvement

One of the challenges highlighted throughout the interviews was the need to raise awareness of the service within wards and hospital departments. There are still frequent cases of HHDS not receiving referrals until the day of discharge despite the patient being in hospital for several weeks. This has drastically reduced since the start of the pilot but there is still a way to go. Also, several interviewees reported that hospital staff are not aware of their Duty to Refer and the benefit of referring into the service in reducing their workload whilst improving outcomes for patients.

It was also raised on several occasions that education on the NHS' Duty to Refer is lacking, which could be addressed through more promotional work through the HHDS if their capacity was increased.

The teams' effectiveness could be increased by the provision of a city-wide Homelessness General Practice facility or outreach nurse. The HHDS worked effectively within the Devonshire Green and Hanover Medical Practice Homeless MDT ensuring timely treatment for people in the community. However, it was identified that continuity of care for anyone registered outside of the Devonshire Green Practice was drastically reduced due to other practices not taking a trauma informed approach to providing primary health care to this cohort.

The HHDS provides outreach support at A&E and this was mentioned positively a number of times. However, members of the HHDS team feel that there is the potential to enhance this provision through increased capacity to ensure that its potential benefit can be maximised.

Concern regarding the gap in provision should the pilot end:

If the service was to close, all interviewees foresee severe consequences including increased delayed discharge, heightened pressure on an already stretched adult social care and hospital staff, risk to patient safety and even higher levels of self-discharge and discharge to NFA.

It was clearly articulated that one of the implications was that patients who were not suitably discharged would inevitably re-present at A&E and probably in a worse state of health.

The thought of the service closing brought one ward Consultant to tears and a sense of dread for others.

It was agreed across all interviews that the emotional and practical toll on hospital staff and adult social care within the hospital would be significant, as they lack the time, expertise, and resources to safely discharge this complex cohort of people.

The closure would leave a number gaps and deficits within the system.

SECTION 4: ACTIVITY DATA CONCLUSIONS

The HHDS have collected data throughout the duration of the pilot in order to evidence its efficacy and identify trends and areas for improvement. The analysis of this data has provided insights into demographics, health needs, referral sources, discharge timing, post discharge accommodation and access to primary care for homeless individuals who were admitted and discharged through the HHDS pilot.

Ward Referrals and Service Utilisation

From May 2023 and September 2024 the service received 262 referrals, of those 262, 36 were repeat referrals (29 people) therefore 226 individual people were referred. Of the 262, 131 were deemed as suitable and met the service eligibility criteria. Of the 131, 100 consented to support (76%) and 11 were repeat referrals. The volume of referrals alone evidences a high demand for structured discharge planning for the homeless population as well as the dedication of the team to actively promote the service within Sheffield Teaching Hospitals.

The volume of referrals clearly evidences the dedication of the team to actively promote the service within Sheffield Teaching Hospitals.

Demographics of Ward Referrals

Figure 1 shows the demographics of the 100 referrals who consented to support from the HHDS:

Age	Gender	Ethnicity
16-24	2 Female (67%) 1 Male (33%)	3 White British (100%)
25-34	1 Transgender (6%) 5 Female (29%) 11 Males (65%)	2 Any other ethnicity group (12%) 3 Asian (18%) 3 Black African (18%) 1 Unknown (6%) 1 White and Black Caribbean (6%) 7 White British (41%)
35-44	Female 9 (30%) Males 21 (70%)	2 Any other ethnicity group (7%) 5 Asian (17%) 3 Black African (10%) 1 Unknown (3%) 19 White British (63%)
45-54	5 Female (20%) 20 Male (80%)	3 Any other ethnicity group (12%) 2 Any other white background (8%) 1 Asian (4%) 3 Black African (12%) 2 Unknown (8%) 14 White British (56%)
55-64	1 Female (5%) 18 Male (95%)	1 Any other white background (5%) 1 Black African (5%) 1 Black British (5%) 1 Unknown (5%) 15 White British (80%)
65-74	1 Female (20%) 4 Male (80%)	5 White British (100%)
75-84	1 Male (100%)	1 White British (100%)

Figure 1

76% of referrals were male, 23% female and 1% transgender broadly reflecting the profile of the Street Homeless Population. This suggests a predominance of male referrals among homeless individuals needing discharge services. However, women experiencing homelessness are even less likely to seek care due to fear of judgement or perceived lack of services tailored to their needs, reducing their interaction with hospital and discharge services, therefore this disparity does not necessarily highlight a lesser level of need amongst women. [6]

