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# Wakefield Housing Support Evaluation (WHoSE): Main Project Report

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# Abbreviations

Housing support coordinator: HSC
Service user: SU
Wakefield District Housing: WDH
University of Sheffield: UoS

# Executive Summary

## Introduction

This executive summary reports on the evaluation of the Housing Support Coordinator service being delivered by a social housing provider; WDH, in Fieldhead (South West Yorkshire Hospital Trust) (a mental health hospital) and Pinderfields (Mid Yorkshire NHS Trust) hospitals (an acute hospital). The service involves a Housing Support Coordinator (HSC) working with hospital inpatients to assist them with their housing related needs. The aim of the service is to help facilitate hospital discharge and improve outcomes for patients. As a new service, both NHS and housing partners wanted to understand the impact of the HSC project through an evaluation.

The University of Sheffield was commissioned to evaluate the service between January 2020 and December 2021 (with an extension to the economic element until March 2022). The aim of the evaluation was to understand whether and through what mechanisms and to what extent, the HSC service has an impact on service user's health and housing outcomes, hospital costs and the process of hospital discharge. This extended executive summary provides an overview of the main evaluation findings and can be read as standalone document. It includes a summary of the project's methodology, key findings, and the conclusions and recommendations arising from the analyses. For further exploration of the findings, including data tables and direct quotes from participants, please refer to the sections in the full-length report.

## Methodology

We employed a mixed methods process evaluation comprising of the following elements:

- Questionnaires to service-users at the point of referral to HSCs and a questionnaire after receiving support (n=37 service users)
- Analysis of routinely data collected by WDH (n=488 service users)
- Qualitative interviews with the HSCs in both sites, key housing staff, and service users and health care professionals in Fieldhead hospital only (n=16)

- Development of a logic model explaining the pathways through delivery and the impact of the service.
- Economic evaluation to assess costs of the intervention.

The quantitative and qualitative data were integrated together to produce overall project findings. This executive summary focuses on these integrated findings. The economic results will be described in a separate report.

**Impact of Covid-19 on evaluation and recruitment**

As the evaluation was carried out during Covid-19 there were a number of impacts on the work undertaken and recruitment to the study. Reduced capacity within the NHS research teams alongside staff sickness and an influx of Covid related studies meant that the study was paused for periods. Multiple changes were made to the study because NHS research teams could not visit inpatients to discuss the study in person. Consequently, the number of service-users participating in the study, particularly the questionnaire, is lower than anticipated.

# Key findings

# Development of the role

The HSC roles were initially piloted in Fieldhead hospital, supporting people hospitalised for mental health reasons in April 2018 and then rolled out in September 2018 to Pinderfields Hospital, an acute trust. The service was established because many inpatients have unmet housing needs which caused stress on individuals and on the wider hospital system. Furthermore, resolving housing issues cost clinical staff a considerable amount of time, resulting in unnecessary delays to discharge. The aspiration of the HSC service was that having dedicated and specialist staff to support people's housing needs would reduce the housing-related stress that people experience and improve the overall hospital discharge pathway.

**Implementing the role**

Both HSCs were experienced housing officers who had a wide range of knowledge of the different housing options and other external services available for onward support post discharge. This experience and skills in developing rapport with service users appeared essential to the success of the role. HSCs needed to be able to work autonomously as they were the sole people delivering that role and thus were not

part of a wider team of people doing a similar role within the hospital. The HSC role required a proactive approach as a key part of the work involved developing referral pathways and raising the profile of the role with different health care professionals and hospital wards. For example, the HSC in Fieldhead worked as part of the discharge team and attended joint ward rounds and discharge meetings on regular basis.

**The nature of the support provided**

The HSCs provided an important liaison function between clinical staff and housing and community services. The main components of the role included:

- Meeting with service users to understand their housing related needs and concerns (e.g. why they are unable to return home, types of housing required and whether they need further support to sustain their tenancies e.g. financial, health or via supported accommodation, etc.)
- Locating and arranging suitable accommodation (including filling housing forms/applications if required)
- Signposting to external services to support them with wider health and wellbeing issues (e.g. financial management, tenancy support)
- Liaising with health care professionals (HCPs) and other services and organisations such as the council to understand tenants' situations and issues (e.g. whether there have been previous issues with the tenant relating to antisocial behavior or rent arrears).

In both settings, the main form of support was helping people to navigate the housing system to organise new accommodation for example, by helping with assisted bidding, home search applications or an application for Health and Medical Rehousing. The range of support provided by the service showed how the HSCs were skilled in providing personalised care, tailoring their support and offer to meet the specific needs of each person.

**Who and why people accessed the service**

There were 488 service-users referred to the project between April 2018-June 2021 - 238 in Fieldhead and 250 within Pinderfields (service began in September 2018). The majority of the people supported by the service were male (n=325,66.6%). However, the age profiles of the two services were different, with the HSC in the acute trust supporting an older population (over half of service users were over 65,

n=132, 52.8%) compared to the Fieldhead HSC (over half of service users were under 45 years old, n=142, 59.6%).

It was apparent that service users led complex lives and often experienced several social issues alongside their housing situations. This included substance misuse, debt and safeguarding issues such as abuse at home. A third of service-users at Fieldhead were experiencing homelessness (n=79/239, 33.1%). Furthermore, many had multiple hospitalisations due to their mental health. In Pinderfields, reasons for hospitalisation included amputations, strokes, fall related injuries and exacerbations of chronic long-term conditions such as MS and IBS.

There were a variety of reasons for people needing HSC support. Issues included their previous accommodation no longer being suitable due to mobility issues, needing supported accommodation because of their mental health, previous disputes with neighbours, difficulties looking after properties, issues with payments due to rent arrears, needing home adaptions or wanting to move to be closer to family.

The types of support HSCs provides differs between the acute and mental health settings and demonstrates how the HSCs carefully tailor their support the needs of service users. Although both HSCs have similar skills which helped them within their role, it was clear that each role required specific knowledge and experience. For example, an HSC working within an acute setting needs knowledge on adaptions and occupational health assessments, whereas an HSC working within a mental health setting needs greater knowledge of how a history of substance abuse impacts on housing options. This has implications for the type of person recruited to the roles and the skills and knowledge required for successful delivery.

**Referral process**

It is important for healthcare professionals to understand the role and remit of the HSC and to be familiar with the appropriate referral process. Late referrals pose problems for the HSC and do not give time for suitable accommodation to be located, particularly if the service user needs are complex, or if they are homeless. Although the principle of referrals is the same for both HSCs, in practice it works differently across the two hospitals. The Pinderfields HSC referrals often receives referrals much later, sometimes just before discharge, compared to the Fieldhead HSC which are usually received within a few days of admission. Reasons for this were possibly due to the different patient groups at each Trust, the elderly care patients at Pinderfields are often transferred into respite care where they can be

assessed to get a full picture of their housing needs, or down to more awareness and understanding of the HSC role amongst ward staff and consultants at Fieldhead. Delays can also occur when healthcare staff refer service users to the service without their prior consent which is a key requirement of the service.

There was no pattern to referrals - some months they were higher than others. Rates of referrals were dependent on whether current inpatients had housing related issues (not all patients needed the HSC support). Despite fears, referrals did not appear detrimentally impacted by Covid-19. It was difficult to plan an optimum case load because each person required different amounts of support and the HSC needed capacity to provide immediate support to new referrals because of the need to solve housing issues quickly to facilitate a suitable hospital discharge. Overall the HSCs felt they were working pretty close to capacity. This indicates that any further proportion of the HSC role such as on different wards needs to be accompanied by increased hours/additional HSCs.

**Key components of the HSC service**

**There appears a number of key components of the HSC service including:**

- **Facilitating communication with health care professionals and service users which helped to keep the discharge process moving forward –** HSCs are in constant communication with service users and other members of hospital Multidisciplinary Team (MDT). Regular contact with service users and the MDT is essential as people's needs may change during their admission, which has implications for the types of support they require on discharge. Part of this communication included attending regular joint meetings with various healthcare teams. Particularly in Fieldhead, the HSC was considered a valued member of the discharge team and was well embedded within the hospital. It was apparent that the HSC has strengthened joint working between housing and health services.

  Although communication between service users and the HSC was generally well received, there were instances of some people not being satisfied with the communication they had received mainly because they felt unable to build up a relationship with their HSC. For example, one participant felt that they had not received much communication from the HSC without the presence of other healthcare professionals which altered the power dynamics. Some service-users felt that there needed to be better communication with the HSCs and different professionals to ensure there was consistent messaging

and support. Some of the dissatisfaction with the service was related to unrealistic expectations of the service and the housing options available (discussed further in the impact section).

- **Facilitating referrals to a range of other agencies and services and to in-house support** - Supporting people to access appropriate services was key, with over three quarters of people (n=376, 77.7%) being supported by the HSC to access further support. The organisations were wide ranging - relating both to housing but also wider financial and wellbeing support. Services included Wakefield District Housing Estates Team, Cashwise and the Adaptions Team. Many of the services referred to were also delivered by WDH, highlighting that there may be benefits from the same organisation delivering a range of housing related services as it facilities referral between support and prevents a service-user from feeling they are being passed onto multiple organisations.

- **Length of support -** Support from HSCs was generally short, with over half of service-users being supported for less than a month (n=296, 61.9%). Less than 10% of people were supported over 6 months. Whilst the HSC is viewed as a an intermediary service, there was desire from some service-users and other stakeholders for the HSC to be able to provide support post discharge to be able to resolve outstanding housing issues and to provide a point of support if further housing issues arose. The latter is relevant because service-users were often discharged to temporary housing situations. Occasionally in Pinderfields support was provided post-discharge and this approach could be developed further (discussed further in developments section).

# Impact of the service

The impact of the service was multi-layered- having an impact on HCPs, service users and the hospital system. Impacts included:

**Having a positive impact on the hospital discharge pathway-** HCPs felt that the introduction of the role had improved the overall hospital discharge system, reducing unnecessarily delayed discharges and average length of stay. In particular, the service had assisted in discharging service users who had received effective treatment and were feeling stable in their mental health, who otherwise would have had to remain in hospital for a longer period of time due to housing related issues.

**Relieving pressure on healthcare services and HCPs-** Healthcare staff at all levels commended the service for alleviating pressure on overstretched healthcare services and dramatically lightening workloads. Having a dedicated person with specialist knowledge of housing related issues was very valuable for improving overall hospital services but also by reducing pressure and stress on individual clinical staff who do not have the time or specialist skills or knowledge to appropriately deal with housing related issues. HCPs felt that the HSC service should continue to be funded and potentially expanded.

**Impact on housing outcomes -** Based on the routinely collected data, there were a variety of housing outcomes that service users experienced and these differed in the acute and mental health setting. In Fieldhead, the most common outcome was people remaining in hospital after the support was complete (n=49/225) (21.8%) or people moved to temporary accommodation (n=35/225) (15.6%). The staying in hospital outcome is generated from a standard outcome from the WDH database. Given this, it is important to contextualise this. It may occur because the HSC in Fieldhead provides support to people early on during their hospital stay, putting in plans for their housing so that when they are medically ready to be discharge, they can leave. Because of this, service users will remain in hospital once the HSC support finishes because of medical need. Within Pinderfields, the most common outcome was people going home to WDH accommodation (n=47/236) (19.9%) or temporary accommodation (n=42/236) (17.8%).Other outcomes include returning to their own home, moving between accommodations such as from non-WDH to WDH housing or moving into a care home. The outcome of being moved to temporary accommodation is partly because in the acute sector people are more likely to move to intermediatory care beds to be assessed.

**Opinions on the support provided by the HSC**

Service users generally valued the support provided by HSC - feeling that the HSCs were knowledgeable, supportive and kept them informed. Service users found it reduced their stress knowing that someone was taking responsibility for dealing with their housing issues.

