Increasing and improving the provision of specialist, intermediate care for people experiencing homelessness

A report for national policy makers

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About the author

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- This report is aimed at national policy makers, service commissioners and planners with responsibility for hospital discharge and the provision of intermediate care for people experiencing homelessness. The report describes the current challenges associated with ensuring safe discharge for people without a home, focusing particularly on the provision of specialist intermediate care. It analyses relevant policy frameworks and key evidence around the benefits of intermediate care and shares the findings of a recent in-depth review of homeless intermediate care provision in a Care Partnership area in England. Finally, it suggests where policy makers should focus their attention to expand and improve specialist provision to support complex hospital discharge processes for this patient group.
- Providing specialist intermediate care, which is tailored to meet the needs of those facing homelessness, is critical to safe recovery for this population and to enabling the Government's ambitions to shift care from hospital to the community and to move toward a preventative approach to healthcare.
- Despite evidence of need and the NICE guideline recommending provision of intermediate care for people experiencing homelessness, several audits and evaluations acknowledge a significant lack of investment and a severe shortfall in the provision of intermediate care compared with need.
- There are several policy frameworks and guidance documents in place to support the interface between hospital discharge and securing suitable onward accommodation for people experiencing homelessness. In theory, these frameworks provide the building blocks for ensuring all patients requiring intermediate care have access to it. In reality, many of them lack focus on the specific needs of people experiencing homelessness and collectively do not provide a positive entitlement to safe discharge.
- Implementation of policies is patchy, driven by lack of accountability mechanisms, making it possible to discharge people to the street without consequence. As with most services for inclusion health populations, national policy does not prioritise access, experience and outcomes for this group of people, leading to precarity and short-termism in the provision of these services.
- Barriers to establishing and sustaining homeless intermediate care services include: a lack of secure, long-term funding; shortcomings in data and evidence gathering to support the case for specialist intermediate care including the routine capture of patient housing status in NHS data; lack of political will to prioritise this issue across the health, homelessness and adult social care system; significant gaps in the various legal frameworks and duties governing housing, care and homelessness and inconsistent application of these duties.

- The report shows a clear evidence base highlighting the merits of specialist intermediate care for people experiencing homelessness. The potential for cost savings, improved health outcomes, system transformation, increased integration and reduced street discharges is clearly articulated in the evidence.
- The upcoming NHS 10-year plan and cross-government homelessness strategy provide a major opportunity for Government to commit to bringing an end to unsafe discharge through the expansion and improvement of specialist intermediate care services.
- The report recommends the following:
    - Implementation of a National Safe Discharge Programme, scaling up existing, cost-effective specialist hospital teams and intermediate care services;
    - Reform of Better Care Fund guidance to meet the needs of people facing homelessness, incentivising their safe discharge and promoting the provision of specialist intermediate care to meet the specific needs of this population;
    - Capture patient housing status in NHS data to inform local needs assessments for intermediate care.

Introduction

The upcoming NHS 10-year plan is set to outline three significant shifts that the government aspires to make in health and care – from an analogue system to a digital one, from a system that treats sickness to one which prevents ill health and a shift in care from hospital to the community. The latter will be more difficult to achieve for people facing homelessness. Their access to primary and community healthcare is poor, leading to intensive use of hospital-based services. People experiencing homelessness attend emergency departments six times as often as housed people and stay in hospital three times as long[1].

Making a reality of this shift for people facing homelessness relies on two things; driving up the quality of their hospital stays and creating safe places for people to recover after a hospital admission, helping to prevent readmissions. Providing specialist intermediate care, which is tailored to meet the needs of those facing homelessness, is critical to safe recovery for this population and therefore to enabling the Government's ambitions to shift care from hospital to the community and to move toward a preventative approach to healthcare.

This report is aimed at national policy makers, service commissioners and planners with responsibility for hospital discharge and the provision of intermediate care for people experiencing homelessness. The report describes the current challenges associated with this type of specialist intermediate care provision. It analyses relevant policy frameworks and key evidence around the benefits of intermediate care, and shares the findings of a recent in-depth review of homeless intermediate care provision in a Care Partnership area in England. Finally, it suggests where policy makers should focus their attention to expand and improve specialist provision to support complex hospital discharge processes for this patient group.

