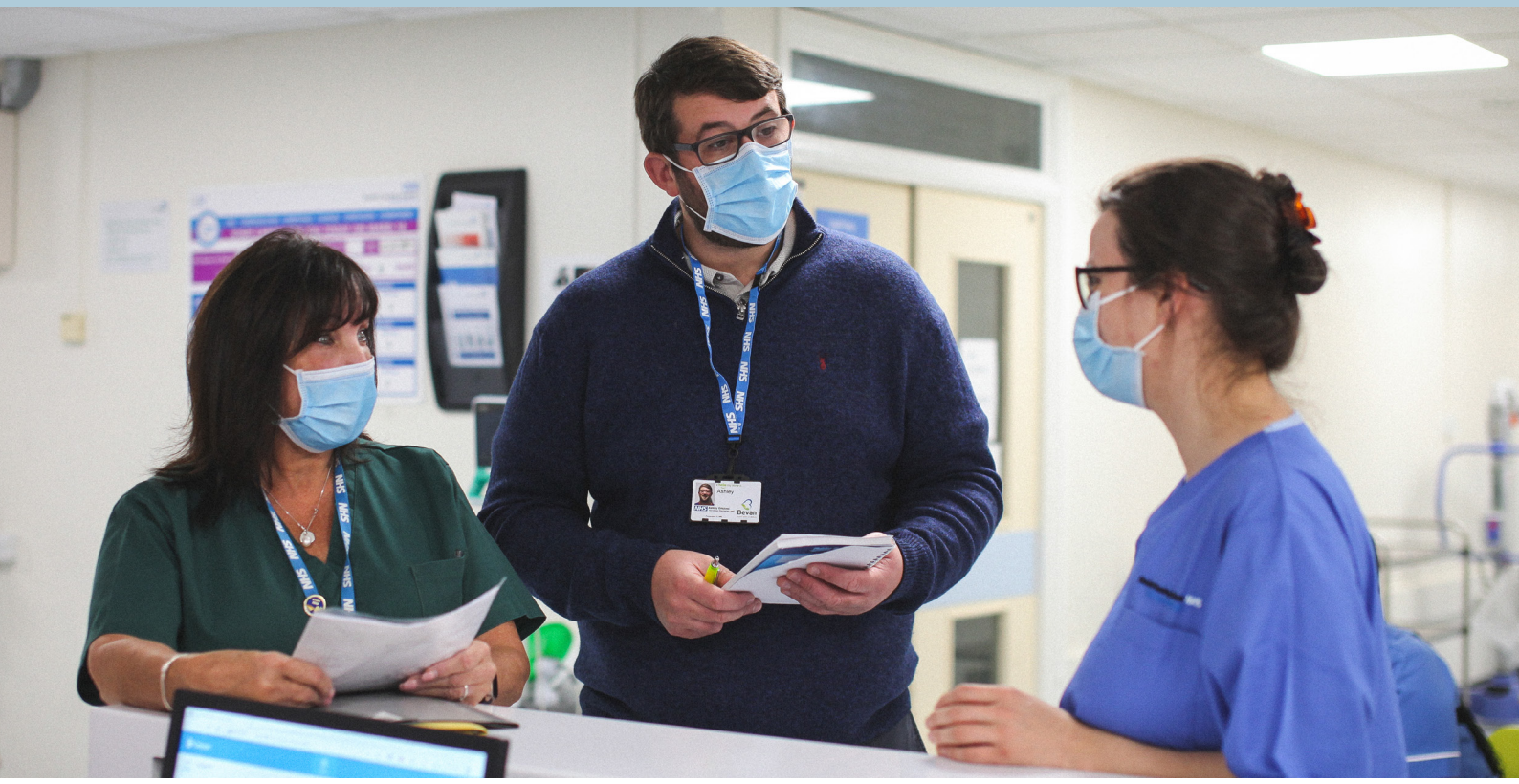
Beyond the Ward:

Exploring the Implementation of the Duty to Refer in Hospital Settings

Emily Page and Chris Hicks



pathway
Healthcare for homeless people

Working with
Crisis
Together we will end homelessness

Pathway & Crisis Policy Report 2023 Beyond the Ward

Contents

Pathway & Crisis Policy Report 2023 Beyond the Ward

About Us

Pathway is the UK's leading homeless and inclusion healthcare charity. We work with the NHS to help spread and develop our successful model of enhanced care coordination for people who are homeless and other excluded groups. We work to improve the quality of healthcare that people experiencing homelessness receive by developing and sharing best models of care; increasing specialist skills of workers in healthcare; influencing policy; and reducing stigma in healthcare against people experiencing multiple exclusion.

Crisis is the national charity for people experiencing homelessness. We help people out of homelessness and campaign for the changes needed to solve it altogether. As well as helping to end homelessness for individuals by providing practical support, we campaign on the policy changes needed to end homelessness for good and conduct research to understand and highlight the scale, causes and consequences of homelessness.

Since 2021, Pathway has been part of the Crisis group, forming a strategic alliance that helps to maximise our impact for people experiencing homelessness. Together we are advocating for policy responses to homelessness that save lives and promote positive health outcomes. Our partnership aims to:

- Work with the NHS and wider health and social care services to help them prevent homelessness through evidence-based programmes that will ensure people get the support they need to leave homelessness behind for good.
- Fill in knowledge gaps in inclusion health and homelessness research, including how to improve services, narrow health inequalities, assess the impact of government policies and consider the solutions needed to end homelessness for good.

Acknowledgments

The authors of this report would first and foremost like to thank all those across the health and housing sectors involved for their time and participation in providing the invaluable reflections included in this report. Thank you to members of Pathway's Experts by Experience programme and Groundswell's Homeless Health Care Navigators Programme who took the time to share their lived experience with us.

We were supported by multiple partners who were instrumental in sharing this work with appropriate partners, providing detailed case information, and generally supporting the development of our research: Theresa Nguyen and JJ Nadicksbernd (formerly) at Transformation Partners in Health and Care; Mathilde Dupuoy and Martin Murphy at Groundswell; Dan Sumners at the Royal College of Physicians; Lydia Duncan at Salford Dual Diagnosis Homeless Team and Chris Harris at Sussex Health & Care. We would also like to acknowledge the support and expertise provided by Bren McGowan formerly at Healthwatch England and members of the Royal College of General Practitioners in shaping the recommendations presented here.

Thank you to our colleagues in Pathway and Crisis for your guidance along the way and support with proofing and feeding in on the draft findings and report.

Finally, a heartfelt thank you to Kunle Osinaike, who passed away suddenly in February 2023. Kunle worked tirelessly on delivering the Homeless Out of Hospital Care Model programme in North East London and was an active participant in his local Duty to Refer forum, bringing a diligent, kind, and jovial spirit to discussions. He is sorely missed by his colleagues and all those who knew him.

Foreword

Members of Pathway's Experts by Experience Programme all have lived experience of homelessness. They also have experience of serious health problems and challenges accessing appropriate healthcare. They work with us to ensure that the voices of people experiencing homelessness are heard at all levels of the health and social care system.

It takes a tremendous amount of mental energy to ask for help – just to make an appointment, to go to a doctor, or to speak to a healthcare professional. So to then be treated like you are not even a person when you get there, it is difficult to comprehend how far this knocks you back. Yet feeling dehumanised in healthcare settings is an experience we are all too familiar with. Between us, we've witnessed hospital staff apologising to patients because there was somebody who was homeless sat next to them in the waiting room; we've been told that we would have to be sprayed down with air freshener; we've been asked ''how the likes of you came in an ambulance?''.

The impact of homelessness on an individual's health is catastrophic. The average age of death for people experiencing homelessness is 45 for men and 43 for women. A third of homeless deaths are caused by treatable illnesses. That means hundreds of homeless deaths could have been prevented. It is shocking this happens in the UK. We continue to see untreated homeless people ignored by health services and allowed to fall through cracks in health service provision. People are discharged from hospital without any accommodation or package of support in place, often back to the streets which made them sick to begin with.

We know it doesn't have to be this way. We envisage a world where homelessness is recognised as everyone's problem, where health and housing services work collaboratively to prevent homelessness. And we know that good practice exists: discharge nurses who act as a liaison between agencies, care navigators that offer peer support in navigating complex systems for those who are otherwise isolated, a person who is able to say ''we've got you and we're here for you''.

This future cannot be realised by a healthcare system that does not recognise homelessness as its responsibility. Education has the power to bring people together and create space for empathy - healthcare staff must be provided training to be able to ask the right questions about people's housing and to join the dots about their risk of homelessness. Together we must build an understanding of how stereotypes can get in the way of effective health treatment and raise awareness of a practitioner's legal duties.

With the cost-of-living continuing to rise, and pressure mounting on the NHS, there has never been a more crucial time to make a change. The cost of inaction is simply too great.

The task at hand appears daunting but the solutions really are simple. We begin by listening without judgement, asking questions openly and honestly, and above all, recognising that we are all human.

Gareth, Jamesy, Jeff, Lily, Mandy, Pete, Tony
Colleagues with lived experience

Pathway's Experts by Experience have shared some of their experiences of stigma and discrimination on film. 'Less?' was released in January 2023 as a training aid to encourage frontline staff to reflect on their attitudes and prejudice. Watch the film here: *https://journeystohealth.co.uk*

Executive Summary

Background Information

1. 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.

   If this referral provides the authority with reason to believe that the individual might be homeless or threatened with homelessness, and the individual indicates they would like assistance, it triggers an application for assistance under Part 7 of the Homelessness Code of Guidance for Local Authorities.

2. The duty was designed to ensure that public services, including hospitals (in emergency departments, urgent treatment centres, and inpatient care settings) intervene to prevent homelessness

   The duty aimed to facilitate closer collaboration and partnership working between public bodies that each bear some responsibility for responding to the holistic needs of people experiencing or at risk of homelessness.

3. The NHS has a crucial role to play in preventing and ending homelessness, including identifying homelessness through the Duty to Refer (DtR). A hospital admission acts as an opportunity to identify that someone is homeless, or at risk of becoming homeless, and to act to prevent that homelessness from happening, or to resolve it promptly.

4. This report is the first to investigate the effectiveness of the Duty to Refer (DtR) within hospital settings specifically. It aims to understand how the DtR is working in hospital departments; identify opportunities and barriers to successful patient outcomes; and assess the extent to which the legislation is successful in preventing homelessness.

5. Through an online survey and workshop discussions with key stakeholders, we have found that there is a significant implementation gap between the objectives of the duty and actual provision.

Pathway & Crisis Policy Report 2023 Beyond the Ward

Key Findings

- The objectives of the duty indicate a positive shift in the right direction, but the surrounding systems in which the duty sits have not evolved in the same way. Whilst the DtR has a key role to play in the prevention of homelessness, a referral mechanism is only as good as the systems into which an individual is referred. The efficacy of the DtR is continuing to be threatened by health and social care systems which are under immense pressure, a housing system in crisis, and an increasingly hostile immigration system.

- The DtR is more productive, and is likely to result in positive patient outcomes, in areas where integration between health and housing services is robust. Areas in which the duty has been implemented with relative degrees of success are those that have truly joined up health and care services which are improving the lives of people in their area. The implementation of the duty therefore acts as an indicator for the overall health of the system at large.

- The duty is mainly used in response to people who are already experiencing homelessness, rather than being employed to identify people at risk of becoming homeless, in line with the preventative spirit of the Homelessness Reduction Act.

- The likelihood of a referral being made from a hospital setting, and resultant patient outcomes, is dependent on geographical location. There is substantial variation in the percentage of referrals made by health organisations under the DtR between different local authority areas, with the largest being 63.2 per cent compared to 1.4 per cent as the lowest proportion.

- The DtR has not been designed in a way to meet the needs of marginalised communities, meaning that navigating the referral process, and achieving positive outcomes from the DtR, is most challenging for the most vulnerable people.

- There is a lack of effective governance, oversight, and accountability at both local and national level of the DtR, which allows lack of adherence to the DtR to continue unchecked.

We have identified nine recommendations that would go some way to address current barriers, make a significant impact in improving the efficacy of the duty within the confines of current system pressures, build on existing good practice, and begin to close the implementation gap. These are:

Recommendations for System-Level Change:

Recommendation 1:
To better meet patients' health, care and support needs, the Department for Health and Social Care (DHSC) and the Department for Levelling Up Housing and Communities (DLUHC) should ensure that local authorities and health bodies have access to a wide range of housing options for people experiencing homelessness discharged from hospital with complex needs, specifically provision of dedicated step-down and intermediate care facilities.

Recommendation 2:
To ensure integration between health services and local authorities, DHSC should explore requiring all emergency departments, urgent treatment centres and hospitals in their function of providing inpatient care, to have a dedicated housing officer.

Recommendation 3:
To encourage adherence to the duty in areas that see high levels of patients experiencing homelessness, DHSC should consider requiring specialist homelessness teams in hospitals providing inpatient care that admit more than 200 people experiencing homelessness each year.

Recommendation 4:
To better identify housing need before patients reach crisis point, DHSC and DLUHC should explore extending the DtR to other parts of the NHS where the opportunities to prevent homelessness may be greater. This should include primary care, community mental health, and drug & alcohol services. They should work with the primary care sector, including the Royal College of General Practitioners and the British Medical Association, to examine how this could work in practice and commission pilots to test operational considerations and devise the most effective implementation of the DtR in these settings.

Recommendations to drive improvements at a local level:

Recommendation 5:
To ensure the availability of safe accomodation options for people to be referred to, Integrated Care Systems (ICSs) should assess the current availability and effectiveness of intermediate care for people experiencing homelessness in their areas, and commission services appropriately in line with NICE guideline NG214.