Some people still valued the HSC service, even if their housing issues were unresolved. There was a small proportion of people who were dissatisfied with the service which largely related to people not having their housing issues resolved. Sometimes this was because of external issues like the appropriate accommodation not being available or having unrealistic expectations of their housing options. For

other people, communication within the service could be improved. This entailed HSCs being clearer about issues related to their proposed housing solution such as the potential costs involved or expectations about property management.

## Mechanisms of success

**A number of key components of the HSC service were identified including:**

- **Having skilled and experienced housing officers -** Having skilled HSCs was critical to the success of the service. Being able to deliver personalised support, focusing on the specific needs of each service-user appeared key, alongside skills in having difficult conversations with service users especially in terms of managing expectations on how their housing issues may (or may not be) resolved. To do this, HSCs needed prior experience of delivering housing related support and a wider knowledge of the different housing options and services. As the role was new and was not embedded within an established housing team, HSCs needed to be able to work autonomously and undertake service development as part of their role.

- **Developing effective relationships between different organisations** - Key to the success of HSCs is the importance of partnership working and developing good working relationships with internal and external services to support with housing and wider/health and wellbeing issues. Knowing what services exist for referral is key, particularly in relation to repairs or homeless services to reduce delayed discharges.

- **Embedding HSCs within hospital discharge teams** - This can take time and requires significant work at the start of the project to ensure the correct people are involved, and that agencies understand each other's remits, priorities and what the service can provide. The success of the intervention is also dependent on buy in from healthcare management to help promote the role.

- **Being embedded within Wakefield District Housing -** By being employed by WDH the HSCs were able to provide value. Some of the service users were already WDH tenants and some referrals came from within WDH. Furthermore**,** the HSC used their role to support service users access other services provided by WDH including debt advice. This 'added' value of having one provider deliver several housing related services within the region was beneficial not only in terms of facilitating referrals but also provided some

stability for service users in terms of not being signposted to multiple different organisations.

- **Providing patient centred support** - A major strength of the service was how each HSC tailored their support according to the population and individual need. Each participant had very individual, and often quite complex experiences. Taking a holistic approach, understanding how housing issues were also linked to prior experiences and future needs was key. The HSC service appeared particularly valuable for service users with more complex needs including:

    - Service-users that present as homeless
    - Service-users with a history of addiction to alcohol and/or drugs
    - Service-users who are refusing to go home.

- **Supporting homeless patients and other complex cases -** The specialist knowledge and support provided by the HSC to supporting complex cases was also a clear mechanism of success. The complexity of homeless cases required specialist knowledge of housing systems and a flexible, patient centred approach tailored to the circumstances of each individual. Before the HSC was in place, the hospital or community teams would make a referral to homeless services with no further follow up. Having a dedicated housing specialist involved with the homeless individual from the start meant that they provided consistency of support through the discharge pathway and beyond through referral to more specialist support if required.

## Challenges to delivery

There was a number of challenges to service delivery:

- **Organisational differences –** Where the role sits and is managed in each Trust affected how the HSC role worked. In Pinderfields, the HSC sits within the social work team and has access to council housing systems. In Fieldhead, the HSC sits within the wider healthcare team with management oversight from the healthcare service. In Fieldhead, the HSC is considered as part of the discharge planning team, they regularly attend discharge meetings, ward rounds and any other clinical meetings as appropriate. In addition, the Fieldhead HSC has access to NHS medical records and systems, and are therefore able to access notes made by other HCPs. In Pinderfields the HSC appears to feel less embedded with the ward staff and does not have the

same relationships with HCPs that have been established in Fieldhead. Being based in the social work team also impacts on timing of referrals as the HSC often receives them late in the discharge pathway and close to the SU is due to be discharge from hospital, which has implications for the support they can provide. However, being linked with the social work team means that the HSC has greater scope to provide post discharge support. It appears on balance, having the HSC role placed within a health and care team responsible for hospital discharge is important.

- **The availability of suitable housing and external services –** A key challenge was that service-users were often dissatisfied with the housing solution they were provided with. This was often because there was a lack of suitable housing options available such as social housing not being available in their area of choice. For mental health service-users, there was a lack of supported housing for people being discharged who wished for onward support with their mental health. In the acute trust there was a lack of suitable accommodation for those with complex physical needs (such as amputees). Often, whilst HSCs could help facilitate a more effective discharge and support in the community, they could not necessarily speed up how quickly someone was discharged because the delays were encountered within the wider system. This may mean that the service has more impact on supporting service-users and reducing the time HCPs spend on housing issues rather than necessarily facilitating shorter hospital stays. For example, if someone is awaiting adaptions to their housing, the HSC can organise these but the patient's discharge is still delayed until the necessary changes can be made.

- **Managing service user expectations -** Often there is little acknowledgement or understanding from service users on the external factors which impact on the support they may receive. It was apparent that a key part of the service was having difficult conversations with service users about the housing they required but also managing expectations about what housing was available. There may need to be ways of reiterating information such as providing written copies of information.

- **The complexity of people's housing and personal situations -** Many of the people supported had multiple complex issues alongside their housing problems such substance misuse, homelessness and financial issues. These issues could impact on what housing options were available to people. For example, difficulties with rent arrears or previous histories of violence, which then go on to preclude the SU from getting a further tenancies. HSCs had to

navigate these, acting as a conduit between the service user and the wider system. Often the service users themselves would often not be aware of this and the HSCs had to have difficult conversations whilst still seeking to maintain engagement and rapport.

- **Some service users needing longer-term or follow-up support -** Some service users desired onward support post discharge from their HSC, particularly when housing issues remained unresolved or new housing issues emerged and they did not know who they could contact to help address them. HSCs and housing management also agreed that specific housing related support (rather than medical) was required to prevent hospital readmissions.

### Impact of Covid-19

During restrictions Covid-19 created considerable challenges for both service delivery but also housing solutions. In terms of service delivery, the HSCs were no longer allowed on wards which at times was detrimental to engaging service-users and developing referral pathways with HCPs. For housing solutions, people faced barriers like not being able to review properties or finding it difficult to arrange repairs. However, this appeared to only cause short term disruption. The change to virtual and telephone-based working did not adversely affect service delivery or affect referrals, although some SUs missed face to face contact. Remote working was also found to free up valuable time which could be spent on providing support to other cases.

## Recommendations

We make a number of recommendations that are relevant for both improving the current HSC service and for those developing similar services in other geographical areas.

### Organisational and Management

- Our evaluation highlighted that for HCPs the service was vital and significantly reduced the time they spent supporting service users housing needs, enabling them to focus on other tasks. Committing to funding the service permanently rather than on a short-term basis would be beneficial. This would provide reassurance to HCPs that the HSCs support will continue but also help to

retain high calibre, experienced and effective HSCs who are at risk of leaving giving uncertainty of ongoing funding for the project.

- The working model should ensure that HSCs are placed within a health and care discharge team, with access to health and care IT systems, to ensure that there is the right awareness and support at a trust, managerial and ward level.
- HSCs need appropriate managerial support, within a patient flow or discharge team, from healthcare managers who understand the role, and can help promote it within the organisation.
- When establishing the HSC role, significant communication with internal and external agencies/charities will be required to ensure the correct people are involved, and that all involved understand each other's remits, priorities and what the service can provide. This includes working with ward staff and discharge teams to develop understanding about what constitutes an appropriate referral and when referrals should be made.
- There is not a clear pattern to referrals. There may be scope for increasing referrals across a wider range of wards but there would need to be further HSC resource to accommodate this given the specialist knowledge required.
- A clear strength of the service was the HSCs being embedded within the housing association due to its knowledge and access to other potential support services. The WDH model of delivering both housing and other services in the area such as debt support is advantageous because service users could be supported by one organisation and the HSC was aware of the support available. Given the benefits, a recommended model is that HSCs are based within an organisation which provides multiple services. If this is not possible HSCs should invest time in learning the availability and remit of different local services to ensure they reflect the complexity of service user needs.

**Background and experience of HSCs**

- It was clear that the background and experience of the HSCs were instrumental in the successful implementation of the role. Organisations need to appoint people who have experience in providing housing related support, have the ability to deliver person centred care, be pro-active in establishing relationships and can work independently. Appointing people with experience of supporting SUs with complex needs such as homeless patients, and an awareness of external services would be advantageous.
- Given the high skillset required to deliver the role, commissioners wishing to fund these types of services need to provide a pay scale which is appropriate

to the role to attract senior level housing officers who are comfortable with autonomous working and undertaking service development without the support of a wider housing team based within the hospital.

**Providing person-centered support**

- HSCs need the flexibility to shape their support to the individual needs of each service user. This includes the amount of support, means of support and considering issues beyond housing that may need addressing to facilitate tenancy sustainability, such as signposting to debt advice.

**Impact of external availability of accommodation and services**

- Whilst HSCs provided support they were constrained by what external housing options were available. Given this, commissioners need to consider funding the HSC service alongside increased investment in wider housing options and other services across the healthcare system. Although our research demonstrates some positive impacts from the service, it remains the case that even with HSC support, service-users cannot be discharged quicker from hospital if there is not suitable housing available to meet their needs.

**Managing Expectations**

- HSC need to manage expectations of SU and HCP from the onset:
    - SU need to be informed of what housing options are and are not available to them and why.
    - HCP and the wider MDT need to be aware of likely timescales regarding discharges.
- Given the vulnerable nature of the service user population, it is likely that this information will need reiterating throughout the process. It may be useful to also provide written copies of information.

**HSC Support Post Discharge**

- It was clear that many service users desired support from the HSC after being discharged from hospital, particularly when their housing issues remained unresolved, and they did not know who to contact to resolve them. We recommend that the process of onward support is streamlined across the two hospitals by introducing a system whereby the HSC follows up service users 6 months post discharge, checking in and providing patient centred support if

required at regular intervals (e.g. at 1 month and 3 months and 6 months post discharge) and if needed, to refer the service user to other services if applicable. This process may help prevent future readmissions for the most vulnerable service users.

**Homelessness support**

- It was clear that the HSC service was highly valued in the support of homeless cases but practically support was challenging. Reducing or removing ID checks for homeless individuals if the housing team can verify their identity would be beneficial to help streamline the process.

**Future research evaluation and the use of outcome measurements**

- Given the difficulties in recruitment and the comprehensive nature of WDH routine data, there is scope to develop the routine data collected by the HSCs to potentially include some evaluation questions or outcome measures (e.g. on whether people's housing situations cause them stress) to be able to better track the impact of the service and to justify further funding. This will also enable the partners to continue to develop the evidence base once the formal university-led evaluation finishes. It is also recommended that similar initiatives may want to ensure that their front-line workers are collecting information such as demographics, service received, outcomes and the service-users' perspectives to build up an evidence base on impact.

# Chapter 1: Background and Introduction

## 1.1 Background and rationale for evaluation

### The impact of housing issues on hospital discharge services

In 2020 there were estimated to be nearly 100,000 hospital bed-days attributed to delayed discharge from hospital of which a high proportion were linked to housing related issues (e.g., awaiting care packages, adaptations/equipment, awaiting care home referral) (NHS England, 2020). This is problematic because it is well documented that timely and successful transfer of care from the hospital to the home is vital for improved health outcomes for patients and reduced demand on services (NHS Providers, 2015). Issues with poorly planned or uncoordinated discharge can incur healthcare costs, increase risk to patient safety and lead to delayed transfer of care and hospital readmissions (Hesselink et al, 2014, NICE, 2015, Ohta et al, 2016). In March 2017, the Department for Health and Social Care reported a target to reduce bed days lost to delayed discharges to 3.5%. To support this, the Government invested £2 billion funding to address delayed discharge of care (Cornes et al, 2019). The new 2021-2022 Better Care Fund (BCF) policy framework also focuses on reducing length of stay in hospital and requires local plans to include improving outcomes for people being discharged from hospital (Better Care Fund, 2021).