The report was produced by homeless and inclusion health charity Pathway as part of NHS England's Health & Wellbeing Alliance. Groundswell and Homeless Link supported the complementary review for a local Care Partnership in their role as consortium partners.

What is intermediate care?

The term ‘intermediate care’ as used in a mainstream context is usually focused on reablement. In specialist homelessness provision, however, ‘intermediate care’ is understood to mean ‘step-down’ or ‘step-up’ provision which focuses on recovery, including:

- medical in-reach support;
- social support such as attending appointments and making applications for welfare assistance; and
- co-ordinated planning around more permanent housing.

The overall purpose is the same as in mainstream contexts - achieving a safe and appropriate discharge from hospital.

Why Intermediate Care is important for patients experiencing homelessness

People facing homelessness are intensive users of acute services. A safe and supportive discharge can be transformative, putting an end to revolving door of A&E presentations and admissions. Too often, however, this is not the case, and large numbers of people are discharged to the street or to unsafe temporary accommodation. A recent Freedom of Information request found that at least 4200 people were discharge to 'No Fixed Abode' in 2022/23[2].

The provision of intermediate care to enable safe discharge is recommended by the 2022 National Institute for Health and Care Excellence (NICE) guideline on homelessness[3]. It states that health and social care services 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.*"

Many patients facing homelessness have care and support needs on discharge, at levels far higher than the general population. While routine data is not collected by the NHS, evidence from a number of small-scale studies back this up. A 2022 snapshot inpatient audit found that 4 in 10 patients were projected to need short-term intermediate or step-down care. Intermediate care needs assessments carried out by Pathway[4][5] in two London sub-regions had similar findings. Both areas reported high levels of unscheduled service use for this population with a combined total of 1500 A&E attendances and around 430 admissions in one year. The assessments also revealed that:

- 22% of patients facing homelessness had communication difficulties relating to reduced mental capacity or limited language skills;
- Patients in this population had higher support needs due to higher levels of addition, mental health issues, tuberculosis (TB) and poorly managed chronic disease and cancer;
- Patients often had significant mobility problems and/or required substitute prescribing;
- Patients in these London hospitals were more likely to have no recourse to public funds (NRPF) (around 22%);
- Most patients had immediate housing issues (i.e. were rough sleeping, sofa surfing, at risk of homelessness or could not return to existing accommodation).

This in-depth audit of patients in these two areas of London highlighted where some form of intermediate care would have been helpful to their recovery. Further analysis showed that patients facing homelessness requiring intermediate care cannot be treated as a homogenous group. Different intermediate care responses are required

to meet everything from low level clinical recovery to support for chaotic, tri-morbid patients with significant care needs.

What's the problem?

Despite the evidence of need, and consequent impacts on the healthcare system, national audits of intermediate care (carried out in England until 2018) acknowledge a significant lack of investment and suggest that the capacity for intermediate care for all patient groups remains stubbornly stuck at a level below the threshold for whole-system impact. The difficulties are compounded for people facing homelessness. Specialist hospital teams report that these patients are often turned away from mainstream settings, while commissioning of specialist services falls far short of need.

The difficulties are almost nationwide and the impacts are significant:

- On *patients*, with 24% of patients experiencing homelessness being discharged to the street (Homeless Link, Homeless Health Needs Audit), an unsafe outcome that risks increasing morbidity and mortality; a further 21% are discharged into accommodation which is not suitable for their needs.
- On *hospitals*, with delayed discharge of patients facing homelessness, a major issue in recent DHSC analysis[6]. In the snapshot audit of patients in London hospitals, almost half (44.2%) remained in hospital longer than needed due to a lack of safe and appropriate options,
- On *trusts and ICBs*, with costs arising from readmissions and Emergency Department visits due to unsafe discharges.

A recent examination of homeless hospital discharge and intermediate care provision in a Care Partnership area in England highlighted several barriers and challenges which are being mirrored at national level. The findings from this local study are discussed later in this report.

What does the evidence say about effective intermediate care for people experiencing homelessness?

There is a strong and growing evidence base highlighting the benefits of intermediate care focused on people experiencing homelessness. Evidence shows that multi-disciplinary intermediate care models improve patient experience and outcomes by delivering safer transfers of care, reducing delayed discharges, and increasing access to planned healthcare. Intermediate step-down care also improves housing outcomes for people who experience homelessness on discharge from hospital and relieves pressure on hard-pressed mainstream services.