Recommendation 6:
To encourage the duty to be used in a more preventative manner, NHS Trusts should provide relevant healthcare professionals with the knowledge to: identify patients experiencing/ at risk of homelessness, understand their duty to refer under the Homelessness Reduction Act, and become aware of the local operational structures in place to support them to do so, in their mandatory induction training programmes.

Recommendation 7:
To provide oversight of the duty in their local area, all ICSs should have a senior responsible officer for homeless and inclusion health who coordinates an ongoing integrated homelessness forum which includes health, housing, and social care representatives to consider best practice.

Recommendation 8:
To enable ICSs to have oversight and compliance with the duty in their area, all NHS Trusts should be required to publish data on the number of referrals made under the duty to enable transparency. This data should be cross-referenced with existing hospital data sets that record patients who present with insecure housing status.

Recommendation 9:
To drive greater accountability of the duty, Healthwatch England should provide the Local Healthwatch network with the resources to examine the implementation of the DtR within their locality when updating its 'Enter and View' guidance. This will provide context to the DtR and include recommended practice on this area of exploration i.e., key questions to ask patients and staff about how the duty works for them.

Local Healthwatch organisations should explore using their legal power to enter and view health and social care services to take a view on how well DtR is implemented. This would enable them to make recommendations to inform changes in the local DtR process for individual services and relevant local partners, as well as system wide.

1 Introduction

Health bodies and homelessness prevention

> Homelessness is a healthcare issue. The average age of death among men and women experiencing homelessness is 45 and 43 respectively[1], as a result of the significant prevalence of major health conditions among this population, such as cancer, respiratory and heart disease[2]. People who are homeless are much more likely to experience physical, mental health, and substance issues.

Multi-morbidity, where people experience more than one health condition simultaneously, is particularly prevalent among people who are homeless. Health needs are both a cause and consequence of homelessness. The recent Homeless Link Health Audit found that 63 per cent of respondents to their survey reported that they had a long-term illness or disability, 72 per cent of respondents reported experiencing depression (compared to a national rate of 10 per cent pre-pandemic) and 45 per cent of respondents self-medicate with drugs or alcohol to help them cope with their poor mental health[3].

This in turn places additional burden on the health and care systems. High use of unplanned care, such as A&E, is common, and resultant stays in inpatient care are much longer than for the general population[4]. A study of nearly 3,000 homeless patients discharged after an emergency admission from 78 hospitals between 2013 and 2016 revealed almost 2,000 were readmitted within a year, at almost double the rate of those with homes to go to[5]. This is driven by a failure from our health, social care, and housing systems to identify health and housing needs early enough to prevent people from reaching crisis point.

The NHS has a significant role to play in preventing homelessness itself, including identifying homelessness and acting accordingly. However, too many people are discharged from hospital onto the streets or inappropriate temporary accommodation, only for them to accumulate further health issues which require intensive healthcare. This is despite hospital admission being a key point of contact where preventative action could be taken, including the opportunity to link people into wider services such as housing and homelessness teams, to ensure that when someone is in contact with public services, all opportunities to prevent and resolve their homelessness are taken.

Systemic prevention failures therefore include the failure to prevent homelessness itself, the failure to prevent health conditions that can lead to homelessness (such as mental health problems), and failure to prevent and/or better manage health conditions that disproportionately impact people experiencing homelessness.

Crisis and Pathway were keen to understand how effectively health bodies play their part in homelessness prevention, in particular, in relation to the Duty to Refer, which places a duty on certain public authorities to identify people experiencing or at risk of homelessness and refer them to the relevant local authority.

Through a series of workshops, a survey of healthcare professionals, and analysis of H-CLIC data we have sought to understand how health bodies and local authorities believe the DtR is working in practice, five years on from its implementation, and what recommendations can be made to ensure it is as effective as it can be. We have also considered how effectively the duty has improved hospital discharge for people experiencing homelessness.

Policy Context– Homeless Healthcare

> Momentum has been building around homeless and inclusion health in recent years, particularly in light of the wider move towards integration across the NHS, and the recognition that people experiencing homelessness not only face some of the most extreme health inequalities, but that too often they are falling through gaps because of a lack of integration. This has begun to be reflected in national government policy on homeless healthcare

For example, the Government's guidance for Integrated Care Systems on the Health and Care Bill implementation recognised that a lack of data on homeless and inclusion health groups can be a key barrier to ensuring successful provision for these groups. Statutory guidance states that all integrated care strategies 'should identify opportunities for research where there are gaps in evidence either of health and care need or gaps in how those needs might be effectively met'[6]. It also states that the integrated care strategy should ensure that the needs of populations that experience significant health inequalities, such as people who are homeless, are identified and met through the Integrated Care Board, NHS England, or responsible local authorities exercising their functions. Recent analysis of the integrated care strategies that have been published so far suggests that around 27 out of 42 have specifically mentioned homeless and inclusion health[7].

Recent initiatives to support better healthcare provision for people experiencing homelessness include the Out of Hospital Care Fund and Core20PLUS5. The Out of Hospital Care Fund distributed £16 million for pilot projects to support people experiencing homelessness after being discharged from hospital, with schemes specifically designed to reduce pressure on the NHS and help people who are homeless to find accommodation. Pilots were funded in 17 areas[8]. The fund was not extended and recently came to an end, though some services may be continuing through funding at a local level.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level[9]. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The 'Core20' relates to the communities who make up the 20 per cent most deprived areas of the general population, while the 'PLUS' references other groups that experience the most significant health inequalities, such as homeless and inclusion health groups.

There are five clinical areas of focus which require accelerated improvement among the 'CORE20PLUS' population. These are: maternity care, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding. Many of these clinical areas intersect with homelessness, as people who are homeless are much more likely to be affected by mental illness, respiratory disease, and cancer. This approach is intended as a framework for Integrated Care Systems to tackle health inequalities.

The most significant development has been the publication of the first NICE guidelines on 'Integrated health and social care for people experiencing homelessness' in March 2022[10].

The guideline includes recommendations on ways to improve access to—and engagement with—health and social care services for people experiencing homelessness. It also gives advice on how commissioners, planners, providers and practitioners across disciplines and agencies can work together to support and improve outcomes for people experiencing homelessness.

Headline recommendations include:

- Commissioners of health, social care and housing services should work together to plan and fund integrated multidisciplinary health and social care services for people experiencing homelessness.
- Homelessness multidisciplinary teams should act as expert teams, providing and coordinating care across outreach, primary, secondary and emergency care, social care and housing services.
- Services should be designed and delivered in a way that reduces barriers to access and engagement with health and social care, for example, by providing outreach services, low-threshold services, flexible opening and appointment times, and trauma-informed care.
- Commissioners and providers should provide intermediate care services with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care.
- Commissioners and providers should recognise the need for a range of accommodation types that are suitable for the varied needs of people experiencing homelessness, such as self-contained accommodation and accommodation with specialist onsite support for people who are particularly at risk, or who might otherwise benefit from higher levels of support.

If fully implemented, the NICE guidelines would significantly reshape provision for people experiencing homelessness and ensure systemic improvements to commissioning and provision were made. However, it is widely acknowledged there is currently a significant implementation gap between what the NICE guidelines recommend and provision across many areas of the country.

What is the Duty to Refer (DtR)?

> The DtR came into law in the Homelessness Reduction Act 2017, which significantly reformed England's homelessness legislation by placing duties on local authorities to shift towards a more preventative approach to homelessness, helping to identify and respond to someone's homelessness at an earlier stage.[11]

Research shows that the act has opened up support and assistance for significantly more people facing homelessness than previously.

However, reviews of the Act have idenfitied changes to the legislation that would further widen access to support, therefore preventing and ending the homelessness of more people.[12]

The DtR requires various named public bodies to refer service users who they identify as either at risk of homelessness or already homeless to the relevant local authority. The aim of the duty is to 'help to ensure that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities.'[13] It was also anticipated that the duty would ensure closer collaboration and partnership working between public bodies that each bear some responsibility for responding to the holistic needs of people experiencing or at risk of homelessness.

The duty requires the specified public authorities to identify and refer a service user who is homeless or may be threatened with homelessness to a local housing authority and allows service users to choose which local housing authority they are referred to.

The specified public bodies subject to the DtR are (in England only):

- Prisons
- Young offender institutions
- Secure training centres
- Secure colleges
- Youth offending teams
- Probation services (including community rehabilitation companies)
- Jobcentres in England
- Social service authorities (both adult and children's)
- Emergency departments
- Urgent treatment centres
- Hospitals in their function of providing inpatient care
- Secretary of State for Defence in relation to members of the regular armed forces

At present, brief Government guidance outlines the approach that should be taken for the DtR, including recommending that 'local housing authorities should work with public authorities in their area to design effective referral mechanisms which meet their local circumstances'.[14] Guidance also stipulates that 'local housing authorities should make referral mechanisms as simple as possible, based on the minimum information required by law for a public authority to make a legitimate referral – this is the contact details and agreed reason for referral'.[15] Importantly, the guidance also recommends that good practice involves local housing authorities going beyond referral procedures and working closely with other public authorities to prepare a comprehensive assessment of need for the service user.

Specific Department of Health and Social Care guidance which provides an overview of the DtR for healthcare staff was also published in 2018.[16] The guidance describes factors that might indicate that an individual may be threatened with homelessness and should be enquired about, who has priority need for accommodation, the process for referrals, what referrals should include, and an example checklist of what information could be gathered as part of the referral, developed by the Faculty for Homeless and Inclusion Health.

Data collection and oversight of the DtR is at present relatively limited. The Homelessness Case Level Information Collection (H-CLIC) is the quarterly data return on local authorities' action under statutory homelessness legislation.[17] All cases where a homelessness assessment application is taken and any legal duty accepted should be reported to the Department for Levelling Up, Housing & Communities. H-CLIC is designed to collect data on, for example, demographic information such as nationality and ethnic group; the circumstances leading to and following on from a household's homelessness application being made; the actions taken by the local authority on each case; and the number of referrals they receive under the DtR. However, more detailed information such as whether a prevention or relief duty was owed in each case, the type of accommodation offered, and the length of time before the placement commenced, are not currently available at the time of writing.

Policy Context – How is the DtR currently working?

> Several organisations have sought to understand how successfully the Homelessness Reduction Act, including the DtR, has been implemented in practice.

Firstly, the Independent Review of the Homelessness Reduction Act, conducted by ICF Consulting Services Limited in association with Kantar Public and Heriot-Watt University, found that local authorities' overall perceptions of how effectively they have responded to the Act were positive. 50 per cent of local authorities in the survey said they had responded very effectively, 48 per cent fairly effectively, and 2 per cent neither effectively nor ineffectively.[18] However, 50 per cent of local authorities cited insufficient access to affordable housing as a significant challenge. 43 per cent of local authorities also cited the administrative burden associated with implementation of the Act, with concern related to additional resource constraints placed on frontline staff and potential time taken away from practical casework with service users.

With regard to the DtR specifically, the report found that local authorities had undertaken a range of activities to ensure effective implementation, including the provision of information, guidance, meetings, briefings and light-touch training for public authorities about the new duty, and the creation of new referral processes for public authorities to use. Some local authorities also reported introducing colocation and secondment arrangements with public authorities, which was an effective means of facilitating referrals under the new duty. Jobcentres and probation services were perceived to have responded effectively to the DtR by over two-thirds of local authorities in the survey – more than any of the other public authorities the duty applies to, with perceptions of effectiveness and referral numbers lowest for adult social services, children's social services, and health providers.

Pathway & Crisis Policy Report 2023 Beyond the Ward

Data on the number of referrals from health services is complex and it is difficult to discern a clear picture of the effectiveness of the DtR from the data alone. H-CLIC data tells us that in the year from April 2021 to March 2022, 53 per cent of homelessness assessments came via a DtR referral; 17 per cent of these referrals came from health organisations (11.7 per cent from acute hospitals and inpatient settings, and 5.3 per cent from mental health hospitals). In this year, healthcare settings provided the second largest number of DtR referrals, behind probation services (32.9 per cent).[19] However, it is unclear whether 17% should be considered proportionate or not to the number of people experiencing homelessness that come into contact with the health service. Only 6% of all referrals to local authorities (not just DtR) came from hospital settings (A&E, Urgent Treatment, or inpatient care).

In the independent review, the most effective examples of the DtR working in practice were characterised by a belief amongst public authority staff that making a referral could benefit both the referring organisation and the service user. Positive perceptions were reinforced by real examples of clients who had been referred and helped by the local authority, which requires feedback after referrals are made.

A perceived lack of time and staff resource were cited as the main reason why certain public authorities in certain areas, including health bodies, were not making referrals under the DtR, and the duty does not require public authorities to engage further with Housing Options teams after making a referral. This was an element of the duty that several local authority staff and some public authority staff said they would like to see changed. Joint casework and other forms of collaboration were perceived to be the ideal means of securing positive outcomes for service users who were referred - especially those with more complex and multiple needs.

The report recommended the following to ensure improvement of the duty:

- Further promotion of the DtR at national level by Government.
- Introduction of national guidelines and monitoring arrangements around the DtR to promote more consistent and effective engagement amongst public authorities in all local areas.
- A future review of the scope of the DtR in terms of which public authorities it applies to and possible reformulation as a 'Duty to Collaborate'.
- Local authorities providing feedback to public authorities on referrals as a means of ensuring effective future referrals under the DtR.