### Housing and health

Within the context of an overburdened healthcare system and delayed discharges, there is increased integration of health, social care and housing providers to identify innovative solutions (Chevin, 2014, NHS England, 2014). Recognising the long-established relationship between housing and health (Shaw, 2004), social housing providers have played a role in addressing the public health related needs of their tenants (Power, Provan & Herdern, 2014). For example, the Housing+ programme currently being delivered in Sheffield, UK, allocates a dedicated housing officer to each household. Officers undertake an annual home visit with tenants to discuss issues wider than those relating to their tenancy, such as health, finances, crime, and community engagement, as a way of helping prevent problems reaching crisis point (Holding et al, 2019, Blank et al, 2018). Other examples of housing interventions include support for rent payments and housing improvements (Bambra

et al, 2011). Taking this perspective, there is potential for social housing providers to develop interventions to support hospitals with addressing delayed discharges due to housing issues.

**The impact of homelessness on hospital discharge**

Within the context of delayed discharge, there are additional challenges for people experiencing homelessness. Rising numbers of people experiencing homelessness since 2010 has had knock on effects on hospitals (St Martin's, 2020). Between 2010-2019 there was a steep increase in hospital attendances for people with no fixed address, as well as a threefold increase in emergency attendances and admissions to hospital by people experiencing homelessness since 2011 (Lacobucci, 2019). In one mental health trust, homelessness was independently associated with a 45 per cent increase in length of stay, and the need for housing was the most common cause for delayed discharge from hospital for homeless individuals (Tulloch et al, 2012). Leaving hospital is often a traumatic experience for people without a fixed address, and questionnaires suggest that 30%–70% of homeless inpatients are 'discharged to the street' (i.e., sleeping rough immediately after discharge) (Doran et al., 2013, Link, 2014). This causes considerable stress for people as other priorities rather than their health or recovery become their focus, such as managing street living by accessing hostels (Gelberg et al., 2004; Gunner et al., 2019; Wen et al., 2007), greatly increasing the likelihood of hospital readmission (Lewer et al, 2020). In 2013-2016 the UK government set up the 'Homeless Hospital Discharge Fund' which funded partnerships of NHS and third sector organisations to develop supported discharge services for people experiencing homelessness. The schemes varied and included (a) having housing specialists who helped people access housing services and community health service; (b) intermediate care facilities that provided accommodation and clinical support and (c) multidisciplinary teams (Cornes et al, 2019).

**The housing support and coordination service**

Recognising the issues of delayed discharge and the potential role of housing providers, several housing interventions aimed at improving hospital discharge have been developed. These include funding new housing related posts with responsibility for facilitating hospital transfer and an increased number of housing step down units (Chartered Institute of Housing, 2017, National Housing Federation, 2017). It was identified that there was a gap in the housing advice and support that is available to inpatients of Fieldhead Hospital, a mental health trust based in Wakefield, UK (part of the South West Yorkshire Partnership Trust). This lack of housing advice can

cause a delay for a patient being discharged from hospital if there are barriers encountered with finding or locating suitable accommodation in the community, particularly when the responsibility for locating housing falls to non-specialist members of staff. Homelessness was also identified as a particular issue impacting on the hospital discharge pathway, with patients often being admitted to hospital with no fixed abode. In response to this a social housing provider, WDH and South West Yorkshire Partnership Trust (SWYPT) agreed to run a pilot in 2018/19 (roll out April 2018) to understand the impact of a Support Coordinator (HSC) on hospital discharge.

The HSC works with the Fieldhead Hospital team to provide housing advice and support at the earliest opportunity to people in hospital and to help facilitate an efficient discharge to appropriate accommodation in the community. After identifying a similar gap in support and with emerging evidence that the service was being positively received in Fieldhead, the service was also rolled out in Pinderfields Hospital in September 2018 (Mid Yorkshire Hospitals Trust), a specialist acute hospital, also in Wakefield, UK. Homelessness was also identified to be an issue in the acute trust due to individuals not being able to return home as their housing no longer met their physical needs (e.g., due to an amputation).

Referrals to the HSC predominantly come from clinical staff on the wards at the point a patient is admitted to hospital and a potential housing barrier is identified which could prevent a timely discharge. Following receipt of a referral for support the HSC arranges a meeting with the patient to discuss any potential barriers to discharge. Dependent on the barriers identified the coordinator will either provide direct support to the patient, for example: to secure accommodation for when they are ready for discharge or refer the patient into other support services to facilitate their discharge. In some cases, the HSC provides continued support after discharge to reduce the risk of a hospital readmission via referrals or signposting to other services e.g., debt advice services. HSCs have provided support with issues including housing benefit applications, supporting people to access new accommodation, arranging repairs or care packages for people's existing accommodation and facilitating referrals to other support such as wellbeing services.

**Rationale for evaluation**

Whilst there are now a wide range of different interventions that aim to facilitate hospital discharge and support vulnerable tenants, there remains a dearth of evidence in relation to their effectiveness, cost effectiveness and impact on outcomes. Few evaluations consider the outcomes of importance to all relevant

stakeholders including individual patients (wellbeing, independence, reduced housing related concerns), housing providers (sustainable tenancies, reduced rent arrears) and health services commissioners and providers (reduction in delayed discharges, bed occupancy and costs). We aim to bridge this gap in evidence through an evaluation of the Housing Support and Coordination service in Wakefield, UK. This report presents the findings of our evaluation. The original idea and application for funding for the evaluation came from housing colleagues and the project was co-produced and delivered in partnership to meet their needs. As well as contributing to the development of the service, we hope our findings will have wider relevance for those wishing to develop and implement similar housing and health integrated services.

# Chapter 2: Methods

In this chapter we present our methods for this mixed methods evaluation involving a questionnaire, use of routine data collected by WDH and interviews with service users, the HSCs in each hospital and key NHS and WDH staff. This quantitative and qualitative data has been analysed and synthesised through the development of an intervention logic model. The economic evaluation will be reported in a subsequent report and publication (due March 2022).

At the time of ethical approval only one hospital had received concurrent onward funding for the intervention, therefore the qualitative interviews with service users and hospital staff all took place in Fieldhead Hospital (South West Yorkshire Partnership Trust) only. Interviews with current and previous post holders of the HSC role, the questionnaire and the economic element of the study took place in both hospital sites.

## 2.1 The Impact of Covid-19 on the evaluation

The study began on 01/01/2020 just before the outbreak of Covid-19. As this project is an evaluation of an intervention in two Wakefield hospitals, Covid-19 has had a significant impact on this study. We had planned to start fieldwork in June 2020 having obtained NHS ethics approval on 4th May 2020. However, we were unable to launch, as the NHS sites involved in the study lacked capacity to deliver the research due to increased workloads, an influx of Covid-19 related studies, staff sickness and restrictions on research staff visiting wards for consent procedures.

Despite the difficulties described above, the study formally launched in Fieldhead Hospital on the 26th November and Pinderfields Hospital on the 22nd December – six months later than originally proposed. At the time of launch both hospitals experienced an influx of Covid-19 patients because of the Delta variant, in addition to decreased staff capacity due to sickness. Due to the delays in the fieldwork starting and reduced capacity within the NHS sites, we reduced the sample size of the study, so that each site had a recruitment target of 20 rather than the planned 75. This reduction mainly impacted on the number of questionnaires completed.

## 2.2 Ethical approval

Ethical approval for this project was granted by North of Scotland Research Ethics committee and the Health Research Authority (REC reference: 20/NS/0050) (4th May 2020). We submitted several ethical amendments in response to Covid-19 to ensure the continued safety of participants and researchers involved in the project, and to add the economic element to the project.

As the study was NIHR funded, it was also adopted onto the NIHR CRN Portfolio.

## 2.3 Study management

**Management team**

Eleanor Holding is the overall project lead.

A project management group, including those team members coordinating and delivering the evaluation, met every month during the project via video call to oversee day to day management of the project. The role of the management group was to ensure the successful delivery of the project, including dealing with any site specific or data collection issues.

**NHS research teams**

In each site there was an NHS research team who had overall responsibility for coordinating all aspects of questionnaire recruitment. The NHS research teams met with key members of the project management team every two weeks to ensure the effective delivery of the project.

**Advisory group**

A project advisory group was also established to ensure the project was informed by academic topic experts and patient and public representatives. We recruited two public representatives to sit on the project advisory group who have been actively involved in study design and planning of the evaluation. In addition to topic experts the advisory group also included members of the existing project management group and other colleagues at Wakefield District Housing who are involved in the delivery of the intervention but independent from the sponsor/study researchers. The role of the advisory group was to provide ongoing advice on specific issues such as

regulatory and ethical review application, the suitability and acceptability of essential study documentation (such as consent forms/information sheets), study design, methods, and dissemination.

## 2.4 Aims, research questions and objectives

**Aim**

The aim of this study was to understand whether, through what mechanisms and to what extent, the HSC service has an impact on service user's health and housing outcomes, hospital costs and the process of hospital discharge.

**Research questions**

1. What are the characteristics of patients referred to the HSC and the reasons for referral?

2. What are the identified housing related and other non-clinical barriers to discharge?

3. What support does the HSC provide (e.g., advice, support, and referral to other agencies)?

4. What impact does the HSC have on the pathway to discharge, outcomes for patients (including their mental and physical health and housing situations), and the wider community?

5. What are the mechanisms by which the HSC may have an impact on outcomes?

6. What contextual factors influence the impact of the HSC role (e.g., availability of resources, access to other services, appropriate housing options)?

7. How do hospital staff feel the HSC supports the delivery of their role?

8. Does the HSC improve the experience of discharge for hospital staff and patients?

**Objectives**

1. To co-produce a questionnaire to collect relevant data on the characteristics of those referred, information on the support, referrals and interventions provided by the HSC and outcomes during admission and on or after discharge.

2. To collect data on all individuals referred on their clinical characteristics, support needs, pathway to discharge and housing outcomes

3. To conduct a qualitative process evaluation using in-depth interviews with the HSCs, intervention recipients, hospital managers and other relevant stakeholders as appropriate

4. To use the questionnaire and interview data to develop an evidence based "logic model" to describe both the intervention pathway and influence of relevant contextual factors.

5. To share the learning from the evaluation both to inform the viability and potential development of the service and recommissioning locally and to inform development to integrate health and housing services more generally through wider "health and housing" research and practice networks

## 2.5 Study setting

The study took place in two participating sites which currently deliver the HSC service; Fieldhead Hospital; South West Yorkshire Partnership NHS Trust, and Pinderfields Hospital; Mid Yorkshire Hospital NHS Trust in Wakefield, UK. Both sites have had responsibility for all aspects of questionnaire data collection, including identifying potential participants, seeking informed consent, questionnaire administration and data inputting.

## 2.6 Inclusion and exclusion criteria

The sample is defined as all patients aged 18 and over referred to the service during the data collection period. Those that lack the capacity to consent, who pose a potential risk to researchers (as identified by HSC/ward staff on referral to the service), or are unable to comprehend English, were excluded.

## 2.6.1 Inclusion Criteria

**Questionnaire (Pinderfields and Fieldhead)**

Adults aged 18+ referred to the HSC service in either Fieldhead (South West Yorkshire Partnership NHS Trust) or Pinderfields (Mid Yorkshire Hospital NHS Trust) hospitals

Able to provide informed consent to take part.

**Qualitative interviews with service users and NHS staff (Fieldhead only)**

Adults aged 18+ who have received support through the HSC service

Able to provide informed consent to take part

All staff involved with or have experience of the HSC service

In addition to the above we interviewed each HSC (and previous postholder if applicable) in both hospital sites, along with other key housing staff from WDH who are involved with or have experience in the HSC service.