Much of the early literature on this topic is from the US where homeless medical respite services[1] originated. A 2009 paper from the American homeless respite care network identified standalone services as more effective than hostel-based ones but recognises the higher costs associated with standalone services[7].

A 2014 study highlighted the problems arising without *specialist* medical respite services[8]. Health and care staff must 'search for workarounds' to find suitable local placements.

International evidence also shows a range of positive outcomes achievable through specialist homeless intermediate care services. Key findings include reductions in hospital admissions, readmissions and length of stay.

Similar findings are evident in the UK. An economic evaluation from 2011 showed a 77% reduction in admissions and a 52% reduction in A&E attendances following intermediate care stays in a hostel-based service. A further finding showed provision was cost neutral[9]. Another study estimated a return on investment of between £1.50-£8 for every £1 spent and savings in secondary care costs of £280,000 within the first year[10].

These findings are consistent with a recent cost-benefit analysis which found that investment into a national programme of specialist intermediate care over a 10-year horizon would generate a positive return on investment, with every £1 invested returning £1.20 in financial savings and generating £4.30 in societal value[11]. These cost savings are associated with reducing unsafe hospital discharge, moving away from unplanned emergency services, and increasing the use of planned outpatient services, as well as minimising delayed hospital discharges.

An evaluation of the then Department of Health's Homeless Hospital Discharge Fund (HHDF) concluded that access to dedicated intermediate care accommodation alongside specialist link worker support improved housing outcomes. 93% of clients were discharged to appropriate accommodation compared to 71% overall (Homeless Link, 2015)[12].

[1] Alternative term for intermediate care.

Policy frameworks & guidance for homeless intermediate care

There are several policy frameworks and guidance documents in place to support the interface between hospital discharge and securing suitable onward accommodation for people experiencing homelessness. In theory, these frameworks provide the building blocks for ensuring all patients requiring intermediate care have access to it. In reality, the documents lack focus on the specific needs of people experiencing homelessness and, together, do not provide a positive entitlement to safe discharge. Implementation of the policies is patchy, driven by lack of accountability mechanisms, making it possible to discharge people to the street without consequence. Finally, as with most services for inclusion health populations, national policy does not address funding stability, leading to precarity and short-termism in the provision of these services.

Better Care Fund: Policy Framework for 2025 - 2026

The Better Care Fund (BCF) is designed to facilitate the delivery of integrated health and social care[13]. It is the main policy lever for funding and delivery to support safe hospital discharge, but as it stands, does not meet the needs of people who do not have homes.

The BCF was introduced across the NHS and local government with the aim of improving person-centred care, driving more sustainable models of care and achieving better incomes for individuals and their carers. The fund is delivered through pooled budget arrangements and integrated spending plans jointly produced by the NHS and local authority partners.

While the intention of the previous round of the BCF was to have money flowing to support a range of local integrated care priorities, the focus tended towards supporting older people in health and social care settings. The evaluation of the Out-of-Hospital Care Model (OOHCM) Programme found no clear evidence that the BCF used the programme to tackle health inequalities (see below for more details of these evaluation findings).

The BCF objectives for 2025-26 are more aligned with the government's goal to reform the delivery of care, specifically to support the shift from sickness to prevention and to support people living independently and the shift from hospital to home.

These shifts complement government plans for neighbourhood health services which will provide integrated, person-centred care for people with more complex health and care needs. BCF plans should outline how multi-disciplinary teams will provide integrated and proactive care for people with complex needs, including recovery-focused intermediate care services.

While in theory this approach aligns well with the needs of people facing homelessness, key metrics for BCF are skewed towards the needs of the over 65s and people who are housed, focusing on:

- Emergency hospital admissions for people aged 65+,
- Average length of delayed discharges for all acute adult patients,
- Long-term admissions to residential care/nursing homes for people aged 65+

People facing homelessness are often 'young frail'[14][15], experiencing high levels of premature frailty and multi-morbidity, which means that age alone is a poor indicator of need for this population. In addition, the policy lacks detail on how to support people who do not have a home to be discharged to.