Local authorities were keen to see legislation that includes other public authorities currently not subject to the DtR, including GPs.[20] The Government responded to the report by stating that they will work with the Department of Health and Social Care to continue to encourage this and promote the sharing of best practice locally, and that any formal inclusion of GPs within the DtR would be subject to discussion and agreement with the British Medical Association as part of future GP contract negotiations.[21]

Crisis conducted its own research into the Homelessness Reduction Act, published in 2022.[22] The three-year research study looked across six local authority areas in England. It included a total of 1,477 participants with lived experience of homelessness, recruited through direct referrals from the local authorities and homelessness organisations supporting people in these localities.

Respondents reported very strongly that partnership working had improved in the first two years of the HRAs implementation. Crisis also found that as the study went on, the DtR led to more people approaching local authorities for help following advice from another organisation (59 per cent in wave 3 compared to 39 per cent in wave 1). Both staff and people using Housing Options described the positive impact that the involvement of other services had, on ensuring people were guided to relevant support, and on speeding up the receipt of support. The report concluded that the DtR is successfully connecting more people to Housing Options when they engage with other services.

The research also found that those discharged from institutions tended to have either typical or better experiences of the Homelessness Reduction Act than others. They felt more positively about assessments and after using Housing Options they were 8 per cent less likely to feel their accommodation was neither suitable nor secure and 7 per cent more likely to say their needs were met by Housing Options support. This suggests that the pathways to homelessness support taken by those discharged from institutions – likely to be different from others as a result of the involvement of a hospital, probation, or other service – may be more effective than the more typical routes used by others. Although, a larger-scale piece of research with this cohort may be needed to verify this.

However, staff highlighted that the duty can be difficult to administer and that the level of information provided by the referring services can be poor; Housing Options teams are sometimes being sent very limited information about individuals referred to them, meaning they have to work harder to build up a picture of their needs. For many staff there needed to be a much stronger relationship with the NHS, community mental health teams, the probation service, and others. Staff felt that more could be done to give other organisations a stronger role in preventing homelessness.

Some local authorities would welcome 'a more muscular 'duty to cooperate'' in place of the DtR. While the DtR is seen to have improved practice and partnership working, it is also seen to perpetuate the view that local authority Housing Options fundamentally 'carry the can' in responding to homelessness.

A 'duty to collaborate' has been proposed by local authorities and key stakeholders as one way to ensure that integration between housing and other public services that work with people experiencing homelessness is more effective. However, what such a duty would look like in practice has not been fully detailed. Learnings from the work of the Prevention Review Group in Scotland may be helpful, where recommendations have gone to Scottish Government to include health bodies with 'ask and act' duties on homelessness, including an approach whereby the local authority and relevant health bodies work together in a case management approach for people whose homelessness is compounded by health needs.[23]

Other Existing Evidence on Hospital Discharge and Homelessness

> Findings from other studies into the implementation of the Homelessness Reduction Act show a mixed picture of the DtR in practice.

There is some evidence to suggest that overall, the DtR is having a positive impact, with 59 per cent of respondents in Homeless Link's Homeless Health Needs Audit being advised to approach Housing Options from another service in 2018 - 2021, up from 39 per cent in 2012-2014.[24] Both staff and people using Housing Options described the positive impact that this involvement of other services had, on both ensuring people were guided to relevant support, and on speeding up the receipt of support.

These findings are particularly important to note in light of the audit finding that a total of 38 per cent of respondents had been admitted to hospital in the 12 months before participating in a Homeless Health Needs Audit and 11 per cent of respondents had used A&E services more than three times in the last 12 months. Of those discharged from hospital, almost a quarter of respondents (24 per cent) were discharged onto the street and a further 21 per cent of respondents were discharged into accommodation which was not suitable for their needs.

And in their evaluation of the impact of the Act, Shelter reported that one of the biggest areas of difficulty in the implementation of the DtR is referrals from the NHS, stating that in many hospitals, staff are completely unaware of the Act and have no performance objectives to make referrals.[25] This can lead to huge costs to the NHS in the form of repeat A&E admissions and 'bed-blocking'. They therefore recommend that the NHS should be required to provide training on the Act for staff, including receptionists, and that the DtR is included within their staff objectives and data collection.

References

[1] ONS. (2022). Deaths of homeless people in England and Wales:2021 registrations. *https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2021registrations*

[2] Story, A. (2013) Slopes and cliffs: comparative morbidity of housed and homeless people. The Lancet. Nov 29. Volume 382. Special issue. S1-S105.

[3] Homeless Link. (2022). The Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit.

[4] Department of Health (2010). Inclusion health: improving primary care for socially excluded people.

[5] Lewer D. et al (2021) Hospital readmission among people experiencing homelessness in England: a cohort study of 2772 matched homeless and housed inpatients. J Epidemiol Community Health. 5;75(7):681–8. doi: 10.1136/jech-2020-215204.

[6] Department of Health and Social Care. (2022). Guidance on the preparation of integrated care strategies. Available at: *https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies*

[7] Analysis conducted by Crisis and Pathway.

[8] *https://www.gov.uk/government/news/fund-to-help-end-cycle-of-homelessness-and-hospital-readmissions*

[9] *https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/*

[10] NICE (National Institute for Health and Care Excellence). (2022). Integrated health and social care for people experiencing homelessness. *https://www.nice.org.uk/guidance/ng214*

[11] *https://www.legislation.gov.uk/ukpga/2017/13/contents/enacted*

[12] 'I hoped there'd be more options' Experiences of the Homelessness Reduction Act 2018-2021 (2022) Sutton-Hamilton, C., Allard, M., Stroud, R and Albanese, F.

[13] Department of Levelling Up, Housing & Communities (formerly Ministry of Housing, Communities & Local Government). (2018). Guidance: A guide to the duty to refer. *https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer*

[14] Ibid

[15] Ibid

[16] Department of Health and Social Care. (2018). Guidance: Homelessness: duty to refer – for NHS staff. *https://www.gov.uk/government/publications/homelessness-duty-to-refer-for-nhs-staff*

[17] *https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness*

[18] ICF Consulting Services Limited. (2020). Evaluation of the Implementation of the Homelessness Reduction Act: Final Report. Ministry of Housing, Communities and Local Government. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/919748/Evaluation_of_the_Implementation_of_the_Homelessness_Reduction_Act_Final_Report.pdf*

[19] Department for Levelling Up, Housing & Communities (2022) Statutory homelessness: Detailed local authority-level table. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1105929/Detailed_LA_2021-22.ods*

[20] Ibid

[21] Ministry of Housing, Communities & Local Government. (September 2020). Homelessness Reduction Act 2017: government response to the call for evidence. *https://www.gov.uk/government/consultations/homelessness-reduction-act-2017-call-for-evidence/outcome/homelessness-reduction-act-2017-government-response-to-the-call-for-evidence*

[22] C., Allard, M., Stroud, R., and Albanese, F. (2022) "I hoped there'd be more options:." Experiences of the Homelessness Reduction Act, 2018-2021. London: Crisis.

[23] Crisis. (2021). Preventing Homelessness in Scotland. Recommendations for legal duties to prevent homelessness: A report from the Prevention Review Group. *https://www.crisis.org.uk/media/244558/preventing-homelessness-in-scotland.pdf*

[24] Homeless Link. (2022). Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit. *https://homeless.org.uk/knowledge-hub/unhealthy-state-of-homelessness-2022-findings-from-the-homeless-health-needs-audit/*

[25] Shelter. (2020). Caught in the Act: A review of the new homelessness legislation. *https://assets.ctfassets.net/6sxvmndnpn0s/6frbAC5wMSHSxuC-2JNXgfv/ee7beffb50529ea5e7eb0347bc-1c029a/Caught_in_the_Act_-_A_review_of_the_new_homelessness_legislation.pdf*

2 Methodology

> Whilst evidence has so far concentrated on local authority perceptions of and responses to the DtR, very little, if any, analysis has been conducted into the experiences of healthcare professionals in working with the duty.

The aim of this work was to better understand how the DtR is working in hospital departments, identify opportunities and barriers to successful patient outcomes, and assess the extent to which the legislation is working to prevent homelessness. We want these insights to drive action by central government, local partners, and healthcare leaders in addressing barriers and improving the implementation of the duty.

The findings in this report are drawn from aggregating data gathered from a survey of healthcare professionals, opinions, and impressions of those working within the system gathered via workshop discussions held with local authority housing and hospital staff, and analysis of existing H-CLIC data.

Survey

We designed an online survey for healthcare professionals to assess the understanding, implementation, and outcomes of the DtR in hospital settings. It asked staff to rate their understanding of the duty, including whether they had ever received training or education regarding the DtR, and to assess the quality of this training. Further questions addressed the referral process itself, examining the frequency at which staff conducted referrals, and the level of communication held between respondents and the relevant local authority regarding referral progress and outcomes. Staff were also asked what they perceived to be the positive benefits of the DtR as well as the factors that would improve their ability to implement the duty and secure positive housing outcomes for their patients. The survey was distributed through existing networks such as the Pathway Partnership Programme, The Faculty for Homeless and Inclusion Health, The Royal College of Physicians and the FutureNHS Collaboration Platform, to ensure that responses represented staff with all levels of awareness of, and interaction with, the DtR and corresponding homelessness legislation. A total of 84 responses were collected, of which 51 (61 per cent) represented people working in specialist homelessness or inclusion health fields.

Workshop Discussions

The North Central London (NCL) and North East London (NEL) DtR Forums were convened by Transformation Partners in Health and Care to provide an informal space where key local health and housing partners could come together to review current DtR practices and discuss ways to address some of the challenges across the system through partnership working and share learning.

Frontline hospital and local authority housing colleagues involved in submitting and processing DtR referrals in the relevant subregions attended. Membership lists were collated through named discharge leads at local hospitals and introductions at meetings attended by local authority leads.

Since September (NCL) and October (NEL) last year, the groups have met on a bi-monthly or quarterly basis respectively, with colleagues volunteering to chair sessions. The North East London DtR forum has since merged with their local Community of Practice groups to facilitate a broader opportunity for partnership working.

Pathway and Crisis facilitated a discussion at two of these forums, and attended subsequent meetings, to allow local health and housing partners to feedback on their experiences of the DtR, share best practice and discuss key challenges identified. This approach was then replicated in areas across England where Pathway and Crisis hold common stakeholders: Hull, Leeds, Manchester, and Sussex. Participants were selected to represent a range of specialist homelessness and inclusion health practitioners, healthcare staff with less direct experience of hospital discharge processes, and representatives of local authority housing departments. Focus groups were also carried out with people who have lived experience of homelessness and difficulty in accessing appropriate healthcare, including Pathway's Experts by Experience and Groundswell's Homeless Health Care Navigators Programmes. In total, we spoke to 111 people who shared their experiences of working with the duty or receiving homelessness assistance.

Focus group discussions were guided by the following questions:

> What does the DtR process look like in the local authority area? How is this working? What are the enablers and barriers to success?

> How has the DtR enabled partnership working between housing and health colleagues?

> How does the DtR fit into the wider homelessness system? Is it successful as a preventative approach to homelessness?

> What would you like to see in an ideal world that would allow health to play a greater role in preventing homelessness?

3 Findings

Overall, our research shows a mixed picture in terms of the DtR's effectiveness in hospital settings. Many participants highly valued the legal mechanism which means that people can now get support at an earlier stage, and many felt it had improved partnership working between health and housing.

However, our findings also highlight significant barriers and structural issues that are preventing the duty from being carried out as effectively as it might otherwise be. There is an implementation gap between these aims and the outcomes of the duty in hospital settings. And while we have also seen pockets of good practice, these tend to be in areas that have pre-existing collaborative relationships between services, such as those with a Pathway team or housing staff embedded into hospital settings. Best practice is vitally needed in all areas.

This section summarises the main findings from the workshops, survey of healthcare professionals, and our analysis of the H-CLIC data. Throughout this chapter, we refer to 'participants', those representing the voices of the NHS and healthcare professionals, local authority staff, and people with lived experience who responded to our survey or spoke to us in workshop discussions.

Pathway & Crisis Policy Report 2023 Beyond the Ward

Our findings can be summarised as follows:

Finding 1: The DtR's effectiveness is undermined by wider system pressures in both the NHS and local authorities.

Finding 2: Implementation of the DtR is severely affected by a lack of integration between housing and health, though there are examples of good practice.

Finding 3: The DtR is more often being used as a crisis response mechanism, rather than a tool through which to prevent homelessness before it has happened.

Finding 4: A lack of standardisation of the referral process has resulted in variation in procedure and patient outcomes between geographical areas.

Finding 5: The DtR has not been designed in a way that meets the needs of marginalised communities, such as people with no recourse to public funds.

Finding 6: There is a lack of effective governance, oversight, and accountability at both local and national level of the DtR, which allows lack of adherence to the DtR to continue unchecked.

Finding 1

The effectiveness of the DtR is undermined by wider systemic pressures

One of the main themes that emerged from the workshops and survey was how challenging it is to both implement the DtR and to secure good outcomes from it when both the health and housing systems are under such significant strains.

1. An NHS under pressure

It is axiomatic that the health and care system is under immense pressure. A combination of a lack of investment, a severe workforce shortage of both doctors and nurses, combined with immediate crises related to Covid-19 and flu, the legacy impact of the pandemic, and a social care system challenged by reduced funding and poor-quality provision, has left the NHS in a state of emergency.[26]

While the issues with regard to emergency care, the elective treatment backlog, and ambulance waiting times have received most media attention, workshop participants commented that all parts of the system are under huge strain. This includes those that are most likely to support people who are homeless or at risk of homelessness, such as hospitals, general practice, mental healthcare, and social care. Participants noted that securing support in hospital from these wider services, such as mental health, has become more difficult, impacting on the ability for truly multi-disciplinary responses to people's needs.