Most referrals fall in the 25-64 age range (91%), with the largest subgroup aged 35-44 (29%). This age concentration aligns with patterns of chronic homelessness and health deterioration.[7]

Referrals received were predominantly White British (64%), with smaller percentages of other ethnic groups, including Black African (10%) and Asian (9%). This reflects the diversity of the homeless population while indicating a higher representation of certain ethnic groups.[8]

Ward Referral Sources

Figure 2 shows which hospital, ward or external organisation made the referral into the HHDS:

[6] Obstetrics & Gynecology Health Care for Homeless Women

[7] Health matters: rough sleeping - GOV.UK

[8] Statutory homelessness 2018 archived - GOV.UK Ethnicity facts and figures

Northern General Hospital	Number of Referrals
A&E	15
Acute Medical Unit/Firth 5 and 6	9
Adult Social Care	6
Alcohol Care Team	12
Brearley 1-4 - Respiratory	3
Chesterman 2 - Cardiology and Cardiothoracic Surgery	1
Chesterman 3 - Cardiology and Cardiothoracic Surgery	2
Chesterman 4 - Cardiology and Cardiothoracic Surgery	1
Clinical Decisions Unit	1
Critical Care Unit	1
Decisions Unit - Mental Health	1
Firth 2 - Vascular	2
Firth 3 - General surgery and colorectal	1
Firth 4 - General surgery and Colorectal	1
Firth 7 - Cardiology	1
Hadfield 3 - Gastroenterology	3
Huntsman 6 - Orthopaedic Trauma	3
Huntsman 7 - Respiratory Medicine	1
Surgical Assessment Unit/Centre	2
Vickers 2 - Diabetes Endocrine	1
Vickers 4 - General Medicine	2
Royal Hallamshire Hospital	**Number of Referrals**
E1 Ward - Infectious Diseases	3
E2 Ward - Infectious Diseases	7
F1 Ward - Urology	1
N2 Ward - Neurology	1
External	**Number of Referrals**
City of Sanctuary	1
Changing Futures	1
Likewise	1
Self Referral	6
Street Outreach Team	1
Unknown	9

Figure 2

The majority of referrals came from A&E (15%), Acute Medical Unit (9%), and Alcohol Care Team (12%) indicating that acute, emergency, and substance related care needs are common entry points into the discharge service. However, given the range of referral sources it is reasonable to conclude that the need is across the Wards and would increase with further awareness raising around the service.

Health Needs and Reasons for Admission

Analysis shows that the most common reasons for hospital admissions were:

- infectious diseases (17%)
- substance or alcohol use (16%)

- physical injuries from falls (13%)

This reflects the complex health needs often seen in homeless populations. [9]

Infectious diseases, particularly cellulitis, tuberculosis, and pneumonia were commonly recorded as presenting needs amongst referrals. Cases of wound infections, leg ulcers, and abscesses also underscore the need for both preventative and follow-up care, which may be limited post-discharge without appropriate community support.

A substantial number of cases involve chronic conditions such as cardiovascular disease, respiratory issues, liver disease, diabetes and cancer. This highlights the challenges in managing chronic illness within the homeless population where access to primary healthcare is limited. This limited access can be attributed to low trust and confidence in primary health care services due to feeling judged by health care professionals[10], restrictive appointment booking systems, long waiting times and a lack of immediacy compared to A and E.[11]

Approximately 9% of referrals presented with co-morbidities suggesting the presence of compounded health problems such as mental health coupled with substance use or chronic conditions. However, this is likely to be grossly underreported as findings from the Homeless Health Needs Audit identified that 81% of people who were homeless had a diagnosed mental health condition.[12]

The portion of unknown reasons for admission suggests potential gaps in communication during referral or complicated presentation that required further investigation. This could hinder the HHDS ability to effectively co-ordinate and plan for the persons discharge and highlights a need for improved documentation and communication in the referral process.

CASE STUDY TWO

In May 2024 the Infectious Diseases ward at Royal Hallamshire Hospital referred in a patient who was being treated for infectious TB which was already resistant to one strain of antibiotics. On his discharge from hospital the beneficiary would require 6 months of ongoing TB treatment to ensure that his TB did not become infectious again and also reduce the risk of his TB becoming resistant to another strain of antibiotics. In order to facilitate this it was imperative that the beneficiary had stable housing.