Hospital Discharge and Community Support Guidance[16]

This guidance from the Department of Health and Social Care (DHSC) makes clear that people at risk of or experiencing homelessness should have access to intermediate care and should not be denied access on account of their homelessness. The guidance acknowledges the positive impact and cost effectiveness of specialist intermediate care services for people experiencing homelessness.

It recognises there is no single model of specialist homeless intermediate care, and recommends a bespoke approach is required to ensure equal access to services, to avoid delayed discharges and support ongoing recovery for patients irrespective of their housing status.

Discharge to Assess

The Discharge to Assess (D2A) model focuses on the provision of short-term care to support patient recovery before assessing longer-term needs for care and support[17]. Short-term care can be in people's homes or in 'step-down' provision to support the transition from hospital to home.

The homelessness hospital discharge guidance described above highlights the need for flexibility around D2A when considering the needs of people experiencing homelessness. It stresses the need for local authorities to provide temporary accommodation to enable assessments to be carried out. It recommends an exception to the general principle of discharge to assess where *"it may be necessary to carry out an assessment before discharge from hospital where it is considered that discharging someone without such an assessment would cause a safeguarding risk."*

D2A pathways 1-3 are expected to make provision for people at risk of or experiencing homelessness. All patients in this category should be viewed as having unmet need and therefore require the assistance of a Care Transfer Hub. The Hub co-ordinates hospital discharge for those who require health and/or social care support and is expected to hold information on support services and accommodation for patients.

Pathway 0 stipulates that patients with no ongoing health or social care needs should be discharged to their usual place of residence. Hospital discharge teams will determine which pathway is most appropriate for patients experiencing homelessness who are deemed to have no ongoing care needs. They will often default to pathway 0 in such cases without considering any wider care or support needs of patients without a home to be discharged to. The OOHCM evaluation found that 79% of patients seen by hospital homeless in-reach teams were discharged to pathway 0. This is also the experience of many of our specialist hospital teams. The designation of so many patients as having no ongoing health and social care needs is clearly at odds with research that finds significant needs among this patient population. A 2022 audit of London inpatients found that just over 46% were likely to require accommodation with a range of support services to meet their health and care needs. Of these, 14% were identified as needing specialist long-term care. The audit identified only one patient (out of 104) who required housing without any other form of support on discharge from hospital.

This default to pathway 0, without proper consideration of need, can drive unsafe discharges, including to the street.

Discharge to Assess and NRPF

Policies that determine that certain migrants should have no recourse to public funds (NRPF) present particular challenges in ensuring the safe discharge of patients with this status. Pathway's specialist homeless teams based in hospitals around the UK experience this challenge daily. In London hospitals, around 20% of patients experiencing homelessness are classed as NRPF. Some patients do have grounds to gain official status to remain in the UK and gain entitlements to housing and social care. They need access to independent legal advice to understand these entitlements and get support for their cases. Opportunities for this are extremely limited with existing immigration advice services either at capacity or struggling to secure long-term funding. For patients lucky enough to receive legal support, they often need to stay in hospital for long periods until their cases are resolved.

NHS England Intermediate Care Framework for Rehabilitation, Reablement & Recovery following hospital discharge[18]

Published in September 2023, this NHS England framework provides guidance on the provision of intermediate care following hospital discharge. The guidance is focused on provision for the population as a whole and spans a range of priorities.

The framework provides very limited guidance on specific provision of intermediate care for people at risk of or experiencing homelessness. Such groups fall under the 'catch-all' category of complex discharges which are dealt with by the Care Transfer Hub.

Whilst the logic of the care transfer model is sound, the framework does not provide any specific guidance on how to address the multiple complex needs of people experiencing homelessness.

Duty to Refer[19]

The Homelessness Reduction Act (2017) *'placed a duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness/housing options teams.'* Specified public authorities include hospitals, emergency departments and urgent treatment centres.

A hospital admission presents an opportunity to use the Duty to Refer (DtR) to work with other agencies to prevent or resolve someone's homelessness. While the duty has undoubtedly been a useful tool for hospital discharge teams, it has not been consistently embedded in all hospital settings.