A snapshot of the pressures within the NHS:[26]

- The NHS backlog is significant. Around 7.42 million people are currently waiting for treatment.
- In comparison to other nations, England has a very low proportion of doctors relative to the population. The average number of doctors per 1,000 people in OECD EU nations is 3.7, but England has just 2.9. Germany, by comparison, has 4.3.
- Compared to other nations, the UK has a very low total number of hospital beds relative to its population. The average number of beds per 1,000 people in OECD EU nations is 5, but the UK has just 2.4. Germany, by contrast, has 7.8.
- The number of patients waiting over 12 hours for an emergency admission in May 2023 is 1.65 times higher than the one seen in May 2022, and 76 times as high as it was in May 2019.
- Whilst the GP workforce is declining, the number of patients continues to rise. In May 2023, another record-high of 62.5 million patients were registered in England.

Pathway & Crisis Policy Report 2023 Beyond the Ward

The impact of system pressures on staff in both the NHS and local authorities were clear in both the workshops and the survey. Survey respondents reported that staff burnout, sickness, and shortages were major issues. Workshop participants and survey respondents commented that staff's ability to conduct DtR referrals and advocate on behalf of patients is made more difficult by high staff turnover (making it difficult to learn local DtR processes) and the high level of burnout.

This context makes it less likely that healthcare professionals can or will devote the time needed to address the needs of patients experiencing homelessness, with stigmatising and discriminatory responses more likely. Participants representing Pathway teams, for example, mentioned that they are under increasing pressure to discharge patients who are seen as 'bed blocking', given the significant pressures in acute care, even when patients do not have safe discharge plans in place. Participants stated that people are still being discharged to the streets or incredibly poor provision of sub-standard temporary accommodation.

1.1 A missed opportunity for healthcare

This is a missed opportunity for healthcare. People who are discharged inappropriately or are forced to recover from intensive treatment in inappropriate accommodation are more likely to develop complications and end up back in hospital, with longer patient stays and increases in bed days. This is bad for the individual and the system and means that more costly healthcare interventions are required.

These system pressures in turn make healthcare staff less likely to see homelessness as their responsibility. One stakeholder mentioned how they had experienced an entire A&E department deciding that they didn't have time to conduct referrals at all and refusing to do so, despite A&E departments being bound by the DtR in legislation:

"One A&E department I worked with thought they shouldn't have to do DtR at all, as the patient is just in attendance, rather than having been an admitted to a ward"

Healthcare professional

Many participants felt that for mainstream healthcare professionals, due to time constraints and need to focus on health issues, the DtR was sometimes just an afterthought:

> *"Often hospital staff are doing so many jobs, often staff are filling the gap in social care. We wouldn't ask housing staff to do nursing. Yet hospital staff must do all sorts such as social care to fill the gaps"*
>
> **Healthcare professional**

> *"It's just not seen as a priority, as well as the pressure staff are under, lack of time, high staff turnover etc."*
>
> **Healthcare professional**

More positively, participants noted that specialist inclusion health teams, such as Pathway Partnership teams, are more able to provide the time and attention required by patients experiencing homelessness, because they are specifically designed to meet the needs of this group. The downside of this is that it can mean that mainstream healthcare professionals see inclusion health teams as having complete responsibility for the DtR and do not engage with knowledge and good practice around the legislation. It was, however, encouraging to hear from participants that, despite these significant pressures, some hospitals had nevertheless implemented policies committed to avoiding discharge to the street.

2. England's Housing Crisis

Similarly, workshop attendees from both the NHS and local authorities consistently commented that the biggest barrier to the duty achieving its full potential is the severe housing crisis. Even though the DtR is meant to pivot the system more towards homelessness prevention, some local authority representatives were keen to stress that prevention is almost a non-starter if there is not genuinely affordable, settled housing.

Healthcare staff felt that the poor housing outcomes they saw and the continued practice of discharging to the street are fuelled by wider systemic housing pressures. In particular, workshop participants mentioned the increase in both the use of the private rented sector and rents within this sector, the lack of affordable social housing, and that the gap between housing benefit and the true cost of renting in the private rental sector is huge, meaning it is increasingly hard to find people accommodation.

Around 1.9 million private renters in England receive benefit to help pay their rent, more than one in three private renters.[27] However, new data from Crisis and Zoopla shows that just 4 per cent of 1–3-bedroom properties listed in the last year were affordable to people who need housing benefit to help pay their rent, 66 per cent lower than the 12 per cent seen last April.[28] This pressure in the private rented sector is made worse by the chronic shortage of social housing in England. For decades, successive governments have failed to address a mounting crisis in the supply of social housing.[29] Research commissioned by Crisis and the National Housing Federation shows that an additional 90,000 social rented homes per year for the next 15 years are needed to significantly reduce homelessness and address the wider backlog of housing need.[30] Over 1 million households are waiting for social homes.[31]

2.1 The need for appropriate accommodation

Many of the housing representatives we spoke to reported receiving referrals for patients with increasingly complex health and social care needs, such as premature frailty, acquired brain injuries, complex trauma and multimorbidity. Health and housing colleagues alike agreed that current housing options are unable to cater for this diverse level of need, with the hardest people to place being those with the greatest need:

> *"It's really difficult to get accommodation for young frail adults, for example those that are wheelchair and disability accessible. The people we work with [people experiencing homelessness] are really high risk so it's a really hard sell sometimes. There are lots of people who are a lot more 'palatable' that also need to be housed – we then end up with people in step-down [accommodation] for months/ years rather than 6 weeks because there's nowhere else for them to go"*
> **Healthcare professional**

> *"We need greater investment in adapted accommodation – we're seeing more young people with limb loss and there is a lack of accommodation options available; lots of wheelchair accessible, adapted accommodation is only for over 55s"*
> **Workshop participant**

The condition of temporary and emergency accommodation was of particular concern to workshop participants. A recent call for evidence from the All-Party Parliamentary Group for Households in Temporary Accommodation provides damning insight into the poor maintenance of such accommodation offers: mould and/or damp, buildings being in a state of dangerous disrepair, infestations ranging from mice, cockroaches to slugs and snails, leaks, and fire safety issues were commonly described by respondents to the inquiry. No or limited cooking facilities, a lack of working/appropriate household goods, no/limited plumbing, no/limited electricity and/or heating were also reported by respondents.[32] Short-term accommodation offers (often just a few nights) that are subject to these conditions are not conducive to achieving positive health outcomes for patients discharged from hospital, yet are commonly offered as housing outcomes for referrals made under the duty:

> *"Emergency and temporary accommodation can't accept patients because of the high level of risk around self-neglect, substance use and high level of health needs and disability - 50 per cent of people in our step-down units are eligible for care and support needs. The average age of Women is 37 and 39 for men – all of which have a level of frailty. One patient was placed in temporary accommodation, to be sent back to us [specialist inclusion health team] after 14 hours as they couldn't keep him – this was not the fault of the hostel as they are not trained to deal with that level of self-neglect"*
> **Healthcare professional**

> *"People are waiting long periods of time for suitable accommodation, and then ending up in emergency accommodation (i.e., a Travelodge) and it isn't very suitable"*
> **Workshop participant**

Qualitative responses to our survey confirmed the findings from our workshops on the significant housing pressures. Healthcare professionals noted systemic factors that were impinging on the success of the duty, including a general lack of affordable and appropriate housing.

2.2 What are the solutions?

These findings are consistent with previous research into the health, housing, and social care needs of people experiencing homelessness. In an audit conducted across hospitals in London last year, two-thirds of patients who were currently experiencing homelessness had three or more different clinical issues and one third had tri-morbidity (mental and physical ill health as well as substance misuse).[33] Most of those audited (92 per cent) were unable to return to their pre-admission living environments as they were not appropriate for their needs, safe, or secure . Due to a lack of safe and appropriate intermediate care or step-down options, almost half (44.2 per cent) of people remained in hospital longer than needed.[34]

In every workshop conducted, attendees expressed the view that that many patients experiencing homelessness require a period of rehabilitation, support, or specialist accommodation such as intermediate care, after a period of hospitalisation and that one change that would significantly improve their ability to prevent homelessness would be the much wider provision of intermediate care/step-down accommodation.

Intermediate care and step-down accomodation are often used interchangeably and describe a type of supported living for people that are medically ready to be discharged from hospital, but cannot immediately return home. In the case of people experiencing homelessness, this is often because a more permanent housing solution has not yet been secured for them, and they require support and care to help them recover. Accomodation of this kind often ensures someone has access to their own kitchen and bathroom, with care and support in place tailored to each persom, often with 24-hour triage and response in close radius.

There is strong evidence to suggest that intermediate care tailored to meet the needs of those experiencing homelessness improves patient experience and outcomes by delivering safer transfers of care, reducing delayed discharges, and increasing access to planned health care. Improved convalescence and rehabilitation also promote more efficient use of available health resources by reducing subsequent admissions to acute care,[35] and thus costs to the NHS. Evidence demonstrates that for people who are medically ready to leave hospital, but require further support to recover, particularly for people for whom no permanent housing solution has been found, step-down accommodation can improve health and housing outcomes. It allows both health and housing partners more time to secure a more permanent housing or care solution.[38]

Participants commented that ultimately it is a sign of the failure of the system that currently some people experiencing homelessness are having to recover from a hospital stay on the street or in unsuitable temporary accommodation, which only decreases the likelihood of someone making a full recovery.

NICE guidance recommends that commissioners and providers should provide intermediate care services “with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care”.[39] [40] NICE also state that intermediate care “would represent a change in practice because this service is currently rare for people experiencing homelessness” and “would need some funding”, though “there is evidence that intermediate care represents value for money”. They conclude that “considering the immense human and societal costs of homelessness, providing care that can support recovery and prevent repeat homelessness is likely to be beneficial to society overall”.

There was also specific praise for Housing First models amongst attendees. Housing First is a homelessness intervention strategy aimed at those experiencing multiple disadvantage.[41] It provides access to permanent housing as starting point to help address other support needs – such as alcohol and drug dependency, ill mental and/or physical health – through coordinated and intensive support. The model is backed by a wide body of evidence internationally and in the UK showing that typically in the region of 80% of Housing First tenants sustain their tenancies.[42] Crisis and Homeless Link research has also identified the scale of need for Housing First, standing at 16,450 places in England (with current provision at around 1,995).[43]

Workshop attendees mentioned how they had seen positive outcomes from Housing First models, while others noted that other forms of supported housing are also incredibly valuable, but lack of social and affordable housing is a major constraint to the availability of both. Ultimately, attendees agreed that more affordable housing is vitally needed to ensure patients have a safe place to be discharged to.

Overall, it seems that unless and until the systemic issues such as the lack of affordable housing and capacity within our health and care system are rectified, the DtR will never realise its full potential. Pathway and Crisis believe that to end homelessness for good, we need to transition to a housing-led system (including significant upscaling of Housing First), and increase funding for housing-related health and care support (such as intermediate care), which is underpinned by a greater focus on tackling health inequalities in the NHS. The DtR has a key role to play, but a referral mechanism is only as good as the systems into which someone is referred.

It is important to note that there were certain groups for whom participants felt it is much harder to secure good outcomes, particularly people with no recourse to public funds (NRPF), because the ability of the local authority to support them is severely limited. This is explored further in subsequent sections of this report.

Finding 2

Implementation of the DtR is impacted by a lack of integration between health and housing services

2.1. A lack of integration between health and housing

The relationship between health and housing services amidst this challenging environment was also a key theme in the workshops and survey.

Workshop participants and survey respondents detailed how a lack of integration between housing and health services, alongside other services such as social care, was holding back effective implementation of DtR processes. This is despite the move towards integration in national policymaking and through Integrated Care Systems at local level. Often poor provision for people experiencing or at risk of homelessness offers a stark example of a lack of integration. Given the often multiple and complex needs of people facing homelessness, coordinated support is required from multiple agencies and parts of the system.

Most workshop participants stated that the DtR had ensured a clearer referral mechanism is in place, which in turn has led to closer partnership working between health bodies and local authorities. However, many participants commented that these improvements in partnership working were limited. It was telling that in areas where staff reported a lack of communication and collaboration between services (i.e., hospitals not good at communicating externally to the local authority, the local authority being unresponsive to the health partner, varying cultures making it difficult for both to navigate complex systems) the DtR felt much harder to implement effectively. In areas that reported strong partnership working, greater communication and shared understanding, or integrated services (such as a housing officer embedded in the hospital), the DtR was generally discussed more positively. If the DtR is more fruitful in areas where integration between services is robust, the implementation of the duty therefore acts as an indicator for the overall health of the system at large. Areas in which the DtR has been implemented with relative degrees of success are likely to have truly joined up health and care services which are improving the lives of people in their area and vice versa.

Many participants commented that housing and health services work very differently and are siloed systems because they both work towards different incentives (i.e., hospitals discharging people quickly, housing services having to establish local connection and priority need). The working cultures also vary whereby hospitals do not communicate with external agencies as often, with local authorities more in touch with local support services and wider agencies, making it difficult for both services to understand each other.