However, due to his immigration status the beneficiary had no recourse to public funds so was not able to seek accommodation through the council. HHDS worked with Discharge Systems, TOC, TB nurses, Infectious diseases consultants, ICB and Public Health England to explore alternative sources of funding for accommodation. After several MDTs organised by Discharge Systems where various options were explored and HHDS were able to provide knowledge of housing systems it was agreed by ICB and Public health England to jointly fund short-term accommodation for OF while he underwent treatment.

HHDS also supported the beneficiary to seek advice around his immigration status in order that he might try to gain settled status and recourse to public funds.

[9] Deaths of homeless people in England and Wales - Office for National Statistics
[10] What homeless people told us about their experience of health and care services | Healthwatch
[11] Health and Multiple Disadvantage - Michael Corbishley
[12] Homeless_Health_Needs_Audit_Report.pdf

Figure 3 shows the reasons for beneficiaries being admitted to hospital:

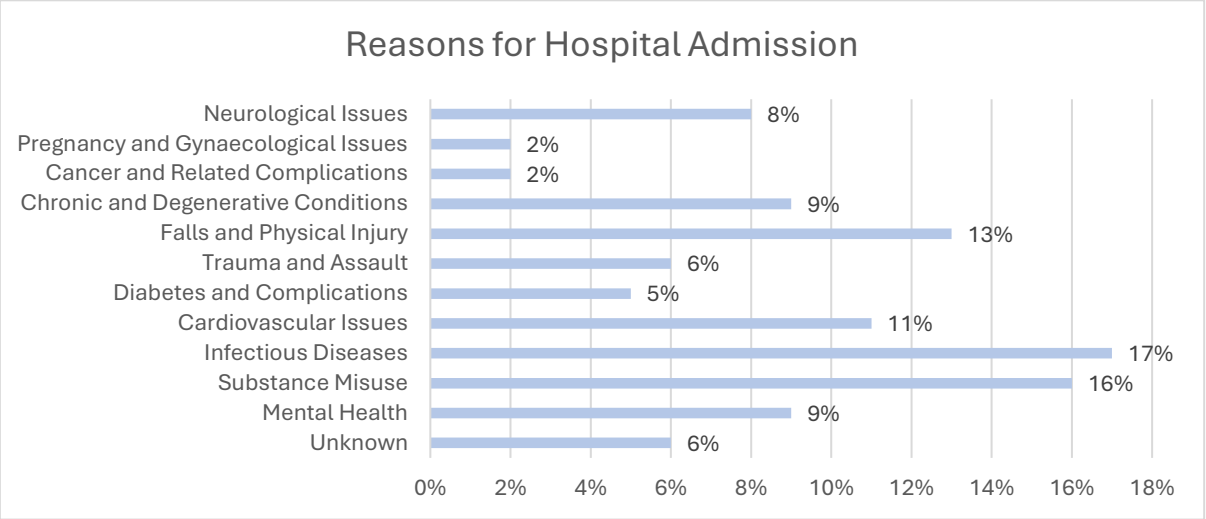


Figure 3

Accommodation Outcomes

On Admission, 55 individuals were classified as rough sleeping or having no fixed abode. On discharge, 10 of the 55 individuals were assisted into other forms of accommodation. This is a positive indicator of the hospital discharge service's ability to connect individuals to housing resources however as the number is relatively low it also indicates limited capacity within the team and limited housing options for this cohort.

40 individuals were discharge back to rough sleeping or NFA. Out of those 40, 23 (58%) were supported to find accommodation post discharge, 3 (8%) are still working with the service to access accommodation, 1 (3%) declined further support from the service and is now living with a friend, and 13 (33%) lost contact with the service.

On Admission, only 4 individuals were in supported accommodation. On discharge this increased to 8, highlighting that some patients were successfully placed into environments with additional support. However, the overall low number indicates a possible limitation in available supported accommodation options.

6 individuals were in temporary accommodation on admission, and this rose significantly to 23 on discharge, showing a large shift towards temporary housing solutions. This reflects the discharge team's use of temporary housing as an immediate intervention, which can help stabilise patients post-discharge while they await longer-term arrangements.