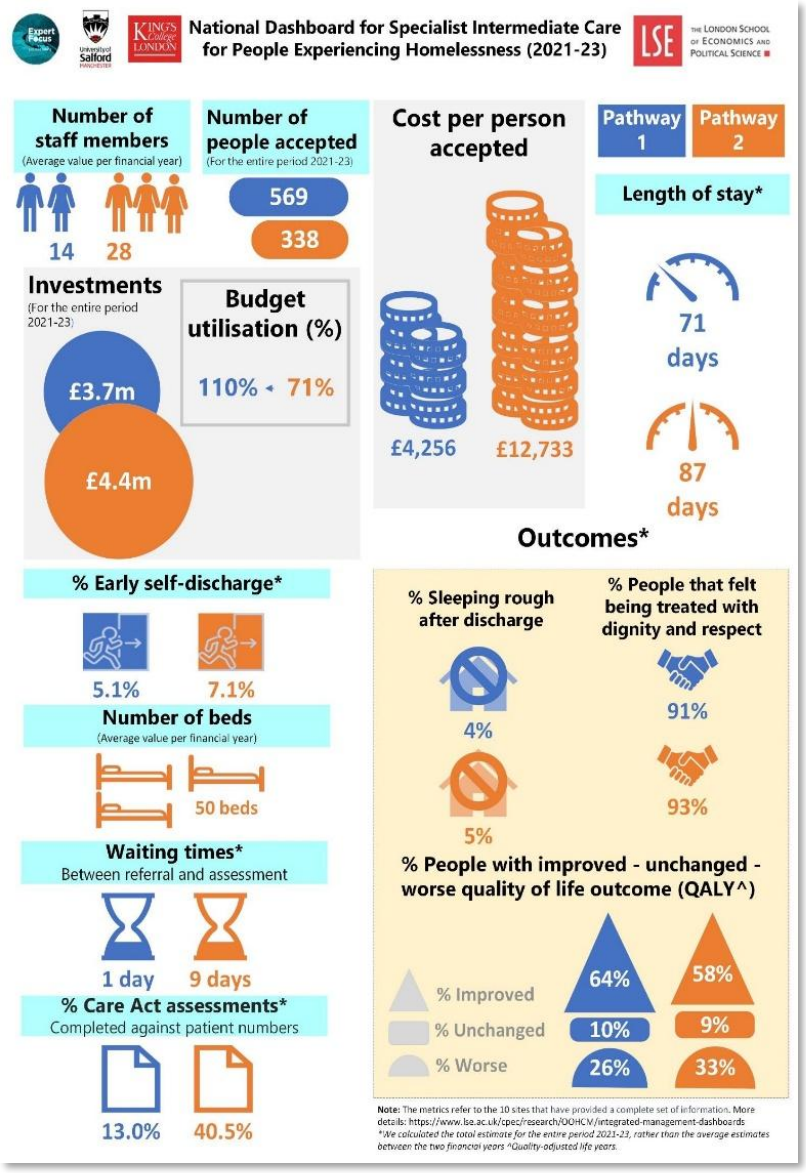
A report investigating the effectiveness of DtR within hospital settings identified a number of challenges associated with the Duty's implementation[20]. The report concluded '*there is a significant implementation gap between the objectives of the duty and actual provision.'*

This gap can be attributed to the duty not being designed to meet the needs of marginalised communities. This is detrimental to achieving positive health and housing outcomes for such groups. A key weakness in the duty is the lack of oversight and accountability at both local and national level. The lack of clear governance means non-compliance with the duty is largely going unchecked. The housing crisis exacerbates the problem with many local authorities struggling to provide enough suitable accommodation to meet demand.

The Out-of-Hospital Care Models (OOHCM) Programme for People Experiencing Homelessness

In 2020, the DHSC launched the Out-of-Hospital Care (OOHC) Programme for People Experiencing Homelessness. The programme aimed to identify the most effective means of replicating successful OOHC services. £16m was provided to support 17 test sites in England. The programme ran from October 2021 until March 2023. A programme evaluation sought to understand why successful, evidence-based models were not being routinely implemented and why too many patients were still being discharged to the street.

An audit framework gathered data on over 50 standardised metrics. This allowed test sites to benchmark performance with other sites as well as gather key performance data across the whole programme (see graphic below). Data was collated into a series of digital dashboards to provide insights on individual patient cases, each of the test sites and across the programme.