Pathway & Crisis Policy Report 2023 Beyond the Ward

Some NHS colleagues also felt that other relevant homelessness legislation, such as priority need, can be used by local authorities as a way of gatekeeping access to secure and appropriate accommodation upon hospital discharge. The general consensus was that there need to be stronger relationships between health and housing to make the DtR work. But the way local authorities can apply homelessness legislation can be a major barrier:

> *"You still need priority need to get short-term accommodation. Otherwise, the DtR gets knocked back, so we are often discharging to the streets. The threshold for priority need is so high"*
> **Healthcare professional**

Healthcare professionals often felt defeatist because they saw the gatekeeping from local authorities as symptomatic of the wider systemic issues around a lack of affordable housing:

> *"DtR doesn't work anyways. People go to the local authority and the authority doesn't actually have anything for them. It's not doing what it was designed to"*
> **Healthcare professional**

And the desire to secure a permanent solution for the patients they work with means that healthcare professionals are often having to navigate difficult and bureaucratic situations, including filling out the DtR form and supplying local authorities with subsequent information that they ask for in such a way that makes the situation clear to local authority Housing Options departments, while recognising the different specialities of each service:

> *"It can feel difficult to fill it in [DtR referral form] from a health perspective. You want to prove the priority need so you put health issues in there – but you also want it to be understood by the housing officer – this is a tricky balance. If you don't get it right, they can just close it down"*
> **Healthcare professional**

2.2 Good practice highlights the benefits of integration in many areas

This said, good practice certainly exists. One area we spoke to found that while it had taken a lot of work, recent practice had improved, with more wards in their local hospital referring people to the local authority at an earlier stage. The main contributory factor to this improvement was seen as having a Housing Options officer embedded within the hospital, which ensures consistency of approach and means healthcare staff have someone to go to directly with any queries. This best practice example highlights the importance of true integration of health and housing services, and the difference that practical implementation of integration can make:

> *"It has taken a lot of work but we are seeing improvements [in implementation] and people are being referred earlier from the wards now. Having a consistent person that the wards can contact (an embedded Housing Options officer) makes a difference and helps with that"*
>
> **Healthcare professional**

> *"Co-location of Housing Options officers works really well, people in the hospital know how to contact [local authority housing staff] and it makes things go more smoothly. Partnership working is key - weekly multidisciplinary team meetings, and lots of communication in between"*
>
> **Workshop participant**

A recurring theme throughout the workshops was the invaluable role that specialist inclusion health services play in homelessness prevention. Inclusion health teams can work with patients to create bespoke care plans for their support, and often operate in multi-disciplinary ways, with a mix of professionals, such as specialist GPs, nurses, allied health professionals, housing experts and care navigators. They can develop stronger relationships with Housing Options teams, given they are specifically designed to support patients experiencing homelessness, and are often better equipped to advocate on behalf of patients to secure a housing outcome.

Example of Best Practice:

Sussex Partnership NHS Foundation Trust

Provider of mental health, learning disability and neurodevelopmental services for people living in South East England

Across Sussex adult mental health inpatient services in 2022/23, the equivalent of more than 40,000 occupied hospital bed days were estimated as a result of delayed discharges. Of these, the equivalent of over 10,000 (25 per cent) days of occupied hospital beds were due to housing-related delays, with delays of this kind equating to a proxy risk adjusted bed cost of £5 million per year.

In response, in December 2022 Sussex Partnership NHS Foundation Trust (SPFT) collocated Housing Specialists within their West Sussex and Brighton & Hove (adult mental health teams. Housing Specialists are attached to host Local Housing Authorities under a partnership arrangement receiving professional supervision, specialist training, and support. A total of 7 Housing Specialists have since been recruited, as well as a Housing Manager, to support mental health team staff to identify housing needs, respond to enquiries, assess applications and provide advice/guidance to people with a range of accommodation needs. A key aspect of these roles is to support the Trust to exercise its duty to refer as a public body as defined under the Homelessness Reduction Act. The exemplar case study below outlines a typical patient journey for someone at risk of homelessness from admission, illustrating the role of Housing Specialists:

Measuring impact:

Not only does the colocation of Housing Specialists within hospital wards equip staff with the opportunity to provide better care and outcomes for patients at risk of/ experiencing homelessness, but it also provides a more efficient use of available health resources; Sussex Partnership NHS Foundation Trust estimate that the introduction of the new collocated housing workforce is reducing housing delays in the area to an in year target of less than 10 per cent of all delays. From a £550,000 investment in the housing roles across the hospital trust, a £2.5 million return of investment is anticipated per year.

A typical patient journey **before** Housing Specialist roles were implemented into local adult mental health services by SPFT.

1. Jim is admitted informally to an acute ward following a mental health crisis. Jim is not previously known to services, has recently lost his job, and has rent arrears for the room he rents in his landlords house.

2. Jim meets his charge nurse who establishes he has housing to return to

3. Jim's 1st ward round agrees an Estimated Discharge Date(EDD) of 2 weeks

4. Jim's landlord calls & says he will be evicted if the rent arrears keep rising

5. Jim is anxious about becoming homeless & his mental health worsens

6. Jim's EDD is delayed due his worsening mental health

7. Jim is referred to a Discharge Support Worker (DSW) to help resolve his housing situation

8. DSW helps Jim make a welfare benefits claim

9. Jim's benefit claim is approved after 5 weeks but doesn't cover the whole rent & arrears are now +£1,000.

10. DSW calls the landlord and asks if the rent can be reduced

11. The landlord is frustrated Jim hasn't been helped to pay his arrears and evicts him

12. Jim is devasted and has nowhere to go

13. Jim is declared Medically Fit for Discharge (MFFD)

14. DSW makes a "Duty to Refer" to the Local Housing Authority as Jim is MFFD and homeless

15. Housing assess Jim as not in priority need for accommodation & are irritated that earlier contact was not made & homelessness could have been prevented

16. DSW seeks independent advice & requests a review – after 2 weeks decision is upheld

17. Referral to a homeless hostel

18. Hostel complete assessment. They offer Jim a room but it will take 2 weeks

19. Jim is discharged to the hostel, 6-weeks after he became MFFD

A typical patient journey **after** Housing Specialist roles were implemented into local adult mental health services by SPFT'.

1. Jim is admitted informally to an acute ward following a mental health crisis. Jim is not previously known to services, has recently lost his job, and has rent arrears for the room he rents in his landlords house.

2. A Discharge Support Worker completes a Housing Triage Form within 72 hours of admission

3. Housing needs are identified so Jim is referred to a Housing Specialist

4. Housing Specialist completes a more detailed housing assessment, contacts Jim's landlord with his consent, & supports Jim to apply for welfare benefits

5. Landlord confirms level of arrears and that Jim may be made homeless if rent continues to be unpaid

6. Housing Specialist completes a Duty to Refer to Jim's Local Housing Authority

7. Jim's 1st ward round agrees an EDD of 2 weeks

8. Local Housing Authority complete full housing assessment, speak to landlord, & develop a Personal Housing Plan (PHP)

9. Local Housing Authority use PHP to agree an arrears repayment plan and negotiate a return home using a Discretionary Housing Payment to pay some arrears

10. Housing Worker supports Jim to complete PHP actions and liaises with landlord (with Jim's consent) about the discharge plan

11. Jim is declared MRFD

12. Jim has a plan in place to return home

13. Jim is discharged home

14. Housing Specialist hands over PHP progress & actions to Jim's community team

2.3 Operational Difficulties and Integration

In the survey, 50 per cent of respondents in healthcare settings found referral processes under the DtR to be easy or very easy, implying that for those familiar with the duty and their associated responsibilities, conducting referrals is a simple and efficient intervention method.

At the same time, respondents reported that local operational difficulties impacted the efficacy of the duty: over a quarter (27 per cent) found referral processes to be difficult or very difficult . Lack of communication from the local authority following a referral was a key barrier, with only 6 per cent reporting always receiving follow up from the local authority after a referral. Where communication is received, 34 per cent felt this is rarely or never delivered within a reasonable timeframe. This undermines hospital staff engagement with the duty, and shows that there is still significant work to be done to ensure that referral processes are accessible and straightforward to navigate for all staff.

Similar difficulties emerged in focus group discussions, with staff also highlighting good practice in their areas and suggested potential solutions. There was a strong association between the good outcomes and effective implementation of the duty and strong working relationships and partnership working with healthcare and housing colleagues, as described previously. This points to the need to drive integration and partnership working to ensure that hospitals can more consistently fulfil their statutory obligations under the Act.

With both the housing and hospital systems under such pressure, it is useful to set out the operational challenges facing implementation of the duty resulting from systemic pressures. Table 1 outlines some of the local operational challenges reported by each respective sector. Table 2 outlines the solutions discussed to overcome these challenges and examples of best practice given by participants.

Table 1:

Local operational challenges

Health

- Pressure to discharge patients quickly to free up hospital bed spaces, resulting in the need to manage the risk of unsafe discharge.
- Staff require time to complete the referral form, collect additional information required by the local authority, and access relevant documents.
- There is an excess in mandatory fields on referral forms, which are beyond the minimum information required by law.
- Inconsistent interpretations of priority need thresholds make it confusing and disempowering for health staff to provide appropriate medical evidence for determining priority need.
- Staff do not always receive communication from the local authority within an appropriate time frame.
- There are inconsistent key local authority contacts for follow-up and escalations.
- Staff spend time challenging local authority decisions.

Housing

- Referrals are received at short notice i.e. on the day a patient is due to be discharged. Many authorities require up to 5 days to process a referral.
- Inadequate information provided on referral forms means that liaison with the hospital may be required to request additional information (i.e. about a disability) to select the most appropriate housing option for the patient.
- Follow up with patients after a referral is difficult if the patient has returned to the streets.
- Due diligence is required to determine if a duty is owed, which can be time-consuming.
- There is a need to manage expectations from hospital teams about the availability of appropriate offers made to patients.

Table Two:

Best practice responses to local operational challenges

Integrated Health and Housing strategies:

- Local authorities should have a dedicated DtR officer who forges relations with health staff and works with each patient from start to finish to avoid handovers.
- The DtR officer should be collocated in the local hospital (including IT systems and buildings) and is part of the discharge team to promote shared learning and collaborative working.
- An automatic response should be provided to hospital staff on receipt of a referral, which lists a named contact that will handle the patient's case.
- Senior management escalation routes for disputed cases should be identified and agreed by local authorities and health trusts.
- Training should be provided by Integrated Care Systems to support healthcare staff to identify those at risk of homelessness on admission to hospital to ensure that patients have a care plan upon discharge.
- Integrated Care Systems should support local authority workforce development to ensure an effective, empathic, trauma-informed approach.
- Space for joint reflective practice and partnership working should be provided through DtR forums and communities of practice.
- Relevant local authority contact details and referral procedures should be readily available and easily accessible for hospital staff.

Example of Best Practice:

London Hospital Discharge Housing Options Directory

The London Hospital Discharge Housing Options Directory is intended to be used by NHS discharge officers and others working in hospital discharge settings and emergency departments. It was designed to support staff to make referrals to local authority Housing Options services (Duty to Refer) in the London boroughs by sharing information about local referral pathways, key contacts for referrals and escalations, and out of hours procedures. This is likely to be needed when a patient is believed to be homeless, or at risk of homelessness on discharge, or where discharge to their current accommodation would be unsuitable or unsafe. The directory is hosted by FutureNHS, a collaborative platform available to everyone working in health and social care to safely connect and share across organisational boundaries; The information presented was collated, and is currently managed, by Transformation Partners in Health and Care.

Information available in the directory:

London Borough

NHS Integrated Care System (ICS) region:
Housing Lead/s

Name:

E-mail:

Telephone:

Alternative contact:

Name:

E-mail:

2.4 The role of social care in homelessness prevention

A number of our workshop participants commented on the important role of social care, with the apparent lack of Adult Social Care involvement in the referral process a key theme.

Participants felt that a trinity of Health, Housing, and Adult Social Care services is crucial in providing a strong multi-disciplinary approach to care for patients at risk of/experiencing homelessness and improving outcomes for those leaving hospital with complex health and support needs. Adult Social Care was referenced as the missing link, a service that needed encouragement to engage in the DtR process, with delays to hospital discharges often a result of issues with access to social care rather than housing:

> *"Often people come out of hospital with much higher care needs than prior to their admission and yet social care are so rarely around the table – we need social care involvement'."*
>
> **Lived experience perspective**

> *"In the discharge to assess process interim measures aren't available to people who are homeless because an address is needed, making access to social care very challenging for people who are homeless – emergency accommodation isn't allocated until the day of discharge so we can't provide this address until then."*
>
> **Healthcare professional**

> *"It's also very important to upskill Adult Social Care to do DtR – patients are left in the middle between services if they don't meet the criteria for specialist housing. Adult Social Care need to lead on this and there needs to be closer working between Adult Social Care and health."*
>
> **Local authority housing professional**

Case Example

A lack of joined-up services

"Kelly" is a 27-year-old woman from Eritrea, with limited English, known to have moved between sofa surfing and asylum accommodation. In June 2022, Kelly presented to an A&E department in Manchester following a mental health crisis. At A&E, the hospital completed a Duty to Refer (DtR) and a mental health assessment. Kelly received an admission under Section 2 Mental Health Act for 28 days. Because of a lack of beds in the Manchester and Salford area, she was admitted to a private bed out of the area.

While in the out of area hospital, Salford Council decided that because of her admittance under the Mental Health Act, she lacked capacity, and so triaged her to their Adult Social Care team and closed the DtR. Adult Social Care received the referral with no known address or way of contacting Kelly, meaning that they were unable to provide any support.

Because Kelly was treated in an out of area hospital, no health bodies in Manchester or Salford had access to her clinical records about her stay. She was discharged from the out of area hospital with a letter stating that she did not reach the threshold for being detained for longer than the 28 days. The hospital failed to complete a DtR and discharged her with a letter about her housing status (which she was unable to read) and told to present at Salford Housing Options.