On Admission, 13 individuals had other types of suitable housing including living with family and friends and Local Authority tenancies. Out of the 13, 2 were able to be discharged back to their original suitable accommodation and 2 others remain unknown. For the remaining 9 individuals, changes to their health rendered their initial accommodations unsuitable. Of these 9:

- 2 Individuals were discharged back to their previous accommodations, which are now deemed unsuitable due to their health conditions.
- 1 Individual was successfully placed in supported accommodation that meets their health needs

- 6 Individuals were discharged to temporary accommodation while more suitable, long term accommodation is arranged.

15 individuals were in unsuitable accommodations (e.g., unstable or unsafe housing). On Discharge, 60% were placed in more suitable accommodation showing a substantial improvement. The discharge service focused on moving these individuals to safer or more stable options.

On admission, 7 individuals had an unknown accommodation status. On discharge, this number increased to 20, suggesting a gap in discharge documentation or follow-up regarding housing outcomes. Addressing this could improve tracking of patient housing stability after discharge.

Figure 4 shows beneficiaries' accommodation on admission to hospital compared with accommodation on discharge:

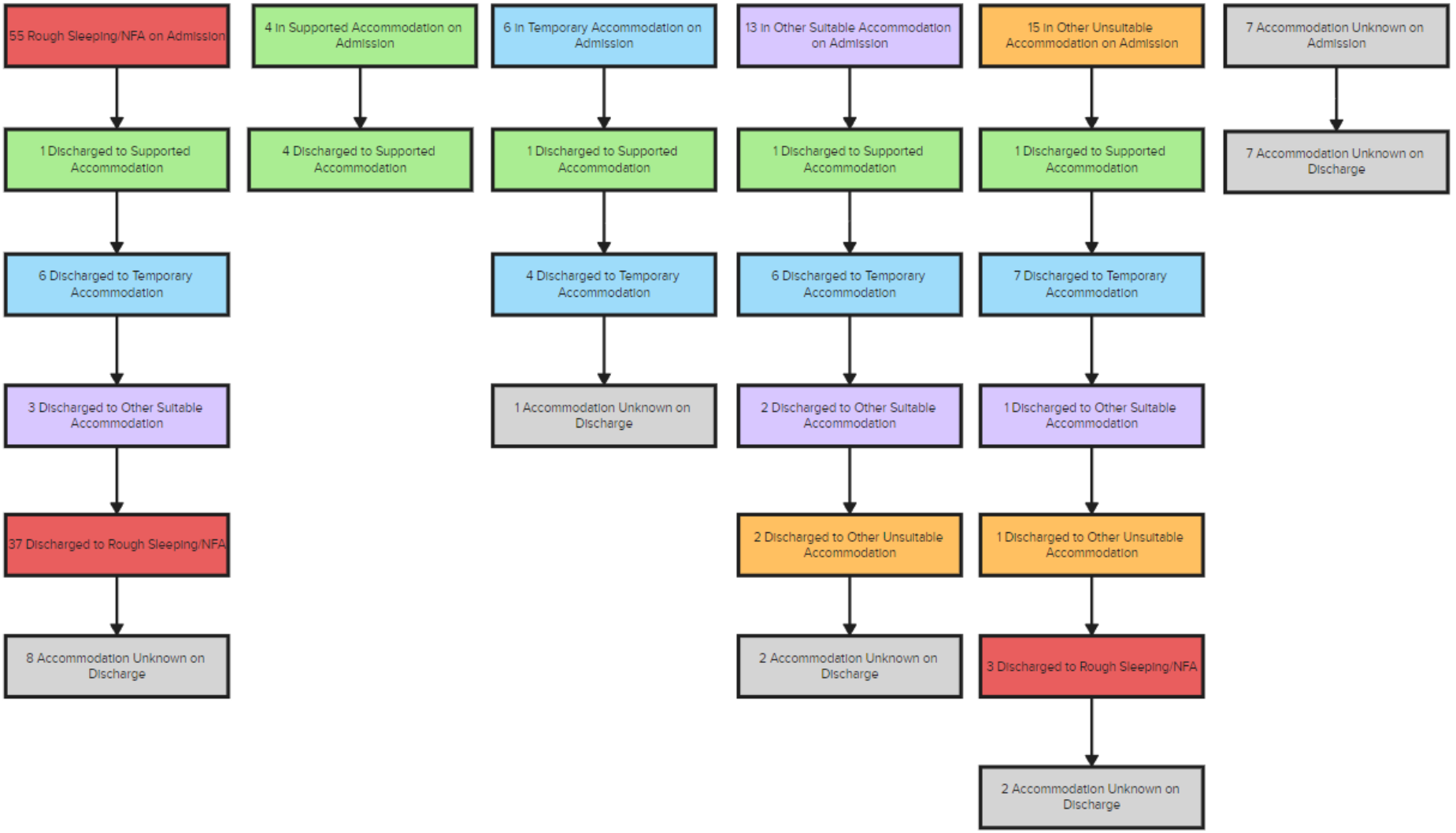


Figure 4

Discharge Outcomes

Figure 5 shows the number of people who were discharged on time:

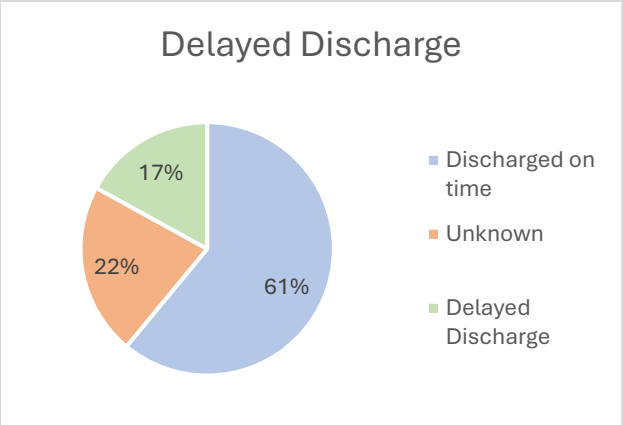


Figure 5

Analysis of this data shows:

- 61% of referrals were discharged on time, with 17% experiencing delays and the remaining 22% not recorded.
- Of the 17 referrals where discharge was confirmed as delayed, 14 have a recorded referral and admittance date which show that staff at the hospital were sending referrals to the HHDS, on average, 9 days after admission with a total of 91 days delay across referrals.

This delay to receiving the referral impacts the services ability and capacity to source suitable accommodation in time for discharge. Further investigation into the circumstances around the delays would be helpful to understand the cause and identify what further action could be taken to reduce this delay.

CASE STUDY THREE

The beneficiary was seen by HHDS on a bus leaving the Northern General Hospital. After a conversation with the hospital it became clear that the beneficiary had absconded from AMU in the middle of treatment for an overdose. The beneficiary was concerned about her dog and was going to the Archer Project to collect the dog from a friend who had only been able to care for it overnight. The Beneficiary has significant trauma and the dog helped her with emotional regulation. After collecting the dog HHDS supported the beneficiary back to AMU and were able to negotiate with AMU staff who agreed to accommodate dog staying with the client while she received the end of her course of IV medication.

74% of people were discharged due to being medically fit or transitioning to a different care setting, with only 5% self-discharging. Self-discharge is reported as common within the homeless population and is often related to anxiety around losing temporary accommodation, unmanaged mental health problems or drug and alcohol problems.[13] Specifically, individuals may feel the need to leave to secure their medication, manage withdrawal symptoms, or avoid perceived stigma from staff regarding their drug or alcohol use which can be evidenced in the Changing Futures Beneficiaries Report. [14]

The service's low rates of self-discharge can be attributed to the effective efforts of the HHDS. By building strong relationships with beneficiaries during their hospital stay, advocating on their behalf and ensuring that their needs are met, the service enables beneficiaries to complete

[13] Safe and effective discharge of homeless hospital patients - Healthy London Partnership January 2019

[14] Beneficiary Outcomes Report June 2024.pdf

their medical treatment in full. This supportive approach fosters trust and engagement reducing the likelihood of premature discharge. As evidenced in the case study.

The discharge service is effective in moving people from unsuitable or no accommodation toward temporary and supported options, though long-term or permanent housing solutions are still lacking. The increase in temporary accommodation placements highlights the importance of immediate but short-term housing options, though they may not fully address long-term housing needs. The rise in "unknown" discharge accommodation status suggests that enhanced tracking and follow-up could be beneficial to fully understand and support post-discharge housing stability.