Together, the evaluation and audit provide key data on process and financial outcomes for the NHS (and other public sector budgets), quality of life and housing outcomes for patients and quality of care experiences.

Key findings from evaluation & audit

The evaluation and audit data found that:

- Test sites improved outcomes for the majority of patients
- Most patients had very positive experiences of the test site services
- Instances of discharge to the street were around 4-5%, a significant reduction on previous levels
- Most sites focused on delivering a single service; few able to integrate specialist services across all D2A pathways
- Services demonstrating high levels of single system integration represented good value for money (where right data available to evidence this)
- Housing-led ‘step down houses’ offered an effective alternative to larger independent living or care home settings
- One test site with two step-down houses and specialist multi-disciplinary team saw significant reductions in A&E attendances.
- The same site calculated a £42k NHS budget release for 52 clients per year

The evaluation also captured findings on issues preventing a more sustainable, long-term approach to providing specialist intermediate care. The evaluation found that:

- A challenging economic environment leaves no scope for routine development of new services within baseline budgets
- Continued reliance on short-term funding leaves many services ‘limping along’
- There is very limited scope to scale-up services; many areas are rolling back on any plans to expand provision
- Many services are not being renewed on completion of initial contract
- Health inequalities still not being addressed through any routine transformation programmes around delayed discharges.
- Services are viewed as a ‘nice to have’ by commissioners; at bottom of list for funding with other issues viewed as higher priority

- No clear evidence that the Better Care Fund (BCF) tackled health inequalities through the OOHCM Programme but some optimism this could happen in the future

Overall, the OOHCM Programme helped progress the integration of specialist step-down services with D2A and found that new models and services provided good care for patients and were cost effective. The funding was a catalyst for partners to plan and implement services together. It brought new opportunities for peer learning and sharing, helping to bring order to complex issues. Despite these positive outcomes, there was not enough capacity to maintain or replicate services.

Barriers to establishing and sustaining homeless intermediate care services

Despite all the evidence showing the clear benefits of specialist intermediate care for people experiencing homelessness, there is still a significant lack of provision. There are several reasons for this:

Lack of secure funding

There are many examples of best practice where intermediate care provision has successfully supported patients to recover, reduced readmission rates, and saved public services' money. However, these are often short-term funded programmes and pilots, on which specialist intermediate care services cannot survive. This is borne out by the experience of too many of the services set up under the Homeless Hospital Discharge Fund and, more recently, the Out of Hospital Care Fund (OOHCF). The evaluation of the OOHCF reported that 5 out of the 12 intermediate care sites funded to provide intermediate care support for pathway 1 did not continue. The pan-London block contract for pathway 2 medical respite provision also stopped at the end of the funding period. Others were only able to secure short-term funding with the expectation of having to resubmit new business cases the following year. This acute lack of long-term investment into the provision of specialist intermediate care for people experiencing homelessness is perpetuated by a lack of political will and a clear business case.

Lack of systematic data and evidence gathering

We know that provision of intermediate care offers a solution to the problem of street discharge and is recommended in the NICE guidance of 2022. Homeless Link's most recent Homeless Health Needs Audit tells us that 24% of people surveyed were discharged from hospital to the street but this does not help us assess the scale of the problem. Hospitals do not routinely collect data on the destination of discharged patients, meaning that the actual number of patients discharged to the street is unknown. As a result, street discharge is not currently well established as a national problem in need of attention.

Similarly, data on the specific intermediate care needs of patients experiencing homelessness is not routinely documented across all hospitals, if at all. Patients often require complex solutions to meet all their care, mental health and addiction needs in a suitable environment. Capturing good data on these complex health issues is a vital component of designing and delivering appropriate intermediate care.

There is a shortage of data on the cost of a national long-term ringfenced support programme for specialist intermediate care, including initial revenue and capital costs, as well as cost savings for wider public services. DHSC's recently published evaluation of the Out of Hospital Care Model (OOHCM) has helped to fill this gap.

Lack of prioritisation

The pressures on the NHS are well documented. Financial pressures are severe and there are difficulties in all parts of the system from getting a GP appointment to increased waiting times for elective care. Vulnerable groups, including people experiencing homelessness, are often perceived as 'challenging' when it comes to providing specialist services to meet their needs. This results in a lack of prioritisation, despite the higher risks and poorest outcomes experienced by vulnerable groups. A lack of visibility on these issues makes it difficult to generate the political buy-in necessary to achieve the step change required.