Upon presenting at Housing Options, she was given an appointment. Staff noted her confusion, and that Kelly was struggling to answer any questions even with an interpreter. She was unsure about where she was staying. Kelly declined to sign any forms and left the appointment without any accommodation in place. She was subsequently lost to all services for an extended period.

What can we learn from Kelly's experience?

This case highlights both operational difficulties and systemic barriers impacting the efficacy of the DtR in several ways:

- Systemic pressures on the healthcare system meant that Kelly was admitted to a hospital out of area, removing her from support systems in place.
- The mental health hospital where Kelly was detained failed to complete a DtR during her stay, discharging her without any plan in place or attempt to work collaboratively with services in Manchester and Salford.
- Due to a lack of communication and information-sharing across boundaries, Adult Social Care were unable to provide Kelly appropriate support in navigating housing support.
- More positive outcomes could have been secured with support provided collaboratively between hospital staff, Adult Social Care, the local authority housing department, her GP, and the Dual Diagnosis Homeless team, to ensure a safer post-hospital discharge.

Finding 3

The Duty to Refer is not always being used as an effective homelessness prevention tool

The Homelessness Reduction Act aimed to move the homelessness system towards a preventative approach, with the DtR designed to identify and respond to homelessness before people reach crisis point. We asked workshop participants whether they felt the duty was being used in this preventative manner.

For some, the fact that the duty is a legal requirement meant they had greater ability to influence their colleagues on an individual or ward level than previously. Having a duty allowed them to convey the importance of implementing homelessness prevention activity to mainstream colleagues; inclusion health teams felt particularly grateful to have a statutory duty in place, which helps them advocate on behalf of patients and remind health and housing colleagues of their responsibilities, by giving homelessness prevention activity more legitimacy.

For others, having a statutory duty had not made a difference in ensuring that mainstream colleagues took the duty seriously; ultimately it was down to personalities and relationships within the hospital. More work is therefore required at a local level to ensure that healthcare staff are informed of the benefits of the DtR, and that the positive impacts it can have are demonstrated, to encourage compliance. Having a legal duty had also not increased the level of strategic interest from within the NHS Trust or the Integrated Care System and had not led to greater awareness of the importance of health's role in homelessness prevention for commissioners and managers. This chimed with the participants' wider view that homelessness more generally was not seen as a priority for senior leaders within local health systems, despite the significant health risks posed by homelessness.

Part of the issue is that hospitals see the DtR primarily as a tool to support hospital discharge. Perceiving the duty in this way distorts the original intention of identifying risk as early as possible (ideally as soon as someone presents in hospital), so that preparations can be made well in advance of a discharge. In many cases, people's homelessness risk is not identified until just before discharge, at which point it can often be too late to secure suitable accommodation:

> *"The local authority housing team feel well linked in on the out of hospital side but find it difficult to infiltrate hospital settings. A lot of the cases that come through are already at a crisis point - people who could've been picked up early. Their housing status isn't seen as a priority until it's a crisis – at which point, they're fast tracked to housing assistance rather than prevention"*
> **Local authority housing professional**

Participants noted that the failure to use the duty in a more preventative way means that people are still discharged to the street or to unsuitable forms of temporary accommodation, even when all efforts are made to prevent someone from returning to homelessness upon discharge from hospital, often because these efforts are too late.

Ultimately, identifying housing status earlier would require hospitals to act in line with NICE guidance, utilising multi-disciplinary approaches with holistic care integrated across health, social care, and housing systems, to identify homelessness risk early on and work together to ensure a secure housing and/or care plan for someone during and post-hospital admission. It would also require a culture change, where homelessness is recognised as everyone's responsibility, including mainstream healthcare professionals, and asking about housing status is embedded within patient care.

Pathway & Crisis Policy Report 2023 Beyond the Ward

3.1 The need for greater awareness and understanding

As to why people's homelessness risk is not being identified until just before discharge, participants expressed that this is due to low levels of understanding of the nature of homelessness, as well as the DtR itself, in mainstream healthcare settings. It was said that hospitals were not engaging with patients' housing needs early on in their admission due to a lack of training, which meant that homelessness risk is often not being identified at all. People who are already homeless were often only being identified just prior to their discharge. Consequently, most people referred under the duty were already homeless, rather than those at risk of becoming homeless within the next 56 days. Lack of awareness of the DtR amongst non-specialist staff was a key and worrying finding from our survey:

> Only 30.3 per cent of mainstream healthcare professional respondents had heard of the duty, with 15.2 per cent of respondents reporting little or no understanding. This means that 45.5 per cent of respondents overall had never heard of or had little to no understanding of the duty.

This is unsurprising, given that only 18.2 per cent of non-specialist respondents to the survey reported having received training or education on the DtR. A lack of awareness of the duty, and corresponding responsibilities, means that mainstream staff are seeing homeless patients, but not making referrals.

For non-specialist inclusion health staff who had never made a referral, 56.3 per cent saw patients experiencing homelessness at least once a week.

Not only is there a lack of awareness of the DtR, but also how to identify and support patients at risk of homelessness. Participants said that non-specialist healthcare staff often do not know how to ask about a patient's housing status, including the kind of questions that should be asked on admission. This lack of awareness was put down to wider systemic pressures preventing adequate training and education around homelessness and the DtR.

As a result of their expertise in this area, inclusion health teams were perceived to be much more familiar with the working of the duty and therefore well equipped to conduct referrals. With 51 per cent of specialist inclusion health respondents to the survey having received training or education regarding the DtR, specialist teams are better placed to work collaboratively with local authorities, advocate on behalf of patients, and challenge housing offers and decisions.

3.2 The role of wider healthcare services

Several workshop attendees noted that the public authorities to which the duty applies could be considered illogical from a prevention perspective, and that wider services such as General Practitioners (GPs) should be included in the Duty:

> *"Why are we expecting the less preventative elements of the healthcare system to lead on homelessness prevention, rather than the more preventative areas of healthcare such as primary care?"*
> **Local authority housing professional**

This was supported by the view that the longer a patient stays in hospital, the greater the chance of efficacy of the DtR. For example, inpatient mental health services were perceived to produce better outcomes for patients than general hospital wards.

This is because admissions tend to be longer, and staff have more time with patients to assess housing need and complete referrals with plenty of notice before a patient is discharged.

> *"When placed under voluntary section, I felt that staff were keen to ensure that I had support in place [upon discharge] and I wouldn't return. But when I was admitted to a general ward my mental health was not supported to ensure that I felt stable and well enough to maintain my temporary accommodation placement."*
> **Lived experience perspective**

> *"It seems to work a little bit better with mental health. Staff tend to have a better understanding on the wards on what's available to patients."*
> **Local authority housing professional**

Given the enormous workload, high patient turnover, and the limited time to establish a relationship with patients, A&E departments were perceived to be the least suited department to meet the demands of the duty:

> *"Frequent emergency department attenders rarely get admitted – [A&E] send home 75 per cent of people we see – if people aren't admitted, there simply isn't the time to establish housing support."*
> **Healthcare professional**

> *"A&E think they shouldn't do it as the patient is just in attendance, rather than admitted to a ward."*
> **Healthcare professional**

This line of thinking was reflected in the survey findings: for respondents working in A&E settings, 0 per cent believed that the DtR improves housing outcomes for patients always or most of the time, compared to 31.3% per cent of those working in inpatient settings.

Therefore, given the more preventive approaches taken in general practice and the less crisis-management focussed nature of outpatient services, such as community mental health, the duty should be applied to wider elements of the healthcare system for it to work as a preventative mechanism.

Some participants were aware of GPs and Primary Care Networks already referring people they identify as homeless to the local authority, though many felt that unless they were legally obliged to do so, practice in this regard would always be patchy. Given the recent moves towards a more multidisciplinary approach in GP surgeries, some people suggested social prescribers as having a key role in homelessness prevention.

This finding supports existing research into the role that GPs play in preventing homelessness. Crisis' report 'A Foot in the Door', which looked at people's experiences of the Homelessness Reduction Act, found that 69 per cent of research participants were engaged with at least one public service at the time they engaged with Housing Options.[44] Over a third (36 per cent) of respondents reported that they had seen their GP before attending Housing Options.

Participants had far more contact with GPs than any other service, highlighting how GPs are one of the most likely services for people to contact before approaching local authority housing support. However, only 28 per cent of people who saw their GP prior to approaching the local authority were advised by their GP to approach the local authority, suggesting scope to enhance GPs' role in this regard.

Subsequent research on the Homelessness Reduction Act by Crisis found that 38 per cent of research participants who had approached Housing Options were in touch with a GP, but only 10 per cent were advised by the GP to approach the council; this is despite 18 per cent of people specifically speaking to their GP about their homelessness situation.[45]

Finding 4

A lack of standardisation in the referral process creates variation in outcomes between areas

Analysis of H-CLIC data tells the story of a postcode lottery of implementation. In data provided by local authorities between April 2021 and March 2022, there was substantial variation in the percentage of referrals made by health organisations under the DtR between different local authority areas, with the largest being 63.2 per cent compared to 1.4 per cent as the lowest proportion.[46] This variation was also evident across cities; for example, 27.8 per cent of DtR referrals in the same year came from health bodies in Manchester, compared to just 4 per cent in Sheffield. Limitations to the H-CLIC data collection method makes it difficult to infer an accurate or conclusive trend behind this level of variation. However, the discrepancies do suggest that the likelihood of a referral being made from a hospital setting, and resultant patient outcomes, is dependent on geographical location.

Workshop participants highlighted that the lack of standardised or mandated referral processes in the design of the DtR has resulted in these local variations in procedure and patient outcomes.

Statutory guidance on the DtR published by the Department for Levelling Up Housing and Communities advises that specified public authorities may make a referral to a local housing authority in any manner they wish as long as they include the minimum information required by law.[47] However, these variations in procedure in different areas can also lead to disparities in the responses received from local authorities and the quality of housing outcomes, creating a postcode lottery of implementation. Given the high rate of staff turnover within the NHS, variations in local procedure makes it more difficult for staff to familiarise themselves with referral pathways.

> *''It's difficult to say how [the DtR] is working because it depends on the area. It is as successful as it can be – but it all depends on the authority you are referring to and the pressures they are under, as well as how quickly [health] colleagues get the duty done''*
>
> **Healthcare professional**

> *There is a real variation in the type of response [from local authorities]; the timeframe, the expectations, how closely local authorities work with health organisations. Where local authorities have a health champion, the relationships and outcomes are better – things don't go as well when there are lots of handovers"*
>
> **Local authority housing professional**

> *"Co-location of Housing Options officers works really well, people in the hospital know how to contact [local authority housing staff] and it makes things go more smoothly. Partnership working is key - weekly multidisciplinary team meetings, and lots of communication in between"*
>
> **Workshop participant**

This variation was also reflected in the survey results: 0 per cent of respondents felt that the DtR secures positive housing outcomes all the time. 26.8% per cent felt that positive housing outcomes are secured most of the time, with 60.7 per cent reporting that the DtR only results in positive outcomes sometimes.

Finding 5

The DtR does not always meet the needs of marginalised communities

Some hospital staff reported difficulties with the DtR due to complexities around capacity assessments when gaining patient consent for a referral to be made on their behalf. Statutory guidance stipulates that the service user must consent to the referral being made, in writing or orally. Practitioners should ensure that the service user understands the purpose of the referral, and consents to information and contact details being passed on to the local housing authority. Referrals without consent may only be made in order to safeguard children or vulnerable adults, in accordance with local safeguarding protocols.

However, staff reported uncertainty and inexperience with capacity assessments and the need for specialist clinicians (i.e., Occupational, Speech, and Language Therapists) to advise on patient capacity due to the complexity of need mentioned above. Whilst they could be considered vulnerable, these patients do no always meet local safeguarding criteria and it can be difficult for non-specialists to make the correct assessment and conclusions, impacting their ability to complete the referral. This indicates the view that while the DtR marks a positive shift in the right direction, the surrounding systems in which the duty sits, have not evolved in the same way. This complexity was also reflected by people with lived experience:

> *"When in the midst of a crisis, battling addiction and ill mental health, it's very difficult to comprehend information from staff and be able to make decisions – some may not have the capacity to agree to a referral being made. I wish that someone could have intervened and made decisions on my behalf."*
>
> **Lived experience perspective**

For other marginalised groups, the legislation was never designed to meet their needs in the first instance. Migrants who are subject to the no recourse to public funds (NRPF) condition, or who do not have any current immigration permission, are not eligible for homelessness assistance or housing allocation in England.

The barriers that NRPF conditions present to successful outcomes of the DtR was a key theme emerging from focus group discussions and the survey, and was highlighted by health and housing staff and those with lived experience equivalently:

> *"There's always going to be people with NRPF – the range of options for NRPF is so limited that beyond six weeks' worth of step-down accommodation [some step-down accommodation is available for NRPF] there's no accommodation solution. 50 per cent of the rough sleepers we work with in Westminster are now migrants (many with NRPF)"*
>
> **Lived experience perspective**

> *"We struggle to support asylum seekers without recourse to public funds. The City Council understands their duty to support but when referring to smaller councils it is difficult to access support and get councils to understand what their duties are"*
>
> **Healthcare professional**

Whilst broader homelessness and migration legislation is beyond the scope of this study, it is again worth noting that the DtR as a referral mechanism is only as successful as the housing and support systems into which someone is referred.

Finding 6

There is a lack of governance and oversight of the DtR

The lack of standardised or mandated referral processes highlighted earlier were part of broader discussions around an overall lack of local and national governance of the DtR, which was closely associated with a lack of accountability. Many participants expressed the need for a senior regulator authority or mechanism to support accountability and to recognise patterns and opportunities for improvement.