Continuity of Care Post Discharge

Figure 6 shows support provided to beneficiaries in the community post discharge:

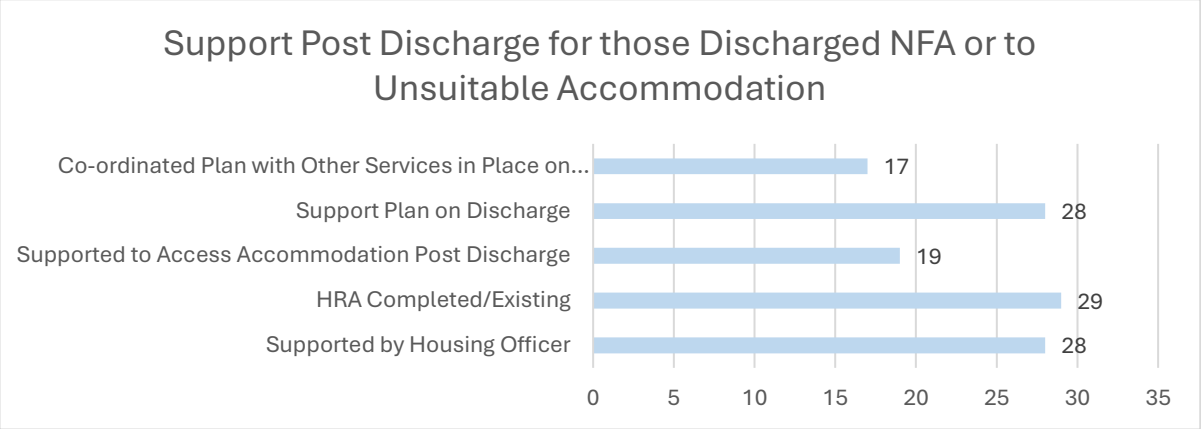


Figure 6

In total 56 individuals (56% of those supported) had a support plan on discharge, with 45 benefiting from coordinated plans with other services. This level of planning underscores the service's emphasis on continuity of care post-discharge.

Of the 46 individuals discharged to no fixed abode or to unsuitable accommodation, support to access accommodation after discharge was provided to 20 individuals (43%), and housing was later arranged for 19 individuals (41%). This underlines a proactive approach in linking discharged patients to temporary or supported housing, though gaps remain.

"I live in Sheffield in a clean, safe and warm home thanks to Michelle Morley.

I first met Michelle I think the first full week I was in the Northern General Hospital.

Michelle is a very straight forward person and doesn't make false promise like some of the support workers I've had before and she genuinely cares. I wouldn't be where I am today without her help and dedication to her job. Everything she has said to me she has done."

Service beneficiary

Access to Primary Care Post Discharge

11 out of 89 individuals (12%) referred to the service were supported to register with a GP in the community after discharge, with 46 (52%) already registered prior to their entry into the HHDS and 19 (22%) were supported to access health care in the community post discharge.

For the 70 who were not supported to access health care post discharge, 4 individuals moved out of area in a planned way with the support of HHDS. 7 individuals moved into supported or assisted living with support to access primary healthcare provided. 13 Individuals lost contact with the service, 2 people died and one was sentenced to custody. However, there were 43 cases where reasons for not receiving support to access health care are unknown. This large number suggests limitations in documentation and capacity amongst the extremely small team. There was also one case recorded as being on the Special Allocations Register' in another locality and this has caused significant delays in the transfer of his records preventing him from accessing any form of primary care.

CASE STUDY FOUR

Beneficiary was being regularly admitted to hospital due to being diabetic and struggling to access his insulin in the community due to a language barrier. Social care referred the beneficiary into HHDS for support around accessing his insulin in community.

The HHDS supported the beneficiary to register with a GP and then supported him to his first GP appointment to start an insulin prescription. The HHDS also supported the beneficiary to access his local pharmacy and explained how to collect his prescriptions preventing further repeat admissions.

With 12% supported to register with a GP and 22% supported to access broader community health care, there remains a gap in the continuity of care for many. This can be attributed to service capacity, individual engagement and co-ordination with other health care services.

Flexibility, collaboration and a trauma informed approach in primary health care services is proving to be vital. Adopting flexible approaches that better accommodate the needs of this cohort, such as simplified registration processes, mobile health services, and trauma informed approaches to treatment help to address the barriers faced by this cohort. This can be evidenced in the disparity of care provided by Devonshire Green surgery, a trauma informed practice, compared with other General Practices in the city.