## 2.6.2 Exclusion criteria

Any individual not referred to or having had any experience of the HSC service in Fieldhead (South West Yorkshire Partnership NHS Trust) or Pinderfields (Mid Yorkshire Hospital NHS Trust) hospitals

Staff members not involved with or who have no experience of the HSC service

Unable to provide informed consent to take part

Participating in the study may present a risk to themselves or others

Unable to comprehend English

Prospective patients with a Covid-19 diagnosis if face to face contact is required

## 2.7 Study design

The overall study design is a mixed methods process evaluation. Since the intervention is new and being modified in relation to staff roles, methods are appropriate to a “pragmatic formative” process evaluation (Evans et al 2015). The study comprises of 4 main components:

1. **Questionnaire and secondary analysis of WDH routinely collected data:** Questionnaires collected for new service users and for those already discharged from the service to understand their health housing related issues and the impact of the service. We also conducted secondary analysis on data that WDH routinely collected on service users to understand referral pathways and housing outcomes.

2. **Qualitative data:** In-depth interviews with service users who have been discharged from the service, the current HSC and the previous post holder in each site, as well as key health care professional and Wakefield District Housing staff who have worked with the HSC service or have been involved in the delivery of the intervention.

3. **Economic evaluation:** in the original proposal we included an economic analysis utilising routinely collected hospital data to understand the potential impact of the intervention on hospital costs. However, due to a lack of available hospital data on delayed discharges the proposed analysis was not possible. Instead, a What-If and Threshold Analysis was conducted to understand the potential savings from the introduction of the HSC service. This report is published separately and includes a framework for undertaking future economic evaluations. This will be of interest to other housing organisations wishing to implement and evaluate similar housing/health integrated interventions.

4. **Logic model:** Documenting the intervention as it is delivered and developing a logic model to map the range of potential pathways and activities between introduction of the new role and changes to the health and wellbeing of customers. This was informed by data collected in component (1) and (2) as well as by consultation exercises with stakeholders (housing staff, patient, and public involvement representatives, WDH, NHS staff) and a review of relevant literature.

## 2.8 Data collection and analysis methods

### 2.8.1 Questionnaire data (South West Yorkshire Partnership and Mid Yorkshire Hospitals Trust)

**Sample and recruitment**

We included two components to the questionnaire in order to maximise the sample size and be able to potentially include people who received the service before the start of the study (and before the Covid-19 pandemic):

(1) **Prospective:** This consisted of 2 time points (a prospective and follow-up) to understand people's experiences before and after receiving support from the HSCs.

(2) **Retrospective:** This was a one-off questionnaire for people who had been discharged from follow up by the HSC and not been recruited to the prospective study.

**Prospective questionnaire**

This part of the questionnaire involved asking service users to complete a questionnaire at two time points. The first time point was at the start of someone receiving support from HSC (so acted as a baseline). The second was administered 8 weeks later, to understand what had happened once someone received support from the HSCs. Having two time points enabled us to explore how things may have changed for a service-user.

On the initial questionnaire, we asked about:

- Participant demographics
- Reasons for being in hospital
- Reasons for needing support
- How their housing issues were affecting their mental and physical health (these are validated questions).

On the follow-up questionnaire, we asked what support people received, what had happened to their housing, whether their issues were resolved and how their housing

issues affected their mental and physical health using validated questions. We also asked about their views on the service.

**Retrospective questionnaire**

This was a one-off questionnaire for service users that had already received support from the HSC. Due to the delays of starting the data collection process, the retrospective questionnaire enabled recruitment of people who had been through the service when the study was on hold due to Covid-19. The questionnaire involved a mixture of questions from the prospective and follow-up questionnaires. It asked about demographics, information on the support they had received, their housing situation and their viewpoints on the service.

**Recruitment to the questionnaires**

**Current service users (Prospective questionnaire)**

On referral to the service, the HSC approached new service users as part of their initial assessment for the service. At this assessment, the HSC provided potential participants with a verbal explanation of the study and asked whether they would be willing to be formally approached about the study by the hospital research team. If they agreed, their contact details were passed on to the hospital research team who approached the service user to provide them with more information about the study (including the participant information sheet) and if they agreed, to take informed consent. Consenting participants were asked to complete the initial questionnaire whilst in hospital. They were contacted again 8 weeks later to complete the follow-up questionnaire. This was done either by post or telephone depending on the participant's preferred contact method. Again, this contact was made by the hospital research team.

**Service users who have already been discharged (Retrospective questionnaire)**

The retrospective questionnaire was posted to all participants who had received support from the HSC (excluding those that died or who requested not to be contacted about the evaluation on referral to the service). If the participant completed and sent back the questionnaire this was taken as implied consent to take part in this aspect of the study. For both questionnaire elements each hospital site inputted data onto a password protected excel spreadsheet which was securely transferred to the UoS for analysis.

**Challenges with questionnaire data collection**

When the initial research proposal was developed, it had been anticipated that the prospective questionnaire would be the main data source and there would be a sample size of n=150. However, there were several challenges which resulted in a significantly smaller number of respondents. These challenges included:

(1) The data collection period was significantly shortened due to delays in starting because of Covid-19.
(2) At times, the retrospective questionnaire was utilised more because it could be sent to people who had received HSC support whilst the study was on-hold. This provided useful information but prevented the before and after comparison.
(3) Members of the research team were not allowed on the wards because of Covid-19. This meant they had to try and get service users to complete the questionnaire over the ward telephone etc. For many service users, questionnaire completion would have been facilitated if the researcher had been allowed to visit and sit with them on the ward to build up rapport and support completion of the questionnaire.
(4) Each questionnaire returned required a lot of researcher time working with the service-user to build up rapport and get the questionnaire completed. It was not a case of simply posting out the questionnaire.
(5) There was a higher response rate amongst acute rather than mental health service users. This is a common occurrence in studies but was again a factor that contributed to low recruitment rates.
(6) No follow-ups could be collected from mental health service users. Many people were experiencing a mental health crisis at the point of the follow-up questionnaire, meaning that they could not complete the questionnaire. Furthermore, people's transient housing situations meant it was difficult for researchers to get in contact with people to complete the follow-up questionnaire.

Given the challenges of questionnaire recruitment, the response rate was lower than anticipated so we supplemented this with secondary analysis of WDH routinely collected data.

## 2.8.2 Routinely collected data

The HSCs recorded case notes on each service-user they supported. Some of this data was quantitative monitoring data on demographics, reasons for referrals, nature of support and outcome of support. They recorded the data on WDH's data management system. Given the richness of this, especially in terms of being recorded for every service-user, we felt it would be valuable to undertake secondary data analysis.

A data sharing agreement was established between WDH and the UoS before data was transferred. WDH extracted the data from their systems into an Excel spreadsheet and ensured it was anonymised before transferring. The data was transferred in June 2021 and consisted of data collected on all service users from the start of the HSC service. On receipt, the research team cleaned the data before analysis.

**Analysis of questionnaire and routinely collected data**

Descriptive analysis was undertaken on the continuous/categorical data (Field et al, 2009). For example, calculating mean days people had received support or presenting percentages of the different housing outcome categories. Where possible, we explored how people changed between categories on the prospective and follow-up questionnaire such as if they were feeling more in control of their housing after receiving support. Due to the nature of the data such as the low response rates to the questionnaires, we were not able to undertake more complex analysis such as whether there were differences in satisfaction with the service depending on the housing solution.

For the free-text questions on the questionnaires, we undertook content analysis. Identifying patterns and arising themes, such as how the service could be improved.

## 2.8.3 Qualitative data collection and analysis

Due to the outbreak of Covid-19 all interviews took place via the telephone or video call. Verbal consent was taken prior to each interview. Interviews were audio recorded with the participant's permission. An anonymised transcript of each interview was produced, following which the recordings were deleted.

Due to concurrent funding for the intervention not being agreed in Pinderfields Hospital prior to evaluation commencing the qualitative interviews with service users (SUs) and health care professional staff (HCPs) took place in Fieldhead Hospital only. In addition to the above we interviewed each HSC (and previous postholder if applicable) in both hospital sites, along with other key housing staff from WDH who are involved with or have experience in the HSC service.

**Sample and recruitment**

**Current service users**

Due to issues with capacity due to Covid-19 and the vulnerable/transient nature of the population we were unable to interview any current service users as per our original proposal (please see recruitment challenges for more information on the difficulties encountered with recruiting service users).

**For those already discharged**

In order to explore the impact of Covid-19 on the service and to compare outcomes with those who have been through the service prior to the outbreak we interviewed service users who have already been discharged from the service. A tick box option which asked new referrals to the service whether they would be happy to be contacted about the evaluation was included on the referral form in December 2019. A member of staff within WDH contacted patients who ticked that box (either via the telephone, post or email, depending on the service users preferred contact method) to ask whether they would be willing for their contact details to be passed onto a member of the UoS research team as part of the interview element of the study. If they agreed, the staff member at Wakefield District Housing telephoned a member of the UoS team to pass on their on the contact details over the telephone.

All service users who took part in an interview received a £10 Love to Shop voucher for their time.

**Challenges to recruitment**

The SU were recruited retrospectively through WDH whilst set-up was delayed in Fieldhead Hospital due to the outbreak of Covid-19. Due to the vulnerable and transient nature of the population and given that SU's were recruited through their involvement with a mental health facility it was not surprising that both the University research team and WDH officer encountered several issues during recruitment

(please see below for more information). This is reflected in the number of interviews that took place.

As stated above, SUs who had received HSC support were first identified by a Housing Officer from WDH, the Housing Officer then attempted to approach potential participants via phone. It became apparent early on in the recruitment period that this would not be a straightforward process as many of the WDH listed contact details were incorrect, or if they were correct people did not answer their phones. For those that did answer the Housing Officer gave a brief explanation about the interview study and asked if the SU would consent to their contact details being passed to the research team who would contact them with further information.
In the initial 22 weeks of recruitment through WDH there were 12 weeks where the research team did not receive any contact details for potential participants; 2 of these weeks were Christmas and New Year, and for one week the WDH Officer was on leave; of the remaining nine weeks there were no new SU on the list. Over the course of 22 weeks (September 2020-February 2021) WDH had 95 SU on their list to approach, but there were incorrect phone numbers for 32 of these therefore no contact was made. Possible reasons for this may the transient nature of this population, and unstable housing situations. The WDH Officer successfully spoke to 33 SU and 15 agreed for their details to be passed to the research team. There was a 2-month period (March and April 2021) where no further names were received from WDH, then in May and June 2021 contact was made with a further 8 SU. There were no new contacts in July and August 2021 after which recruitment to this aspect of the study ceased.

Overall, the research team approached 23 SU recruited via WDH, for 16 there was no response, or they did not want to take part. Reasons were not always given for non-participation, however, some reasons that were offered included worsening mental health conditions, being too busy and readmission to hospital. Seven people agreed to an interview in principle however, one person did not respond when trying to confirm a date for the interview, and another did not pick up the phone on the day of the interview.

**Healthcare Professionals and Wakefield District Housing staff**

In order to understand how the introduction of the HSC role has had an impact on the wider health system we invited HCPs who have experience or knowledge of the intervention, and the current (in both Fieldhead and Pinderfields Hospitals) and previous HSC post holders, to take part in an interview with a member of the research team. The study was introduced to HCP through an email or discussion

with the HSC and those who were interested in taking part were referred onto the researchers to make the arrangements for the interview. Similarly, key WDH staff were invited to take part in an interview via email by the UoS research team. A flexible approach to the timing and process of interviews was undertaken to minimise disruption to busy work schedules. Interviews took place over the phone or via video call due to Covid-19.

**Analysis**

Interview data was thematically analysed using framework analysis. Framework analysis involves using a 5-step process to organize and analyse the data: 1. Familiarization, 2. Identifying a framework, 3. Indexing, 4. Charting, 5. Mapping and Interpretation (Srivastava & Thomson, 2009). An initial thematic framework was derived from the in-depth reading of a small number of transcripts before being modified to reflect the emerging themes. The research team met regularly to ensure the validity of the thematic framework and to discuss any disagreements before a final coding framework was agreed and applied to the transcripts.