Staff felt that improved data collection could be one such mechanism, such as national health datasets to mandate returns of DtR outcomes and patient experiences that are measured over a long period of time:

> *"DtR is not reported on – if there's an incident in a hospital it has to be investigated – It goes to a quality board. But incidents with DtR aren't reported or published – there should be more governance around this"*
>
> **Healthcare professional**

> *"There is no local oversight in terms of DtR outcomes – it's just not recorded so it's hard to assess outcomes. There are no health metrics to support this data. We need to be able to compare health outcomes data for people who are going through the referral process and those who aren't"*
>
> **Local authority housing professional**

Integrated Care Systems were also thought to have an important role in the oversight of local DtR processes and outcomes. Some staff suggested the need for homelessness health oversight boards within each ICS area to assure delivery of a homelessness health strategy including enhancement of DtR practices, as well as the need to drive application of NICE guidelines NG214.[48]

References

[26] These statistics are taken from: BMA (British Medical Association). An NHS under pressure. *https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/an-nhs-under-pressure*

[27] Department for Work & Pensions. (2022). DWP benefits statistics: February 2022. DWP benefits statistics: February 2022 - GOV.UK (www.gov.uk)

[28] Crisis. (2023). Freeze on housing benefit decimating low-income renters' ability to find secure homes. *https://www.crisis.org.uk/about-us/media-centre/freeze-on-housing-benefit-decimating-low-income-renters-ability-to-find-secure-homes/*

[29] House of Commons Library. (2022). Social rented housing (England): Past trends and prospects. *https://researchbriefings.files.parliament.uk/documents/CBP-8963/CBP-8963.pdf*

[30] Crisis. (2018). Housing supply requirements across Great Britain: for low-income households and homeless people. *https://www.crisis.org.uk/media/239700/crisis_housing_supply_requirements_across_great_britain_2018.pdf*

[31] Department for Levelling Up, Housing and Communities. (2023). Social housing lettings in England, tenants: April 2021 to March 2022.

[32] APPG for Households in Temporary Accommodation. (2023). Call for evidence findings: summary, analysis of themes and call to action. *https://householdsintemporaryaccommodation.co.uk/wp-content/uploads/2023/01/APPG-Call-For-Evidence-Findings-Report.pdf*

[33] Healthy London Partnership. (September 2022). Health, housing and social care integration for people experiencing homelessness: needs identified in an inpatient audit.

[34] Ibid

[35] Cornes, Michelle & Aldridge, Robert & Tinelli, M. (2021). Transforming Out-of-Hospital Care for people who are homeless. 10.18742/pub01-007

[36] Ibid

[37] Pathway (2019) A Need Assessment for Homeless Medical Respite Provision in North Central London. *https://www.pathway.org.uk/wp-content/uploads/NCL-Needs-Assessment-FINAL-REPORT-July2019-1.pdf*

[38] Cornes, Michelle & Aldridge, Robert & Tinelli, M. (2021). Transforming Out-of-Hospital Care for people who are homeless. 10.18742/pub01-007

[39] The National Institute for Health and Care Excellence (NICE). (March 2022). Integrated health and social care for people experience homelessness: NICE guideline [NG214]. *https://www.nice.org.uk/guidance/ng214*

[40] Pathway (2022) SPCT Inclusion Pathway Homeless Health Team First Year Report.

[41] Crisis. (2021). Home for All: The case for scaling up Housing First in England. *https://www.crisis.org.uk/media/245740/home-for-all_the-case-for-scaling-up-housing-first-in-england_report_sept2021.pdf*

[42] Dr Peter Mackie, Professor Sarah Johnsen, and Dr Jenny Wood. (2017). Ending rough sleeping: what works? *https://www.crisis.org.uk/media/238368/ending_rough_sleeping_what_works_2017.pdf*

[43] Crisis. (2021). Home for All: The case for scaling up Housing First in England. *https://www.crisis.org.uk/media/245740/home-for-all_the-case-for-scaling-up-housing-first-in-england_report_sept2021.pdf*

[44] Boobis, S., Sutton-Hamilton, C., and Albanese, F. (2020) A foot in the door. Experiences of the Homelessness Reduction Act. London: Crisis.

[45] Sutton-Hamilton, C., Allard, M., Stroud, R., and Albanese, F. (2022) "I hoped there'd be more options:" Experiences of the Homelessness Reduction Act, 2018-2021. London: Crisis.

[46] Department for Levelling Up, Housing & Communities (2022) Statutory homelessness: Detailed local authority-level table. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1105929/Detailed_LA_2021-22.ods*

[47] https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer

[48] NICE (National Institute for Health and Care Excellence). (2022). Integrated health and social care for people experiencing homelessness. *https://www.nice.org.uk/guidance/ng214*

4 Conclusion and Recommendations

The DtR was designed to ensure that services work together effectively to prevent homelessness by ensuring that people's housing needs are considered when they encounter public authorities within the wider legislative structure of the Homelessness Reduction Act, which aims to shift the homelessness system towards a preventative approach.

However, the findings from our project highlight that there is an implementation gap between these aims and the outcomes of the duty in hospital settings. Staff reported that patients continue to be discharged to the street and/or inappropriate accommodation and there is a lack of integration between housing and health services in some areas. Nonetheless, we have also seen pockets of good practice – these tend to be in areas that have pre-existing collaborative relationships between services, such as those with a Pathway team or housing staff embedded into hospital settings.

Overall, the barriers reported (i.e., the quality of information on referrals made, the time it takes for local authorities to respond) seem to be symptomatic of wider systemic barriers around the pressures faced by hospital and housing staff, workforce capacity, and the lack of appropriate accommodation options. The DtR is extremely valuable in highlighting two fundamental principles in the prevention of homelessness: that having a healthy home is a key determinant to a person's health and wellbeing, and that healthcare has a key role in preventing experiences of homelessness. Nonetheless, we conclude that the current landscape in which the legislation sits makes it difficult to implement to its fullest extent – the DtR can better serve its purpose if systemic pressures are addressed, and pockets of good practice are scaled up, driven by better accountability and oversight.

Unless and until these wider systemic pressures are addressed, such as the need for a housing-led system to end homelessness, significant upscaling of funding for housing-related support (which includes health and care), and a relieving of NHS pressures (including a more dedicated approach to tackling health inequalities and ensuring the NHS plays its full role in ending homelessness), the DtR will not make the impact it was designed to.

However, we have identified nine recommendations that we feel would go some way to address current barriers, make a significant impact in improving the efficacy of the duty within the confines of current system pressures, and begin to close the implementation gap.

Pathway & Crisis Policy Report 2023 Beyond the Ward

Recommendations for System-Level Change:

Recommendation 1:

To better meet patients' health, care and support needs, the Department for Health and Social Care (DHSC) and the Department for Levelling Up Housing and Communities (DLUHC) should ensure that local authorities and health bodies have access to a wide range of housing options for people experiencing homelessness discharged from hospital with complex needs, specifically provision of dedicated step-down and intermediate care facilities.

Even those areas that reported strong integration between health and housing, had embedded housing officers in hospital, and/or an inclusion health team, felt that the success of the duty was inhibited by a lack of housing options, particularly for people with complex health needs whose accommodation requirements were more complex. Workshop attendees reported experiences where patients continue to be discharged to inappropriate short-term accommodation that is unable to meet their health, care, and support needs, and in the very worst-case scenario, discharged to the street.

This recommendation looks to tackle the heart of the major difficulties in using the DtR as effectively as possible, namely the lack of housing options available for people with nuanced health/care needs and the systemic pressure in the NHS which incentivises premature discharge from hospital. Step-down/intermediate care improves both health and housing outcomes and allows more time for both health bodies and local authorities to work together to find someone more suitable, permanent accommodation. This would result in a reduced likelihood of readmission to hospital, as well as ensuring that an institutional discharge is used as a key contact opportunity to end someone's homelessness for good.

But it must be accompanied by changes in wider Government housing policy to address the underlying causes of the shortage of genuinely affordable, settled housing options. This should include investment to significantly increase the availability of Housing First and to provide good quality, specialist supported housing where Housing First is not suitable. Unless and until this is rectified, the DtR will not realise its full potential in preventing homelessness.

Pathway & Crisis Policy Report 2023 Beyond the Ward

Recommendation 2:

To ensure integration between health services and local authorities, the DHSC should explore requiring all emergency departments, urgent treatment centres and hospitals in their function of providing inpatient care, to have a dedicated housing officer.

A lack of effective communication and collaboration between services was a key theme emerging from both workshop discussions and the survey. Currently, siloed systems are working to different incentives (for example, hospitals' pressure to discharge patients), making it difficult for hospital staff to navigate complex homelessness pathways and vice versa. Areas that reported an effective referral process were those that had a dedicated housing officer within the hospital and in these areas, despite system pressures, participants felt the DtR worked relatively well.

The appointment of a housing officer in every hospital is a tangible and effective way of achieving integration and would help prevent operational difficulties reported in the DtR process i.e., the quality of referrals made, the information provided on referral forms, and the issues around the time it takes for local authority housing teams to respond to referrals made.

Recommendation 3:

To encourage adherence to the duty in areas that see high levels of patients experiencing homelessness, DHSC should consider requiring specialist homelessness teams in hospitals providing inpatient care that admit more than 200 people experiencing homelessness each year.

It was clear from our research that where inclusion health teams existed, the implementation of the DtR was much more effective, both in terms of the numbers of patients referred to the local authority and the outcomes then achieved upon referral. Inclusion health teams can integrate with local authorities more effectively given they are able to advocate on behalf of patients in a different capacity to mainstream staff, have the capacity and ability to follow up with local authorities, and are able to challenge decisions in a way that mainstream staff often don't have the time or expertise for. Inclusion health teams have more capacity to advocate for Adult Social Care involvement, which participants felt to be the missing link in the DtR process.

At its core, wider systemic NHS pressures mean that hospitals cannot provide the time that patients with complex needs require. Without a huge shift in NHS culture and funding models for inclusion health, it is highly unlikely that this will change without specialist interventions. This recommendation aims to build this capacity and support the referral process, as well as ensuring that hospital settings work for people experiencing homelessness. This would have a significant positive impact on the ability of hospitals that see large numbers of patients experiencing homelessness to adhere to the duty.

Recommendation 4:

To better identify housing need before patients reach crisis point, DHSC and DLUHC should explore extending the DtR to other parts of the NHS where the opportunities to prevent homelessness may be greater. This should include primary care, community mental health, and drug & alcohol services. They should work with the primary care sector, including the Royal College of General Practitioners and the British Medical Association, to examine how this could work in practice and commission pilots to test operational considerations and devise the most effective implementation of the DtR in these settings.

Workshop attendees suggested that it could be considered illogical that the more preventative areas of healthcare, which are more likely to see people before they reach crisis point, are least involved in homelessness prevention.

Bringing preventative elements of healthcare into homelessness prevention efforts could have a hugely positive impact in terms of ensuring an individual's housing status does not reach this stage. The need for the involvement of these wider parts of the system is supported by research that highlights how GPs are the most likely public body for people to interact with prior to making a homelessness application.[49] During our workshop discussions, attendees reported that some wider community services are successfully conducting referrals in some areas, despite not being subject to the duty. However, this policy area is layered and complex, requiring thorough exploration into the implementation of such a requirement.

[49] Boobis, S., Sutton-Hamilton, C., and Albanese, F. (2020) A foot in the door. Experiences of the Homelessness Reduction Act. London: Crisis.

Recommendations to drive improvements at a local level:

Recommendation 5:

To ensure the availability of safe accomodation options for people to be referred to, Integrated Care Systems (ICSs) should assess the current availability and effectiveness of intermediate care for people experiencing homelessness in their areas, and commission services appropriately in line with NICE guideline NG214.

In every workshop held, participants talked about the importance of intermediate care and step-down accommodation in supporting people experiencing homelessness upon discharge from hospital. Intermediate care has been shown to improve patient experience and outcomes by delivering safer transfers of care, reducing delayed discharges, and increasing access to planned health care. By reducing further admissions to secondary care, intermediate care can also save the NHS money. Most importantly, intermediate care can help avoid discharging people to the streets.

NICE guidance clearly recommends commissioning provision of intermediate care that meets the need of people experiencing homelessness. To make this a reality, direction is also needed nationally on the importance of providing tailored intermediate care that is able to cater for varying health, care, and support needs.

Pathway & Crisis Policy Report 2023 Beyond the Ward

Recommendation 6:

To encourage the duty to be used in a more preventative manner, NHS Trusts should provide relevant healthcare professionals with the knowledge to: identify patients experiencing/ at risk of homelessness, understand their duty to refer under the Homelessness Reduction Act, and become aware of the local operational structures in place to support them to do so, in their mandatory induction training programmes.

The lack of awareness and training around homelessness and the DtR in non-specialist settings was a key finding in the results of our survey and was also referenced consistently throughout workshop discussions. These topics are not currently covered by regulated health curriculums in England, with existing training and resources often provided on an ad hoc basis by specialist homelessness teams. Mandatory training is therefore required to educate practitioners on how best to identify patients at risk of homelessness and to understand their duty to refer under the Homelessness Reduction Act. Trusts should also signpost practitioners to the local support structures in place, such as communities of practice and escalation routes, within this training to empower their staff to fulfil their legal duties. Education provided at Trust level can help to overcome the variation in outcomes between areas by embedding the prevention of homelessness into the status quo of mainstream practice.

Recommendation 7:

To provide oversight of the duty in their local area, all ICSs should have a senior responsible officer for homeless and inclusion health who coordinates an ongoing integrated homelessness forum which includes health, housing, and social care representatives to consider best practice.