High Intensity User Group

The HHDS pilot aimed to provide targeted support to the top 100 high intensity A&E users affected by homelessness, facilitated through the use of an information sharing agreement between Framework and the Trust. However, once the service was mobilised it became clear that the trust needed individual consent to share data, except when patients were recorded as having no fixed abode upon presenting at A&E. It soon emerged that reception staff often struggled to identify people as NFA, as this information was not always disclosed or outdated postcodes from years prior were still on record. This led to individuals being mistakenly categorised as housed, preventing data sharing and ultimately access to the service. As a result it has been difficult to track the number of high intensity user patients that the service has supported and whether or not there has been a reduction in their use.

Enhanced Housing Solutions Officer

Co-locating with Sheffield City Council Enhanced Housing Officer has proven to be an asset to the service. In cases where the EHO was involved, HRA's were completed quickly and existing referrals followed up as well as the team and beneficiaries receiving regular updates around accommodation placements. This eliminates the need to attend Howden House or for the navigator and beneficiary to spend extended periods of time waiting on the phone to Housing Solutions, increasing the capacity of HHDS Navigators and improving the service for beneficiaries.

SECTION 5: AN ECOMONIC CASE FOR SPECIALIST HOMLESS HOSPITAL DISCHARGE SERVICES

Value for Money and System Savings – An economic case?

As part of the review and following feedback from the Expert Panels, we were asked to come to a view about the Value for Money of the service and whether there were potential system savings. However, we are constrained in what we could evidence locally because:

- There was limited 'control' or 'baseline' patient or hospital data against which to assess change.
- The service is comparatively small working with around 100 patients, out of the Hospital's 250,000 in-patients per year[15], so any Hospital-wide impact would be largely invisible.
- The Review Team were not health economists, as such any detailed analysis would be outside their skill base.
- The system benefits of the service cut across a range of services and activity, from housing, homelessness, Social Care, Community Safety, Primarily and Secondary Care and Public Health. As such it would be largely impossible to extrapolate where the system benefits exist.

The Logic Model Evidence Base:

Using the Logic Model we can reference a number of Value for Money exercises undertaken elsewhere. The most important and comprehensive is the £800k National Institute for Health Research (NIHR) funded national evaluation of specialist hospital discharge services for homeless patients. In summary its conclusions confirmed that they [homeless discharge schemes] helped prevent discharge to the street, reduced emergency readmissions and were cost-effective for the NHS.[16]

In March 2023, ADASS, the LGA and Partners in Care and Health published an updated support tool and briefing notes complementing the High Impact Change Model for managing transfers of care called 'Home First Discharge to Assess and homelessness'. As part of the briefing they reference NIHR research and reiterate:

- NHS Trusts with specialist homeless hospital discharge teams had lower rates of Delayed Transfers of Care linked to 'Housing' than standard care.
- Employing a range of different economic modelling techniques, specialist out-of-hospital care arrangements were consistently more effective and cost-effective than standard care.

[15] NHS Sheffield Teaching Hospital Annual Report 2022/3
[16] https://www.nihr.ac.uk/story/specialist-support-people-who-are-homeless-reduces-emergency-hospital-readmissions

- Employing a range of different economic modelling techniques, out-of-hospital care models that encompassed a homeless hospital discharge team PLUS direct access to a specialist step-down service were more effective and cost-effective than other models.[17]
- Advocacy provided by 'clinically-led' homeless hospital discharge teams increased access to planned (elective) follow-up care. This is an especially important outcome as 1 in 3 deaths of people in the evaluation cohort* were due to common conditions (eg heart disease) which are amenable to timely health care.

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

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

The NICE guideline highlights the importance of developing specialist intermediate care locally as it represents value for money. 'Intermediate care, including step-down and step-up care, would represent a change in practice because this service is currently rare for people experiencing homelessness. This would need some funding but there is evidence that intermediate care represents value for money'.

The unmatchable NIHR study and conclusions underpin the VfM assessment of the Sheffield HHDS. As the Logic Model represents, in a simplified way, a hypothesis or 'theory of change' about how the intervention works and is based on the conclusions of the NIHR study, then it is reasonable to conclude that the Service is VfM.

Case Studies:

There are several case studies produced nationally that have attempted to put a nominal financial value on the benefits of Homeless Hospital Discharge Services.[18] These have focussed on three areas:

- Staff time saved.
- Admissions reduced.
- Bed used saved.

As a follow up to this report, we will be doing a short piece of work to see if we can come to some nominal financial value of the benefits of the Service based on the case studies generated as part of this review.