## 2.8.4 Logic model

A logic model is a concise summary diagram which maps out a pathway through an intervention, the links in the pathway, and the anticipated outcomes in order to develop a representation of the theory of change or logic behind the intervention. The aim is to identify assumptions which underpin links between factors of interest, and the intended short and long-term outcomes and broader impacts (Baxter 2014)

In this context an a-priori model was developed from the documentation outlining how the intervention was envisaged and how it was intended to be delivered (Figure 2). This initial model was then developed to reflect the new role as it was actually delivered and the associated changes to the health and wellbeing of customers Logic model development was informed by data collected in component (1) and (2) as well as by consultation exercises with stakeholders (housing staff, PPI representatives, WDH, NHS staff), and the consideration of key relevant literature. This allowed the final logic model to represent a more accurate picture of the intervention as it was delivered, the relationship to relevant contextual factors and the related actual, as well as intended, outcomes (Figure 3)

## 2.9 PPI involvement in evaluation

We have ensured appropriate patient and public involvement throughout the evaluation. Patient and public involvement representatives were members of the project advisory group and were therefore directly involved in the design and management of the research. A PPI representative was also recruited to the project at the funding application stage and was involved in the development of the research questions and overall project plan. The design of the study and associated documents were reviewed by SWYPT's PPI group (the 'Research Involvement Group') prior to submission for HRA and REC review. In addition to this, we conducted a sense checking workshop towards the end of the project where we brought together key housing staff (including both HSCs) to consult them on emerging project results and to sense check potential findings.

# Chapter 3: Description of participants

The following section provides a description of the characteristics of our study participants.

## 3.1 Qualitative and quantitative

Before exploring the themes in detail, we present some background and contextual information on participant characteristics.

**Participant characteristics of the qualitative interviews**

**Health care and housing professionals**

We conducted a total of 11 interviews with health care and housing professionals (Health care = 7, Housing = 4). Health and social care professionals held a variety of roles including managerial responsibilities and provision of direct patient care. All staff members working within Fieldhead Hospital who had worked with the Housing Support and Coordination Service were eligible for inclusion. In addition to interviewing health care staff, we interviewed key members of the housing team with knowledge of the intervention. Please see Table 1 for participant demographics and job roles.

**Table 1 – Interview participants – Healthcare and housing professional demographics**

| **Sample characteristics** | **N=** |
|---|---|
| **Gender** | |
| Male | 3 |
| Female | 8 |
| **Role** | |
| Housing support coordinator | 3 |
| Nursing | 1 |
| Manager (e.g., NHS and housing) | 3 |
| Medic | 1 |
| Allied health professionals | 1 |
| Social care | 2 |
| **Time in role (years)** | |

| | |
|---|---|
| Unknown | 1 |
| 1-3 | 6 |
| 4-6 | 2 |
| 7-9 | 1 |
| 10+ | 1 |

**Service users**

Five interviews were conducted over the phone due to Covid-19. We encountered several issues in recruitment resulting in the small number of interviews undertaken (please see recruitment challenges in methods section). The interviews were often quite challenging to conduct. Given the vulnerable nature of the population, at times it was difficult to decipher exactly what had happened including what was happening in relation to service users' experiences of the service and their housing journeys. This may be in part due to service user mental health issues, but also due to confusion brought about by the complexity of service users being supported by multiple services with overlapping roles and remits. We report here, to the best of our knowledge, on what the participant's personal experiences of the service were.

Participant demographics are shown in Table 2; interviews were conducted with two men and three women, with an age range of 22-66 years (mean 28 years). The living situation of participants prior to their hospital admission varied and included one living with family, one in a private rental, one in a housing association property, one in a council provided property and one who was homeless. All participants were recruited to the study after receiving housing support in Fieldhead Hospital. Participants had a range of different mental health diagnoses and reasons for hospital admission (please see following section). All participants identified as White British ethnicity when asked, and marital status was either single or divorced. No participants had dependent children.

**Table 2 – Interview participants - Service user demographics**

| **Sample characteristics** | **N=** |
|---|---|
| **Gender** | |
| Male | 2 |
| Female | 3 |
| **Age group (years)** | |
| 20-29 | 1 |
| 30-39 | 1 |
| 40-49 | 1 |

| | |
|---|---|
| 50-59 | 1 |
| 60-69 | 1 |
| **Marital status** | |
| Single | 3 |
| Divorced | 2 |
| **Index of Multiple Deprivation Decile based on postcode at time of interview (data only available for 4 participants)** | |
| IMD 1-3 [most deprived] | 2 |
| IMD 4-6 | 1 |
| IMD 7-10 [least deprived] | 1 |

**Questionnaire participants**

Within Pinderfields, 8 completed the prospective questionnaire (completed at the beginning of receiving HSC support), with 7 completing the follow-up questionnaire (completed 8 weeks after the prospective questionnaire). In Fieldhead, 8 people also completed the prospective questionnaire with no-one completing the follow-up questionnaire. This was largely because people were experiencing an escalation of mental health issues at the point of follow-up. Across both the acute and mental health services, there were 16 prospective questionnaires completed and 7 follow-up questionnaires.

In terms of retrospective questionnaires (a one -off questionnaire completed after receiving support), in Pinderfields,13 people completed questionnaires and 8 people in Fieldhead. Therefore, across both the acute and mental health services, there were 21 questionnaires completed.

Combining the prospective and retrospective questionnaires across sites, we collected responses from 37 different service users. This is approximately 7.6% of service users that accessed the HSC service during the study (please see Table 3)

The data collection period was substantially reduced due to Covid-19. Furthermore, even during the data collection period, recruitment was impaired because researchers were not allowed direct contact with service users so could not visit people on wards etc. to build rapport to encourage participation. There were challenges in Fieldhead collecting follow-up questionnaires because of people experiencing an escalation of mental health issues. Consequently, the number of people completing questionnaires was considerably less than anticipated. Therefore, whilst the questionnaire data provide some interesting information, in terms of

sample size, the evaluation relies more on the secondary analysis of routinely collected data, which was collected for all service users (n=488) (described below).

**Routinely Collected Data**

The HSCs recorded data on service users as part of their routine practice. This was provided to the research team for analysis. The advantage of this data source is that it captures all service users referred into the service and provides some informative data on who was accessing the service, their needs and housing destinations. The dataset included 488 service users referred from the start of the service until June 2021. This encompassed 238 service users from Fieldhead (service started in April 2018). The other 250 service users were from Pinderfields (service commenced in September 2018). We describe the demographics of these service users later in the next chapter when we discuss who accessed the service.

## Table 3 - Demographics of people completing the questionnaires

| | | Pinderfields | | Fieldhead | | |
|---|---|---|---|---|---|---|
| **Demographic** | **Variable** | **Prospective questionnaire (n=8)** | **Retrospective questionnaire (n=13)** | **Prospective questionnaire (n=8)** | **Retrospective questionnaire (n=8)** | **Total for participants across both sites (n=37)** |
| **Gender** | Male | 6 | 11 | 5 | 5 | 26 |
| | Female | 2 | 2 | 3 | 3 | 11 |
| | | | | | | |
| **Age** | 18-30 | 0 | 0 | 1 | 1 | 2 |
| | 31-40 years | 2 | 1 | 1 | 1 | 5 |
| | 41-50 | 1 | 1 | 3 | 0 | 5 |
| | 51-60 | 1 | 5 | 3 | 2 | 11 |
| | 61-70 | 0 | 3 | 0 | 4 | 7 |
| | 71-80 | 3 | 2 | 0 | 0 | 5 |
| | Over 80 | 1 | 1 | 0 | 0 | 2 |
| | | | | | | |
| **Ethnicity** | White British | 7 | 13 | 6 | 7 | 34 |
| | Mixed White and Black British | 1 | 0 | 0 | 0 | 1 |
| | White- Any other white background | 0 | 0 | 2 | 1 | 3 |

# Chapter 4: Findings

The following findings are based on the results from the questionnaires, routine data analysis and interviews with service users and health care and housing staff, cumulating in the development of a project logic model. Several key themes emerged from the analysis around the development and implementation of the role, including the impact of housing related issues on the hospital discharge pathway, as well as mechanisms of success and challenges, and outcomes and impact.

## 4.1 Contextual findings: development and implementation of the role

**Development of HSC role: the impact of housing issues on the mental health and wellbeing of service users and the discharge pathway**

The HSC roles were initially piloted in Fieldhead Hospital, supporting people hospitalised for mental health reasons in April 2018 and then rolled out in September 2018 to Pinderfields Hospital, an acute trust. There were several reasons for establishing the service: the wider policy context, and the impact on delayed discharge on the hospital system, staff time and needs of service users. Firstly, the policy context of the NHS 5 Year Forward Plan (NHS England, 2014) and then the NHS Long Term Plan (NHS England, 2019) acknowledged the need to greater integration of health with other types of services such as housing associations. This is because of a recognition about the need to take a holistic approach to supporting someone's needs, not just focusing on their health issues.

Before the HSC was in post, HCPs described how front-line clinical staff would deal with inpatients housing problems. The HCP did not have the specialist knowledge, contacts, or time to appropriately deal with often complex housing situations, causing significant and unnecessary delays to discharge. Hospital discharge delays also occur due to a lack of coordination across varied clinical staff groups with different remits, which can cause *'tension'* (HCP4) between clinical and community teams when dealing with housing related issues. For example, tensions can occur when hospital teams feel that the patient is medically ready for discharge, but community teams are still putting community support in place for the individual.

> "*It can cause delays because the community team will express concerns about there not being adequate accommodation in place for a*

> *person. But from a ward's point of view, that person doesn't need to be in hospital anymore. Erm, so it can delay discharge, but it can also cause tension between the ward and the community team"* (HCP2)

Additionally, when patients are particularly vulnerable and therefore need to be prioritised, delays can occur when clinical staff lack the appropriate knowledge to move patients through the housing system quickly. Before the appointment of the HSC role, it was acknowledged that there was not an appropriate system in place for dealing with housing related issues. As well as causing hospital delays and stress for clinical staff (please see impact section for further exploration), it was acknowledged that this was not providing the best care and support to the service-user.

> *"I think there was nobody in particular within the trust that they could go to with that specialist knowledge or understanding…. I think it kind of fell to the social work team in a lot of respect, and they were having to then contact people in housing and trying to work together to get those issues overcome, but nobody really had ownership of that housing issue. I think you know it's not a criticism around health or social care, I think it were just one of those things that you know people in hospital focus on their health and getting people well. And social care focus on a social care issue, but the housing issue is dropped through a bit of a net you know and nobody really knew, had that experience of what the solutions could be or what the pathways were"* (HSC4)

It was clear that housing related issues can result in a significant delay to hospital discharge. Amongst participants completing the retrospective questionnaires, about half felt their discharge had been delayed due to housing issues (Pinderfields: n=6 /13, Fieldhead: n=3/6). Interestingly a smaller number of people completing the follow-up questionnaire in Fieldhead reported feeling their discharge was delayed due to housing issues (n=2/7). These findings are interesting as one of the motivations for funding the HSC service was to reduce delayed discharge. The responses on the questionnaires indicate that even with HSC support, people may still experience delayed discharge because there are hold ups in other parts of the system such as waiting for beds within respite care. What is not known is whether the delays were reduced because of HSC involvement and whether the HSC input prevented other service users from experiencing a delayed discharge.

Across the HSC and HCP interviews it was clear that housing related barriers to discharge had a great impact on the wellbeing of service users. HCPs described how housing related issues was a significant source of stress for individuals which

exacerbated their existing mental health conditions. This would often become evident early on in discussions around the support needs for the individual.

> *"a lot of people's mental health is like, it's deteriorated because of housing situation, like housing circumstances… definitely people have now got a lot more recognition as to, you know, the impact of these things on people's mental health"* (HCP3)

**Implementing the HSC Role**

The HSCs discussed how, as the HSC role was a new one, developing it from the beginning was both challenging, yet rewarding. The challenge came from knowing where to start and being able to establish the necessary relationships with the healthcare teams and rewarding as it gave them "*full ownership*" (HSC2), and the ability to change things if they weren't working.