A lack of integration combined with a lack of oversight of the effectiveness of the DtR at local level was a key theme identified in our research. Provision for people experiencing or at risk of homelessness is often uncoordinated and lacks a multi-agency approach, despite the multi-morbidity often experienced by people who are homeless requiring multiple agencies and parts of the system to play their part. However, good practice exists – this includes DtR forums which have been set up in places such as North Central and North East London to provide a space where housing and health partners come together to understand how to work more closely to ensure referrals are as effective as possible.

Similarly, participants voiced concerns that there is often a lack of oversight over whether an NHS Trust is fulfilling its duties under the Homelessness Reduction Act. Specialist homeless healthcare services mentioned how difficult it can be to secure buy-in at a strategic level within the Integrated Care System on the importance of compliance with the DtR. To rectify this, having a Senior Responsible Officer for homeless and inclusion health would guarantee that compliance with the Act falls within someone's remit at Integrated Care System level. This Senior Responsible Officer should coordinate a forum where implementation of the DtR can be discussed (alongside other issues related to homelessness provision) in partnership between health, housing, and social care.

Recommendation 8:

To enable ICSs to have oversight and compliance with the duty in their area, all NHS Trusts should be required to publish data on the number of referrals made under the duty to enable transparency. This data should be cross-referenced with existing hospital data sets that record patients who present with insecure housing status.

Currently, H-CLIC data collection methods record the number of referrals made under the DtR that are received by local authorities, rather than the number of referrals made by NHS Trusts. The reporting and publication of the latter, alongside the publication of the number of patients who present with insecure housing status, will help ICSs to identify whether the rate of referrals made under the duty by local Trusts are proportionate to the number of patients at risk of homelessness seen in hospitals within their area. This improved data collection, in addition to the insights provided by H-CLIC, would help ICSs to hold NHS Trusts who aren't fulfilling their duties under the Homelessness Reduction Act to account. Enhanced quality of data can also help to evidence the need for a wide range of housing options for people experiencing homelessness discharged from hospital as aforementioned.

Monitoring and evaluation of this data could fit within the remit of a Senior Responsible Officer, acting as a further mechanism for oversight at a local level.

Recommendation 9:

To drive greater accountability of the duty, Healthwatch England should provide the Local Healthwatch network with the resources to examine the implementation of the DtR within their locality when updating its 'Enter and View' guidance. This will provide context to the DtR and include recommended practice on this area of exploration i.e., key questions to ask patients and staff about how the duty works for them.

Local Healthwatch organisations should explore using their legal power to enter and view health and social care services to take a view on how well DtR is implemented. This would enable them to make recommendations to inform changes in the local DtR process for individual services and relevant local partners, as well as system wide.

Healthwatch England has the power to visit health services to see them in action; this is known as 'enter and view'. The purpose of an enter and view visit is to collect evidence of what works well and what could be improved to make people's experiences better. Healthwatch has the potential to use this evidence to make recommendations and inform changes both for individual health services as well as system wide. Healthwatch England has the opportunity to increase the understanding of DtR among their local organisations, who could then provide a valuable service in relation to oversight of the duty by seeking to investigate the implementation of DtR processes in their areas and inciting tangible changes.

Appendices

Appendix 1: Scotland and Wales

It is important to note that while the Homelessness Reduction Act applies to England only, there are developments in Scotland and Wales on the health sector's involvement in homelessness prevention that can be learned from. The Welsh Government has commissioned an independent Expert Review Panel, with Crisis as secretariat, to help them identify where changes are needed to housing and homelessness law to ensure a more preventative approach to homelessness, including consideration of the role that public bodies play in homelessness prevention.

In Scotland, the Scottish Government has accepted recommendations from the Homelessness Prevention Review Group and has committed to introducing these through a forthcoming housing bill. Recommendations include ensuring that all public bodies ask about people's housing situations to identify any issues at an early stage and act where a problem is identified, so that people get the right support to prevent homelessness. It also includes a more comprehensive duty placed on health and care bodies, including that health and social care partnerships should co-operate with the local authority to plan for the needs of applicants for homelessness assistance who may have health and social care needs.

[52] More information on the panel can be found here: *https://www.crisis.org.uk/ending-homelessness/wales-expert-review-panel/*

53 Crisis. (2021). Preventing Homelessness in Scotland. Recommendations for legal duties to prevent homelessness: A report from the Prevention Review Group. *https://www.crisis.org.uk/media/244558/preventing-homelessness-in-scotland.pdf*

Appendices

Appendix 2: Survey Results

Quantitative data obtained from the online survey completed by healthcare professionals.

Background Info

"Please select your primary job role"

	Total	per cent
Nurse	16	19 per cent
Medical Doctor	16	19 per cent
Other	11	13.1 per cent
OT/Physio	10	11.9 per cent
Housing Worker	6	7.1 per cent
"IH Team"	5	6 per cent
Discharge Coordinator	5	6 per cent
Hospital Management	4	4.8 per cent
SM Team	4	4.8 per cent
GP	3	3.6 per cent
Psych Liaison	2	2.4 per cent
Safeguarding Team	2	2.4 per cent

"Do you currently work specifically with a homeless/Inclusion Health Service?"

Inclusion Health?	Total	per cent
YES	51	60.7 per cent
NO	33	39.3 per cent

Appendices

"Where do you primarily see patients? (if you see patients equally between different settings, please select all that apply)"

	Total	per cent
Inpatient Wards	26	31 per cent
A&E + Inpatient Wards	17	20.2 per cent
A&E	15	17.9 per cent
A&E, Inpatients + Outpatients	8	9.5 per cent
Outpatients	5	6 per cent
Outreach	2	2.4 per cent
Virtual Ward	2	2.4 per cent
Other	4	4.8 per cent
N/A	5	6 per cent

"Please select the region of the UK that you primarily work in"

Region	Total	per cent
London	38	45.8 per cent
South East	22	26.5 per cent
Yorkshire & Humber	12	14.5 per cent
South West	5	6 per cent
North West	3	3.6 per cent
East	2	2.4 per cent
Not stated	1	1.2 per cent

Understanding/awareness/training

"How would you rate your understanding of the Duty to Refer?"

	ALL (84)	IH (51)	Non-IH (33)
Excellent understanding	28.6 per cent	37.3 per cent	15.2 per cent
Good understanding	31 per cent	29.4 per cent	33.3 per cent
Aware with some understanding	14.3 per cent	19.6 per cent	6.1 per cent
Aware with little or no understanding	10.7 per cent	7.8 per cent	15.2 per cent
Never heard of	15.5 per cent	5.9 per cent	30.3 per cent

Pathway & Crisis Policy Report 2023 Beyond the Ward

Appendices

"In the last 12 months, how frequently have you made referrals under the Duty to Refer?"

	All (48)	IH (33)	Non-IH (15)
Very Often	50 per cent	63.6 per cent	20 per cent
Often	18.8 per cent	15.2 per cent	26.7 per cent
Sometimes	20.8 per cent	9.1 per cent	46.7 per cent
Rarely	6.3 per cent	9.1 per cent	0 per cent
Never	4.3 per cent	3 per cent	6.7 per cent

"At work, how often do you come across patients who are experiencing homelessness or threatened with homelessness (eg soon to be evicted)? - Non-Inclusion Health Staff"

	Total	per cent	Cumulative per cent
Everyday	6	18.2 per cent	18.2 per cent
Few times a week	12	36.4 per cent	54.6 per cent
About once a week	4	12.1 per cent	66.7 per cent
About once a month	5	15.2 per cent	81.9 per cent
Less than once per month	6	18.2 per cent	

"At work, how often do you come across patients who are experiencing homelessness or threatened with homelessness (e.g., soon to be evicted)? - Inclusion Health staff who had never made a referral"

	per cent	Cumulative per cent
Every day	18.8 per cent	18.8 per cent
Few times a week	25 per cent	43.8 per cent
About once a week	12.5 per cent	56.3 per cent
About once a month	6.3 per cent	62.5 per cent
Less than once a month	37.5 per cent	100 per cent

"Overall, how have you found the referral process?"

	All	IH	Non-IH
Very Easy	14.6 per cent	18.2 per cent	6.7 per cent
Easy	35.4 per cent	39.4 per cent	26.7 per cent
Neutral	22.9 per cent	12.1 per cent	46.7 per cent
Difficult	22.9 per cent	24.2 per cent	20 per cent
Very difficult	4.2 per cent	6.1 per cent	0 per cent

	Housing	Health	Discharge Processes	Connecting Services
Always	0 per cent	0 per cent	1.8 per cent	3.6 per cent
Most of the time	32.1 per cent	17.9 per cent	16.1 per cent	25 per cent
Sometimes	60.7 per cent	53.6 per cent	35.7 per cent	53.6 per cent
Rarely	7.1 per cent	21.4 per cent	26.8 per cent	12.5 per cent
Never	0 per cent	3.6 per cent	5.4 per cent	3.6 per cent
DK	0 per cent	3.6 per cent	5.4 per cent	1.8 per cent

Above questions, split by Inclusion Health Specialists vs non-Inclusion Health staff.

	Housing		Health		Discharge Process		Connecting Services	
	IH	Non-IH	IH	Non-IH	IH	Non-IH	IH	Non-IH
Always	0 per cent	0 per cent	0 per cent	0 per cent	2.7 per cent	0 per cent	2.7 per cent	5.3 per cent
Most of the time	32.4 per cent	15.8 per cent	18.9 per cent	15.8 per cent	16.2 per cent	15.8 per cent	21.6 per cent	31.6 per cent
Sometimes	56.8 per cent	68.4 per cent	54.1 per cent	52.6 per cent	40.5 per cent	26.3 per cent	59.5 per cent	42.1 per cent
Rarely	5.4 per cent	10.5 per cent	21.6 per cent	21.1 per cent	29.7 per cent	21.1 per cent	13.5 per cent	10.5 per cent
Never	2.7 per cent	0 per cent	2.7 per cent	5.3 per cent	5.4 per cent	31.6 per cent	2.7 per cent	5.3 per cent
DK	2.7 per cent	5.3 per cent	2.7 per cent	5.3 per cent	5.4 per cent	5.3 per cent		5.3 per cent

Above questions, split by those who had received DTR training (T-YES) vs those who had not (T-NO)

	Housing		Health	Discharge Processes			Connecting Services	
	T-YES	T-NO	T-YES	T-NO	T-YES	T-NO	T-YES	T-NO
Always	0 per cent	0 per cent	0 per cent	0 per cent	3.6 per cent	0 per cent	0 per cent	7.1 per cent
Most of the time	32.1 per cent	21.4 per cent	14.3 per cent	21.4 per cent	14.3 per cent	17.9 per cent	28.6 per cent	21.4 per cent
Sometimes	60.7 per cent	60.7 per cent	57.1 per cent	50 per cent	35.7 per cent	35.7 per cent	57.1 per cent	50 per cent
Rarely	7.1 per cent	7.1 per cent	25 per cent	17.9 per cent	42.9 per cent	10.7 per cent	10.7 per cent	14.3 per cent
Never	0 per cent	3.6 per cent	3.6 per cent	3.6 per cent	3.6 per cent	25 per cent	3.6 per cent	3.6 per cent
DK	0 per cent	7.1 per cent	0 per cent	7.1 per cent		10.7 per cent		

Above questions, split by whether respondents worked primarily in A&E or Inpatient settings.

	Housing		Health		Discharge		Connecting	
	A&E	IP	A&E	IP	A&E	IP	A&E	IP
Always	0 per cent	0 per cent	0 per cent	0 per cent	0 per cent	6.3 per cent	0 per cent	0 per cent
Most of the time	0 per cent	31.3 per cent	25 per cent	18.8 per cent	37.5 per cent	6.3 per cent	37.5 per cent	31.3 per cent
Sometimes	62.5 per cent	62.5 per cent	37.5 per cent	68.8 per cent	25 per cent	18.8 per cent	37.5 per cent	56.3 per cent
Rarely	25 per cent	6.3 per cent	25 per cent	6.3 per cent	12.5 per cent	31.3 per cent	12.5 per cent	12.5 per cent
Never	12.5 per cent	0 per cent	12.5 per cent	6.3 per cent	37.5 per cent	12.5 per cent	12.5 per cent	
DK								

Appendices

Additional qualitative questions

"Please briefly elaborate on your answer, if you feel able to comment' - following *"How would you rate your understanding of the Duty to Refer."*

"Please briefly elaborate on your answer, if you feel able to comment' - following *"Overall, how have you found the referral process."*

"In your opinion, what changes could be made to the Duty to Refer referral process to improve it?"

"Please briefly elaborate on your answer, if you feel able to comment" - following Housing, Health, Discharge Processes and Connecting Services outcome questions.

"In your experience, what are the positive benefits of the Duty to Refer?"

"In your experience, what (if any) are the key barriers that prevent the Duty to Refer from securing positive housing outcomes for patients?"

"Please describe any other changes you believe are important, and/or elaborate on your answer if you feel able to comment."

"What would improve your ability to implement the Duty to Refer?"

About the authors

Emily Page is the Policy Officer in Inclusion Health and System Change at Pathway. She has previously worked in the National Lottery Community Fund's Fulfilling Lives programme, where she supported system change for people experiencing multiple disadvantage.

Chris Hicks is the Senior Policy Officer at Crisis, leading their work on homeless health. He has previously worked at Mind and the National AIDS Trust (NAT) on health and social policy.

pathway
Healthcare for homeless people

Working with
Crisis
Together we will end homelessness