Conclusions

We have observed that the Service has started to achieve its anticipated and projected outcomes. There is evidence that fewer people have been discharged to the streets, that the awareness of statutory responsibilities in terms of DtR have improved, that there are low rates of self-discharge by patients working with the Service and that staff responsible for hospital

[17] Sheffield has no Step Down facility, though ambitions have existed
[18] British Red Criss Discharge Service, Salford Homes for Homes First, Hull Pathway, Gloucester Pathway, Leicester Pathway.

discharge and meeting social care needs have been supported in their roles. Many of these outcomes will improve over time if the Service becomes part of the mainstream.

We have also considered how the approach can be enhanced or changed to improve potential impact of the Service. We have observed that the Project can be seen as being an 'in-reach' as well as a discharge approach as the lead organisation also provides street- based outreach in Sheffield. This has brough with it a range of benefits in terms of relationship building, continuity of support and care and community connections.

The approach, though having some similarities to other national Pathway Partnership Programmes, is not GP or clinically led. Though for patients who are registered with Devonshire Green Medical Practice have benefited from the Health MDT led by the lead GP, it may be of use to reflect on this and to identify whether this is a deficit in the approach.

The economic case for bespoke discharge programmes for Homeless populations is made by the 3 year national research funded by the National Institute for Health Research that has informed subsequent NICE guidance. However, the research references the added value of 'step down' or 'intermediate care'. This is not part of the Sheffield Model. This may need to be considered within policy discussions.

The Sheffield Model predominately focuses on physical health settings. It may be worth considering whether a similar approach needs to be piloted for other settings such as mental health and substance misuse services.

The evidence gathered from the stakeholder interviews strongly evidences the necessity for the continuation of the HHDS. The service has proven to be an essential bridge between hospital discharge and community support, ensuring that vulnerable individuals are not discharged to rough sleeping or without access to primary care. The testimonials from stakeholders highlight that without the HHDS, there would be significant gaps in discharge provision, leading to increased pressure on already strained hospital and social care staff, delayed discharge and elevated risk to patient safety.

The HHDS's specialist knowledge in housing systems, advocacy skills, and ability to coordinate complex care have demonstrated their critical role in facilitating safe, timely discharges and supporting post-discharge engagement. The service's tenacious, trauma-informed approach and strong integration with other services have enabled improved outcomes and reduced repeat A&E visits. Data analysis has shown that although challenges remain, such as capacity constraints and gaps in discharge documentation, the service's positive impact on discharge coordination and temporary housing placement is clear.

Ending the HHDS pilot would likely exacerbate issues such as self-discharges, delayed care transitions, and recurring emergency hospital admissions, as voiced by the interviewees. This would not only worsen patient health outcomes but also impose an emotional and operational toll on hospital and social care staff ill-equipped to manage these complex cases without the HHDS's expertise.

Therefore, it is reasonable to conclude that the HHDS should be maintained and expanded to build on its successes, improve continuity of care post-discharge, and address existing challenges. By increasing awareness and capacity, the service can enhance its already

significant role in supporting the health and housing stability of Sheffield's homeless population.

Co-authored by Vince Roberts and Molly Dooley

APPENDIX 1:

Qualitative Interviews

Qualitative Questions Script:

Purpose of the interviews:

- To identify from a partner's perspective what is working well within the current delivery Model?
- To identify from a partner's perspective what could be changed to improve the current delivery model?
- To capture any examples (case studies) of how the approach has worked well.

Opening statement:

'Thank you for agreeing to talk to us. We are (introduce our selves). We have been asked by Changing Futures and Sheffield ICB to review the SHEFFIELD HOMELESS HOSPITAL DISCHARGE AND HIGH INTENSITY USER SERVICE being delivered by Framework and identify:

- *If and how the approach has achieved its anticipated and projected outcomes?*
- *If and how the approach can be enhanced or changed to improve potential impact?*

We anticipate that this interview will be informal taking about 30 minutes and we will be taking notes as we go along. What we discuss will contribute to the final report and though not directly attributable, we will potentially refer to what you tell us.

You will get a draft of the final report for you to comment on should you wish.' We have a few prompt questions we wish to explore with you, and we may ask additional clarification questions.

Have you any questions of us?

Prompt Questions:

- What is your role and job title?
- How do you work with the Service?
- From your perspective, what has worked well, and can you give us some examples please?
- From your perspective, what could be improved and why?
- Have you any examples of how patients have directly benefited from the Service?
- In your view, what will be lost if the Service closes in the new year?
- Is there anything else you want to tell us about the Service.