Gaps in legal frameworks and duties

A lack of political focus has also contributed to a complicated and inconsistent legal framework which exacerbates the problem and offers little to prevent people experiencing homelessness from falling through the gaps. There are several legal and statutory frameworks at play in hospital discharge, in addition to the specific guidance and framework documents discussed earlier in this report.
Specific Acts relevant to hospital discharge include:

- Care Act, 2014 (including Section 2.14 on intermediate care; Section 9 on duties to assess and meet needs; Section 23 clarifying the boundary between care and support and housing legislation)
- Housing Act, 1996
- Homelessness Reduction Act, 2017
- NHS Act, 2006 (Duty to Cooperate)
- Mental Health Act, 1983 (Section 117 hospital after care eligibility)
- Equality Act, 2010 (Sections 20, 29 & 149 regarding disability and reasonable adjustments)
- Human Rights Act, 1998

None actively entitles people experiencing homelessness to an appropriate move-on setting that meets their needs.

Immigration law and successive hostile environment policies work against the provision of intermediate care and safe discharge for people with insecure or uncertain immigration status. The majority of people experiencing homelessness who are subject to no recourse to public funds conditions are not entitled to any such provision if they do not have Care Act eligible needs. They can face similar discrimination in the application of social care, safeguarding and mental capacity law, with the result that they do not receive the care a housed person would expect. A Human Rights Act 1998 assessment may be required to determine whether support is necessary to prevent a breach of their human rights. In the context of homelessness, this might require consideration of whether the decision to withhold accommodation-based support or health care would result in a failure to uphold Articles 2, 3 and 8 of the Human Rights Act.

Access to independent legal advice is often the only way to navigate the complex landscape around immigration status (when an individual is entitled to this) and

challenging local authority decisions where duties or priority need guidelines are not being followed. This is often the first step to securing intermediate care placements. Third sector legal advice services are extremely stretched, and funding arrangements are patchy and short term. The funding arrangement among Integrated Care Systems (ICSs) for some London hospitals, for example, will expire in Autumn this year.

View from the front line: findings from anonymised case study on homeless intermediate care

In 2023/24, Pathway, on behalf of the Health & Wellbeing Alliance, completed an in-depth study for a local Care Partnership in England examining intermediate care provision for people experiencing homelessness. The area was experiencing major problems finding suitable discharge solutions for people facing homelessness. This was against the familiar backdrop of a national housing crisis and severe pressures on the NHS. The aim was to use the analysis of homeless hospital discharge cases to understand how local intermediate care provision is supporting complex hospital discharge and what scope there is for improvement locally.

Some of these local findings are equally relevant to the national situation. The findings provide a window into how a lack of clear national guidance on intermediate care for marginalised groups – or adherence to existing frameworks designed to support such groups – is playing out in local areas.

Some notable headline findings are:

- The operating environment is challenging for all parts of the system including housing, health, social care and the voluntary sector.
- Patients facing homelessness often spend longer in hospital than necessary and are more likely to discharge themselves from hospital.
- Patients are still being discharged from hospital to the street or to inappropriate settings for recovery.
- Discharge to Assess Pathways do not adequately meet the needs of patients facing homelessness, contributing to delayed discharge.
- Intermediate care options to support safe and timely discharge are in extremely short supply.
- Constraints in mental health and substance misuse services make it challenging to meet these needs in existing intermediate care settings.

The following case studies from the local research illustrate the challenges posed by a lack of intermediate care options.

Case 1

A 57-year-old male with long history of homelessness and history of drug and alcohol abuse was admitted to hospital following a stroke. He was using a wheelchair and had high support needs for medical recovery and personal care. He regularly left the ward to drink, smoke or try and get access to drugs.

He was previously considered intentionally homeless, but his high level of care needs prompted the Rapid Transfer Service to request a referral to an assessment bed. This was declined due to the patient's substance misuse, behaviour and age. He was subsequently added to the pathway 3 waiting list under D2A. Care homes also refused to accept the referral for similar reasons.

At the time of the case study review, the patient was still on the ward 155 days after his admission. There is agreement the patient needs to be housed with daily care visits but the wait to find suitable housing continues.