Both HSCs that were in the roles from inception identified that from the outset it was important to raise the profile of the role with both the hospital and community teams and establish good working relationships and referral pathways. The HSCs were able to raise the profile of the role and implement a smooth referral process by ensuring there was joint working with hospital staff, regularly attending meetings relating to hospital discharge and increasing the visibility of the HSCs on the wards.

> *"…..when I first started I, I made a point of sort of making myself familiarised with the different teams within the NHS…I attend their team meetings…and then I kind of went to, erm, introduce myself to the discharge team, the occupational therapy team within the hospital, sat in on some of the meetings, and it was at that point that I kind of started to identify where the referrals were gonna come from, whether it was directly from the hospital, was it from the hospital social workers and that's when I realised I kind of needed to make myself available to both sets of teams, so not only was I supporting the hospital social work team I needed to support the discharge team as well"* (HSC2)

There was also an awareness that there were already some discharge systems in place, so it was important to get an understanding of what they were to avoid duplicating, or replacing, processes that were already working.

**The nature of support provided**

HCPs described the HSC role as providing an important liaison function between clinical staff and housing and community services. The main components of the role included:

- Meeting with service users to understand their housing related needs and concerns (e.g., why they are unable to return home, types of housing required and whether they need further support to sustain their tenancies e.g., financial, health or via supported accommodation, etc.),
- Locating and arranging suitable accommodation (including completing housing forms/and applications if required)
- Signposting to external services to support them with wider health and wellbeing issues (e.g., financial management, tenancy support)
- Liaising with HCPs and other services and organisations such as the council to understand tenants' previous situations and issues (e.g., whether there have been previous issues with the tenant relating to antisocial behavior or rent arrears).
- Regular communication/coordination with HCPs, service users and their family members

> *"if we get a patient admitted to my care and say for example is suffering with depression, anxiety and there are issues around finances and housing, what normally happens is the [HSC] gets involved with the patient at the start erm and finds out if there are any concerns regarding housing…she would err have a formal meeting with the patient to find out where he was living before, was he homeless or did he have accommodation, what are the concerns why he can't return back there and then liaise with the local housing officials and find out what, what the problems are in trying to deal with these things…and coordinates with the occupational therapist and the nursing staff on the ward err, which, which again in turn coordinates with the family members to find out how best to support the individual."* (HCP1)

Further detail on what support was delivered is in the next section

## SUMMARY BOX

Before appointment of the HSC there was no system in place to deal with housing related issues that affect discharge, causing stress on clinical staff, service users and on the hospital system

The HSC act as a bridge between ward and community teams

HSCs have specialist knowledge to help patients move through the housing system

HSCs tailed their support to the individual service user, supporting them with a range of complex issues and to access onwards support post discharge.

## 4.2 Who accessed the HSC service

This section describes the characteristics of who accessed the service. We provide information on service users mental health and wellbeing, housing situation on admission, reasons for needing housing support and the impact of housing related issues on health.

Most service users were male, but the two services had different age profiles, with the HSC operating within the acute hospital supporting an older population. This has ramifications for the types of issues the HSCs were supporting service users with (Table 4).

**Table 4 - Demographics of service users**

| Demographic | Variable | Fieldhead (n=238) | Pinderfields (n=250) | Total (n=488) |
|---|---|---|---|---|
| **Gender** | Male | 158 (66.4%) | 167 (66.8%) | 325 (66.6%) |
| | Female | 80 (33.6%) | 83 (33.2%) | 163 (33.4%) |
| | | | | |
| **Age** | 16-24 | 30 (12.6 %) | 1 (0.4%) | 31 (6.4%) |
| | 25-34 | 52 (21.8%) | 11 (4.4%) | 63 (12.9%) |
| | 35-44 | 60 (25.2%) | 20 (8%) | 80 (16.4%) |
| | 45-54 | 50 (21%) | 32 (12.8%) | 82 (16.8%) |
| | 55-64 | 38 (16%) | 54 (21.6%) | 92 (18.8%) |
| | Over 65 | 8 (3.4%) | 132 (52.8%) | 140 (28.7%) |
| | | | | |
| **Ethnicity** | White British | 216 (90.9%) | 235 (94%) | 451 (92.5%) |
| | White Irish | 0 (0%) | 2 (0.8%) | 2 (0.4%) |
| | Asian British | 4 (1.7%) | 0 (0%) | 4 (0.8%) |
| | Asian/Asian British Indian | 1 (0.4%) | 2 (0.8%) | 3 (0.6%) |

| | | | | |
|---|---|---|---|---|
| | Asian/Asian British Pakistani | 1 (0.4%) | 1 (0.4%) | 2 (0.4%) |
| | Other White | 6 (2.5%) | 6 (2.4%) | 12 (2.5%) |
| | Other | 5 (2.1%) | 1 (0.4%) | 6 (1.2%) |
| | British Other | 1 (0.4%) | 0 (0%) | 1 (0.2%) |
| | Fujian | 1 (0.4%) | 0 (0%) | 1 (0.2%) |
| | Portuguese | 1 (0.4%) | 0 (0%) | 1 (0.2%) |
| | Romanian | 1 (0.4%) | 0 (0%) | 1 (0.2%) |
| | Polish | 0 (0%) | 1 (0.4%) | 1 (0.2%) |
| | Other Mixed Background | 0 (0%) | 1 (0.4%) | 1 (0.2%) |
| | Asian | 0 (0%) | 1 (0.4%) | 1 (0.2%) |
| | Missing | 1 (0.4%) | 0 (0%) | 1 (0.2%) |

Two-thirds of service users in both services were male (n=325,66.6%). This is an interesting finding as it raises questions about whether males have greater housing needs and why that may be or whether there is some unconscious bias in terms of who is being referred to HSCs. Issues to consider are: (1) whether there is a greater housing need amongst male service users and/or (2) whether there are barriers to women being referred to the service. When discussing this at the sense checking workshop, housing staff felt this may be because of men not presenting to the GP soon enough with minor problems such as issues with their diabetes which if not stabilised can lead to amputations.

The age profile of service users differed considerably between the acute and mental health services. Within Fieldhead, service users were from across the age ranges with over half of service users being under 45 years old (n=142, 59.6%). In contrast and unsurprisingly, in Pinderfields, over half of service users were over 65 (n=132, 52.8%). This contrast is important as it indicates that the nature of the service and the types of issues will differ between delivering the support within an acute or mental health trust. It also has implications for the skills a HSC may need, as working with a younger person with psychosis may require a different approach to an older person who has had a fall. This should be considered when recruiting people to HSC roles.

Most service users in both services were White British (n=451, 92.4%). There were a small number of service users from other ethnicities including Asian/Asian British and Other White. This highlights the need for HSCs to be aware of particular needs

arising from people's individual circumstances and highlights the ongoing importance of taking a person-centred approach.

**Service users' health and wellbeing and how this relates to hospital admission**

**Admission to hospital**

There were a range of reasons why people were in hospital. Amongst Fieldhead questionnaire participants, people were experiencing a range of mental health issues including psychosis, anxiety, depression, agoraphobia, and paranoid thoughts. In the interviews, some people spoke of how issues with their housing such as falling out with neighbours had contributed to a deterioration of their mental health. Where participants felt comfortable to share information on what led to their admission, people discussed events which included the fire brigade, police and/or family members or being held against their will due to the deterioration in their mental health.

> *"Yeah so, they came, and I wouldn't let them in the house. The next thing I knew the police were knocking on the door and they sent me to hospital. Once the police come you can't refuse them, can you?... That's what happened this time, earlier on this year in June, I came off medication….The doctor and the social worker and five nurses came, four nurses came.*" (SU2)

In Pinderfields, reasons for hospitalisation included amputations, strokes, fall related injuries and exacerbations of chronic long-term conditions such as MS and IBS. The range of reasons for hospitalisations has implications for the housing and support needs. In one questionnaire the participant said they were in hospital because of struggling to look after themselves. Anecdotally, the Pinderfields HSC reflected in discussion that many of the amputations stemmed from unmanaged illnesses like diabetes suggesting there may be scope earlier in the pathway to support people to manage not only their health conditions but also issues that affected their lives more generally like housing. Amongst questionnaire respondents, in Fieldhead, over two-thirds of service users had been hospitalised with the same condition previously (n=11/16). In Pinderfields, the proportion was lower, with 42.8% of patients reporting having been in hospital with the same condition previously (n=9/21). This highlights that for some people, their health issues are ongoing which have implications for their housing needs and indicate the scope to potentially provide a housing solution alongside other support to help reduce the likelihood or the length of future hospital admissions.

**Ongoing implications of health and wellbeing issues**

It was evident that many of the participants interviewed had complex lives and felt their mental health issues meant they struggled with everyday activities including for some, being able to live independently. Most participants interviewed had diagnosed mental health conditions for which they were currently receiving support from mental health or external related services and/or were taking prescribed medication. Some participants spoke of ongoing struggles with their mental health – including one participant who wished he still received support in hospital, and another who found it difficult to leave the house due to agoraphobia and anxiety. A small number of interviewed participants also discussed physical health problems alongside their mental health conditions, such as COPD. For some participants, their mental health conditions stopped them from doing the things they would like to do – such as leaving the house, living independently, or doing the shopping. One participant spoke of how they lost their home due to their mental health issues and a subsequent admission to hospital and were currently residing with a family member. They were hoping to make a recovery so that they could move into their own home and live independently again:

> *'It's my erm, anxiety side, yeah erm, I'll be free erm, that's what's stopping me from, from doing a lot of what I should, I used to be able to do…. having me own home erm and I'd be able to do the basics you know.'* (P5)

HCPs described how the service users were often vulnerable and had experienced complex issues, making their housing issues more complicated. Issues included imprisonment, homelessness, substance abuse, family breakdown, debt and safeguarding issues such as abuse at home. Furthermore, many had multiple hospitalisations. It was clear that housing was considered a complex issue with *'a whole number of factors that contribute to it*' (HCP5).

> "*I got admitted to hospital cause I were thinking all this mad crazy stuff cause of what were going on around me. You know, people were abusing my trust erm… I'm having a lot of problems at the moment and, and nothing's helping like having a lot of debt now I've lost my car, and then I've never missed a payment before it I'm always up to date on my insurance and everything and then all of the sudden just everything went downhill"* (SU4)

> "*I'd say more than half I think we have about 23 on the ward and at least half of them have been, you know, referred to [the service] for housing erm…a lot of people come in homeless as well. And yeah people just don't*

*seem to be managing at home or they've had a relationship breakdown and they're having to move out of that property or there's abuse going on or domestic violence… a lot of the patients do have housing relating issues or that's been a contributing factor as to why they're unwell.*" (HCP3)

**Length of time in hospital**

**Table 5 - Length of time in hospital**

| Length of time in hospital | Fieldhead (Mental health) (n=179) | Pinderfields (Acute) (n=245) |
|---|---|---|
| Less than 7 days | 3 (1.7%) | 34 (13.8%) |
| 1-2 weeks | 14 (7.8%) | 42 (17.1%) |
| 2-4 weeks | 31 (17.3%) | 57 (23.3%) |
| 1-2 months | 65 (36.3%) | 63 (25.7%) |
| 2-6 months | 49 (27.4%) | 38 (15.5%) |
| Over 6 months | 17 (9.5%) | 11 (4.6%) |

As would be anticipated, service users in the mental health hospital had a fairly long admission - with the mean being 79 days, so about 2 and a half months. Almost 10% of people (n=17) spent over 6 months as inpatients. A recent cohort study found that service users requiring rehabilitation or referral to accommodation on discharge did have significantly longer inpatient stays (Crossley & Sweeney, 2020). Interestingly this paper did not find homelessness increased length of stay, although previous studies have suggested this does impact on length of stay. Whilst it is not known whether this was the case for Fieldhead service users, it indicates that housing issues may increase length of admission. What is not known within this dataset is whether people's length of stay was less than it may have been without the HSC input. For cases where people have long admissions, it potentially provides opportunities for the HSC service. If they get involved with supporting people early in their admission, it can give the HSC sufficient time to organise the desired housing solutions and reduce the need to use temporary housing options.

Amongst acute inpatients, the mean admission length was 62 days, about 2 months. Whilst the mean was not much shorter than in the mental health hospital, there was a greater number of people having a shorter admission in comparison to the mental health hospital. Almost a third of service users were in hospital for less than two weeks (30.9%, n-=76) compared to less than 10% of mental health service users. Within the interviews, HSCs spoke about the challenges of supporting people with

shorter admissions. It also has implications for case load as HSCs need spare capacity to be able to provide immediate support to referrals experiencing shorter admissions. In the economic evaluation, we will be exploring how lengths of admission may differ between those who do and do not receive HSC support.

Questionnaire respondents were asked whether their discharge had been delayed due to housing issues. Over half of Pinderfields service users (n=9/16) felt their discharge had been delayed. The perceived amount of time ranged from 3 to 11 nights. Amongst Fieldhead participants, half (n=3/6) felt they had experienced some delay to discharge due to housing issues. The perceived number of nights was considerable higher than in Pinderfields, and included 7, 21 and 365 nights. Given people still experienced delayed to their discharge even when receiving HSC support highlights that whilst the HSC can support people with addressing their housing issues, the service does not eliminate delayed discharge because there will still be external factors detrimentally impacting on discharge e.g. waiting lists for accommodation. People will still face delays because of external factors like waiting lists for accommodation. For example, one questionnaire participant in Pinderfields commented that they spent an additional 7 nights in hospitals whilst awaiting for carers to be organised. Consequently, the benefits of the HSC may be more about helping service users have better housing outcomes and HCPs saving time spent in housing issues.

**Housing situation on admission**

In terms of housing situation on admission, a third of service users at Fieldhead were experiencing homelessness (n=79/239, 33.1%) and over a quarter were WDH tenants (n=65/239, 27.1%) (Table 6). In contrast, 14% of service users at Pinderfields were experiencing homelessness (n=35/250) whilst 40.8% of Pinderfields service users were WDH tenants (n=102/250). Service users were also renting from other housing associations, privately rented, or lived in owner-occupied properties. Notably, there was over double the proportion of Pinderfields service users who lived in owner-occupied housing (n=30/250, 12%) compared to 11/239 service users within Fieldhead (4.6%). The differences in housing situation on admission between Fieldhead and Pinderfields stems from the different populations that accesses service (e.g., age profile) but also indicates that the types of support provided will differ between a mental health and acute setting. The high proportion of people experiencing homelessness is important, because the HSCs at the sense checking workshop felt their input was especially valuable for these service users. This is discussed later in the report under mechanisms of success. On the questionnaire, some respondents provided additional comments indicating that there

current living arrangement were transient such as staying with family/friends temporarily or feeling forced out of their accommodation because of issues with neighbours.

**Table 6 - Housing situation on admission**

| Type of accommodation | Fieldhead (n-239) | Pinderfields (n=250) | Total (n=489) |
|---|---|---|---|
| Homeless | 79 (33.1%) | 35 (14%) | 114 (23.3%) |
| Lodger | 39 (16.3%) | 22 (8.8%) | 61 (12.5%) |
| Owner | 11 (4.6%) | 30 (12%) | 41 (8.4%) |
| Private | 19 (7.9%) | 42 (16.8%) | 61 (12.5%) |
| Registered Social Landlord Tenant other than WDH | 20 (8.4%) | 10 (4%) | 30 (6.1%) |
| Temporary accommodation | 6 (2.5%) | 9 (3.6%) | 15 (3.0%) |
| WDH Tenants | 65 (27.2%) | 102 (40.8%) | 167 (34.2%) |

Amongst the 15 people completing retrospective questionnaires, a third of people (n=5) were living alone. Three people were living with other relatives than spouses e.g., their grown-up children. Other scenarios included: 2 people living in shared accommodation (both Fieldhead), 2 with partners and 2 with spouses/partners and 1 person was living with friends. The number of people living alone or not with a spouse/partner highlights that some people's housing needs may stem from not having someone living with them who may be able to provide support such as personal care.

**Reasons for needing housing support**

From the qualitative interviews it appeared that there was a range of housing problems and housing related barriers to hospital discharge including: difficulty sustaining tenancies and looking after properties, unsuitable accommodation (e.g., due to mobility issues or a need for a supported accommodation to support their mental health), need to be closer to family and other forms of emotional support, issues with payments such a rent arrears or home adaptations. From the quantitative routine data there were some differences in barriers between the mental health and acute sector service users (Table 7). Within Fieldhead, the main barrier was homelessness, which was experienced by over a third of service users (n=90, 38.6%), followed by issues with current accommodation (n=73, 31.1%) and people being unable to return home (n=39,16.7%), e.g., due to previous violent behaviour,

disputes with neighbours and not looking after the previous property. In Pinderfields, the main barrier was issues with current accommodation (n=67, 27%), homelessness was also a prominent issue (n=46,18.5%). Service users at Pinderfields also faced barriers in terms of physical access of properties such as the property being inaccessible (n=33, 13.3%) and going to downstairs living (n=28, 11.3%). Some of the differences between barriers faced by service users demonstrate the wide range of issues that HSCs have to support, as well as the extensive knowledge they need of potential solutions. It also indicates how HSCs working within an acute or mental health setting will be dealing with different types of issues due to the population of patients and this may have implications for who is appointed to which roles, e.g., older patients with physical disabilities will be more likely to be on acute wards and have issues with access, adaptations and repairs. For example, an HSC working within an acute setting needs knowledge on adaptions and occupational health assessments, whereas an HSC working within a mental health setting needs greater knowledge of how a history of substance abuse impacts on housing options.

**Table 7 - Barriers to discharge experienced by the service users**

| | Fieldhead (n-233) | Pinderfields (248) | Total (481) |
|---|---|---|---|
| **Confined living** | 0 (0%) | 19 (7.7%) | 19 (4.0%) |
| **Current home unkept** | 0 (0%) | 14 (5.6%) | 14 (2.9%) |
| **Going to downstairs living** | 0 (0%) | 28 (11.3%) | 28 (5.8%) |
| **Homelessness** | 90 (38.7%) | 46 (18.5%) | 136 (28.3%) |
| **Issues with current accommodation** | 73 (31.3%) | 67 (27.0%) | 140 (29.1%) |
| **Property is inaccessible** | 0 (0%) | 33 (13.3%) | 33 (6.9%) |
| **Refusal to go home** | 25 (10.7%) | 23 (9.2%) | 48 (10.0%) |
| **Repairs required** | 0 (0%) | 18 (7.2%) | 18 (3.7%) |
| **Ineligible for WDH accommodation** | 6 (2.6%) | 0 (0%) | 6 (1.2%) |
| **Unable to return home** | 39 (16.7%) | 0 (0%) | 39 (8.1%) |

In the prospective questionnaires, people were also asked about the issues they were facing with their property on admission to hospital. At Pinderfields, all 8 people reported that the property they were living in before admission was not suitable for their current needs, for example not having a wheelchair ramp. Four people needed support with their care. There were also a small number of people with the following issues: difficulties with the location of their property (n=1), difficulties paying rent/mortgage (n=1), homelessness (n=1) and the property not being in a good condition (n=1). In Fieldhead, the main issue was experiencing homelessness, with 5 of 7 participants reporting homelessness as the key reason they needed support. People expanded on the issues they were facing including needing to move because of difficulties with neighbours, financial pressures, and the lack of appropriate housing even when on a priority housing list. Two people did not feel that they had any housing issues. This raises issues about who is judging whether someone needs supports from the HSC and how HSC manage cases where the service user may not want support or do not feel they have housing issues whereas from the perspective of HCPs, housing related issues are preventing discharge.

**Impact of housing issues on physical and mental health**

Before receiving support, the majority of questionnaire respondents from both settings felt both their mental and physical health were detrimentally impacted by their housing issues, indicating the need to take a whole person approach to a person's needs. In the prospective questionnaire, the majority of Fieldhead service users felt their mental and physical health was impacted by housing issues (mental health: n=6/7) physical health: n=5/7). And in Pinderfields, n=6/8 people felt their mental and physical health was impacted a lot by their housing.

**Aspirations for support**

Questionnaire respondents were asked at the start of their HSC support, what housing outcome they hoped for on discharge from hospital. The majority of questionnaire respondents wanted to stay in the same area and either move into more appropriate accommodation (n=7/12) or have more support in their current accommodation (n=4/12). There was one person who wanted to move to a different area. As will be discussed later in the report, whilst the HSC sought to facilitate an outcome that was desired by the service user, sometimes there were external constraints which made this difficult to achieve.

**SUMMARY BOX**

Housing issues and needs are different between the acute and mental health settings and are linked to the characteristics of patients in these settings.

HSCs cannot necessarily prevent delays to discharge due to housing issues because of external factors however they may support other cost savings in the system like reducing hospital and community staff time on housing issues and better outcomes for service users.

The diversity of housing needs and aspirations require HSCs to tailor their support to the specific needs of service users and to carefully manage expectations of housing options and availability.

## 4.3 Referral process, description of support provided by HSCs and key components of the role

In this section we provide information on the referral process, including rates and sources of referrals, as well the support provided by the HSCs and the key components of the role.

**Referral process**

Upon hospital admission, HCPs assess the needs of an individual before deciding on appropriate care. If a housing related problem is identified during this initial assessment, and an individual gives consent, HCPs refer service users to the HSC service via a referral form, completed either by hand, email, telephone or face to face during a meeting with the HSC. During the referral process HCPs will provide further information on the patient's circumstances (e.g., whether they are homeless), reason for referral and the housing support needs required.

Although the referral process in principle is very similar for each HSC, the timing of when they receive referrals appears to differ. In Fieldhead, issues with housing and a need for the HSC support seems to be identified relatively early in the admission and a referral is made. Even if the SU is not at a stage to receive HSC input due to health issues or other concerns, they are in the system for when the time is appropriate. However, in Pinderfields referral times differ and often the HSC would receive referrals at the point or close to when the SU is ready for discharge. In many cases this is because the SU will be going into respite care before they would be ready for

discharge home. If referrals are received by the HSC late in the discharge process this has implications for the support the HSC can provide and the availability of appropriate accommodation. Delays can occur if HCPs refer service users without their prior consent which is a key requirement of the service. Supporting patients when it is unclear how long they will remain in hospital is also challenging and risks them losing appropriate accommodation if patients are unable to take up housing within the correct timeframe.

> *"I do have a bit of an issue sometimes with this because what I tend to find is sometimes erm, probably the discharge team are guilty of this the most they'll ring me up and say ooh we've got this patient who's homeless and they'll just think I can just get on and deal with it and I'll say well have you spoken to them have you got consent for me to be involved and they'll go oh I'll have to go back and have a chat with them."* (HSC3)

All service users discussed being referred to the service by hospital staff (such as ward staff or consultants) in hospital – but it was not always clear who the referring person was. Timings of referrals varied, with some people being referred to the service after some time in hospital, whilst for others it happened quickly after admission. Where this was discussed, participants were generally happy to receive the referral and felt that they needed support with their housing.