It is worth noting that stakeholders across all parts of the local system noted the presence of the homeless health Pathway team had significantly improved the approach to hospital discharge, as some of the case studies show.

Case 2

A male patient (age 56) was in and out of hospital for three months. He had various health issues including cardiac failure and complex diabetes. He also suffered from severe anxiety. He had lost his tenancy and his family was unable to accommodate him.

After three months of frequent admissions, he was referred to the Pathway team who completed a Duty to Refer (DTR) outlining his housing and care needs based on his health conditions. The patient was discharged to Temporary Accommodation two weeks later where he continued to receive support from the Pathway team.

After three months, he secured a permanent property with a social care package. There were avoidable delays at various stages of the process; the patient did not require an acute bed in the later part of his final admission.

CASE 3

An elderly female patient with a long history of complex mental health issues and homelessness was in hospital for 61 days. During that time, she received multiple Care Act and Occupational Therapy assessments.

The health professionals supporting her had different views on her capacity, the level of care she needed and whether there were any safeguarding issues.

Eventually, the Pathway homeless health team intervened and worked with the Rapid Transfer Service to move her to an assessment bed. This could have happened sooner as, although the patient had complex needs that required detailed levels of assessment, she did not require an acute bed for her entire admission.

On a positive note, local partners expressed a strong appetite for change. They want to see more specialist intermediate care options available for homeless patients. Some partners have access to empty properties which, with the right investment and operating model, could be brought into use for this purpose.

The case study included some recommendations for local system partners to consider, including to:

- **Conduct an independent intermediate care needs assessment** following the steps set out in the Pathway publication 'How to do a needs assessment for a medical respite service.'
- Use findings from needs assessment to **develop a local strategy for intermediate care for people experiencing homelessness.**
- **Set up a cross-agency pilot project/working group** to assess the feasibility of setting up a specialist homeless intermediate care project; identify suitable property for conversion/adaptation for this purpose.

Replicating these actions in different areas would be a useful first step towards creating demand-based, local intermediate care services for people experiencing homelessness. However, without longer term funding to fully embed services in commissioning frameworks, there is limited incentive for local partners to act.

What are the opportunities?

This report shows that there is a clear evidence base, gathered over two decades, highlighting the merits of specialist intermediate care for people experiencing homelessness. The potential for cost savings, improved health outcomes, system transformation, increased integration and reduced street discharges is also clearly articulated. Despite the evidence, efforts to implement any significant transformation in specialist intermediate care are still hampered by the same challenges. Short term and insufficient funding, a severe housing shortage, staff recruitment and retention difficulties, lack of adherence to existing policies, complex legal issues and deficiencies in cross sector working are impacting on efforts to commission services on a large scale. Ultimately, action is urgently needed to end the misery of street discharge and to provide a safe place for people experiencing homelessness to recover after a hospital admission.

The upcoming NHS 10-year plan and cross-government homelessness strategy provide a major opportunity for Government to commit to bringing an end to unsafe discharge through the expansion and improvement of specialist intermediate care services. National policy makers should consider the following policy levers to fund these services, incentivise Integrated Care Board (ICBs) to commission them, and to hold systems accountable for their delivery:

1. **Implementation of a National Safe Discharge Programme,** which scales up existing cost-effective specialist hospital teams and intermediate care, to meet the level of national need. This programme should be underpinned by ringfenced funding in the multi-year spending review. Driving up the quality of hospital stays for people experiencing homelessness and creating positive entitlements to safe places for them to recover after a hospital admission would support Government's ambitions to shift care from hospital to the community and to move toward a preventative approach to healthcare.

2. **Reform of BCF guidance to meet the needs of people facing homelessness.** In order to support the implementation of this programme, future iterations of BCF guidance should include objectives which incentivise ICBs, local authorities, and health and wellbeing boards to direct resource to specialist intermediate care for people facing homelessness.

3. **The routine capture of patient housing status in NHS data.** The Government should promote the use of housing status field across the NHS, as described in a recent Pathway policy paper[21]. Increased visibility of patients experiencing homelessness in local healthcare settings will help to inform local needs assessments for intermediate care, and ensure ICSs are delivering these services at a level which meets local need.

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