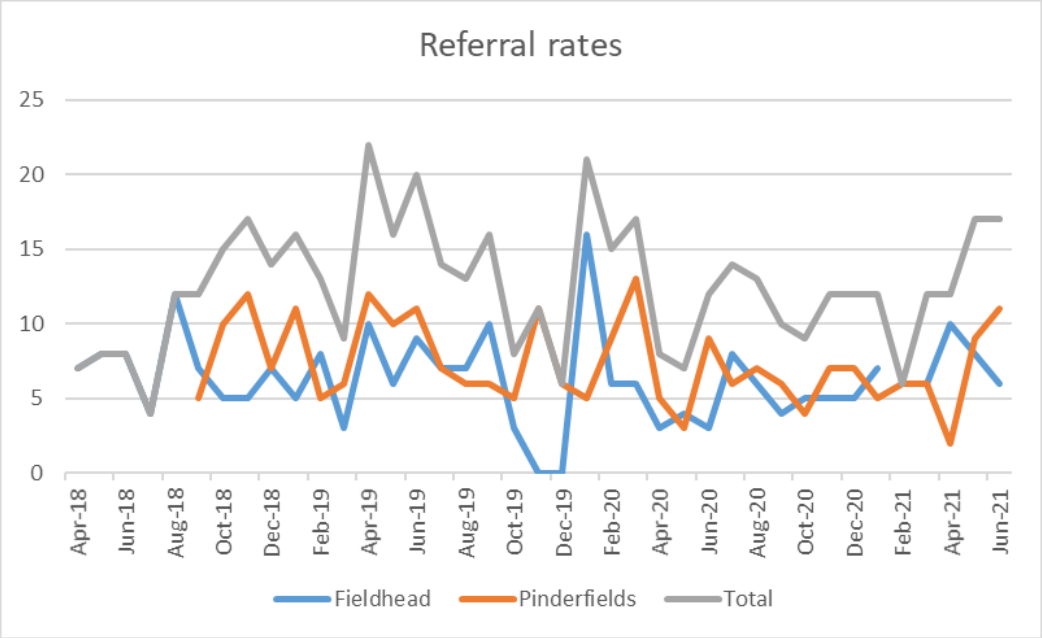
> *"I were happy that they were doing it actually because I wouldn't have known what to do myself."* (SU5)

**Rates and sources of referrals**

There were 489 service users referred to the project between April 2018-June 2021- 239 in Fieldhead and 250 within Pinderfields (service began in September 2018). As illustrated within the graph below (Figure 1) there is inconsistency in referral rates, with numbers ranging from 2-16 per service, per month. There was concern from stakeholders that referrals reduced because of the pandemic and whilst there are fewer referrals in April 2020 and February 2021, the pandemic generally does not appear to have had a noticeable impact on referrals. Referral rates are likely to be inconsistent because they will be dependent on the needs of the current hospital population. Planning optimum referral rates based on service capacity as well as patient need will always be difficult because each case requires a person-centred response and different amounts of input. Furthermore, the HSCs need sufficient spare capacity so that they can quickly respond to new referrals. At the sense checking workshop, the HSCs felt that there had some scope to increase referrals by

a couple of people per month, but they do not have the capacity to take on many more referrals.

**Figure 1. Rates of referrals**




There were considerable differences between Fieldhead and Pinderfields in terms of the number of referrals received from different wards. Within Pinderfields, a larger number of wards made referrals to the service indicating that ward staff throughout the trust know about the service and were actively making referrals. In contrast, within Fieldhead, over half of referrals came from one ward, with that specific ward making 136 of the 236 referrals (57.6%). A second ward made 55 referrals (23.3%).

Whereas most other wards made less than 5 referrals each, with 5 wards making only 1 of 2 referrals. It may be that some of the wards are considerably bigger or act as more as a step-down facility. However, reflecting on why there may be such differences between wards or why some wards only make one or two referrals is important.

We have information on who made the referral within Pinderfields. The majority of referrals were made by the Hospital Social Work Team (n=150/250, 60%). A further 68 of referrals (27.2%) were from the NHS, indicating some referrals were made directly from the ward staff. Interestingly, 19 referrals (7.6%) came directly from WDH indicating the benefits of multiple services being delivered by one organisation to facilitate people accessing a range of support.

**Range of support provided to service users**

Amongst the routinely collected data, the HSC recorded what interventions they supported with (up to 5). Given this, there will be more interventions than the number of service users. So, the amount of support was recorded for 194 service users in Fieldhead and 157 in Pinderfields with the percentages the proportion of these service users who received support with specific issues (Table 8). In Fieldhead, the two main types of support provided were with assisted bidding (n-122, 57.7%) and a home search application (n=116, 59.8%). In Pinderfields, support with a home search application was provided to over half of service users (n=83, 52.9%) along with providing an Application for Health and Medical Rehousing (n=87, 55.4%). Other support included help with rent arrears, organising a house clean, organising an occupational therapist visit and supporting people with being able to stay within their current accommodation.

**Table 8 - Interventions provided to service users**

| Intervention | Fieldhead (n=194) | Pinderfields (n=157) | Total (n=351) |
|---|---|---|---|
| **Arrears** | 13 (6.7%) | 9 (5.7%) | 24 (6.8%) |
| **Assisted bidding** | 112 (57.7%) | 21 (13.4%) | 133 (37.9%) |
| **Gas service request** | | 2 (1.3%) | 2 (0.6%) |
| **HM1 required** | 71 (36.6%) | 87 (55.4%) | 158 (45%) |
| **Homelessness referral** | 17 (8.8%) | 0 (0.0%) | 17 (4.8%) |
| **Home search application** | 116 (59.8%) | 83 (52.9%) | 199 (56.7%) |
| **House clear/clean** | 8 (4.1%) | 17 (10.8%) | 25 (7.1%) |
| **Housing applications with other RSL's** | 24 (12.4%) | 0 (0.0%) | 24 (6.8%) |
| **Sorting issues with current accommodation** | 6 (3.1%) | 0 (0.0%) | 6 (1.7%) |
| **Kirklees Housing Protocol** | 4 (2.1%) | 0 (0.0%) | 4 (1.1%) |
| **OT access visit** | 0 (0.0%) | 47 (29.9%) | 47 (13.4%) |
| **Repairs request** | 0 (0.0%) | 15 (9.6%) | 15 (4.3%) |
| **Standard of current accommodation** | 2 (1.0%) | 0 (0.0%) | 2 (0.6%) |
| **Sundry debts** | 6(3.1%) | 4 (2.5%) | 10 (2.8%) |

| | | | |
|---|---|---|---|
| **Support with tenancy standard** | 20 (10.3%) | 0 (0.0%) | 20 (5.7%) |
| **Sustainability of housing** | 31 (16.0%) | 0 (0.0%) | 31 (8.8%) |
| **Wellbeing support** | 13 (6.7%) | 0 (0.0%) | 13(3.7%) |

Questionnaire participants were also asked what support they received. This information builds upon the routinely collected data as we included some additional categories and highlights the range of support provided. Responses included:

- Organising a new place to live in same area- 8
- Organising a new place in a different area- 6
- Organising temporary accommodation- 4
- Organising repairs to be made- 4
- Arranged additional care- 3
- Signposting to further support e.g., debt advice- 3
- Supported with financial support e.g., applying for housing benefit- 2
- Showed me where to get further support e.g., debt advice- 2
- Organising adaptions to home- 2
- Facilitating support between different agencies- 1
- Organising for therapy assessments- 1

**Key components of the role**

**Facilitating communication between HCPs and Service users**

A key component of the service is the HSC having constant communication with SU and other members of hospital Multidisciplinary Team (MDT) to keep the discharge process moving forward, all aiming for a safe and effective discharge. This aspect of the role is key to the service and can be quite time consuming, particularly when service users are vulnerable and experiencing changes in their circumstances. In Fieldhead, communication with the hospital teams involved the HSC being directly involved in discharge and care coordination meetings on a weekly basis, with HCPs stating that the HSC was '*part of the team'.* In Pinderfields, this involved regular discussions, meetings, and joint visits with the social work team, as well as the HSC sitting with the social work team in the hospital (pre Covid-19). Most HCPs interviewed had regular contact with the HSC, either via email, telephone or face to face and were generally very positive about the communication between the HSC and the wider clinical teams.

However, in one interview it was acknowledged that timing was key, and that problems can arise if things are not communicated at the right time. For example, if the service user is receiving housing support in the community, but this has not been communicated by the HSC (e.g., via clinical notes or face to face), then duplication of support may occur. For this participant, '*there is some scope for improving'* (HCP6) communication between the community staff and the housing staff on the ward.

> *"I would say that probably the only downside that I have come across is that erm sometimes erm there might be like a delay between me knowing that someone is on the ward or with [HSC] their getting involved or the ward staff they won't, just with the nature of how busy things can be…. they won't necessarily look through peoples notes so there has been a few times like where I've been working on a particular issue with somebody for say like 6 months… and it all got a bit like frustrating. She was then going to, like going down her own path… and I was like you know oh no, we have already tried that, or done that so you know so yeah that, to get that update across to her wasn't that easy erm so it did kind of duplicate things a little bit*" (HCP6)

It was clear that HSCs were very skilled in building relationships with healthcare teams, and this is explored further under the mechanisms of success of the service.

**Regular communication with service users**

A key component of the role involves regular communication with SUs and their families. Most service users discussed how they had been in regular contact with the HSC during their involvement with the service, discussing how they had attended regular meetings either face to face or via the telephone (depending on whether the participant was being supported during Covid-19). Many participants were positive about the communication they had received and felt that they had built up a relationship with the HSC, with some stating that the HSCs were regularly available if the service users needed them. However, as SUs were engaged with multiple services (e.g., psychologists, care coordinators, mental health nurses etc.) at times it was not always clear whether they were discussing support they had received from the clinical teams or their HSC. This may be due to the HSC at Fieldhead being highly embedded within the clinical care team and attending ward round visits with patients.

> *"She came every, every week or when I needed her, you know, put anything on or sometimes I struggled erm, to get on and bid myself so she do it, she'd do it for me so she came round every week to see what were going on and when I needed her. Erm, you know, I could just ring her and she'd come over try and sort it out for me, so, yeah she was, yeah she, she were quite good."* (SU5)

> *"A good relationship, yeah, a good relationship…. we got on fairly well.*" (SU2)

However, some participants were not completely satisfied with the communication with the HSC that they had experienced. For example, one participant discussed how they felt that they had not had much personal contact from the HSC without the presence of other healthcare staff so were unable to build up a relationship. This indicates that there are different things that service users may want to discuss in the presence of heath care/housing staff, and that having several professionals involved rather than one to one sessions may alter the power dynamics and make it difficult for service users to discuss specific issues. Furthermore, one questionnaire respondent felt they had not been able to meet or speak to the HSC sufficiently to fully communicate.

> *"Honestly I didn't get much of a relationship going with her because it was …I had more talk with her when I were in the meetings with the [Consultant]… I did speak to her, but I don't think I got everything- I don't think I got everything fully across like I don't think she realised"* (SU4)

However, this could be partly due to this participant receiving support during Covid-19, and therefore only receiving contact via text or the telephone which they were not happy with.

> *"I didn't like it because basically I couldn't talk to her and it were mainly through text we were talking… I would have preferred to have spoken in person."* (SU4)

HSCs need to regularly check in with their SUs as their needs may change multiple times during their admission which has implications for the support they require upon discharge. In a sense each HSC acts as a coordinator facilitating communication between different partners – service users, professionals, and family members.

> *"it's just the constant check in actually, probably keeping up to date as to where somebody is, 'cause you know, things can change so rapidly with, with patients, especially when they're in hospital, it's not so bad if they've moved onto respite things are usually pretty static, erm, but, if they're in*

> *hospital it, it just changes from day to day whether they're medically fit, on day they're medically fit for discharge and then they're not and then something else happens and it delays it, so you're constantly checking where people are, what's happening, erm, so yeah it's pretty much, and just keeping in touch with people more than anything keeping in touch with all the people who I'm currently working with, letting them know where I'm at with everything"* (HSC3)

Even if service users have a prolonged admission, and are not fit for discharge for a significant period or are discharged to a respite facility, the HSC try to remain engaged with the SU and the MDT to ensure that the right things are in place when needed, although the approach post discharge support is not consistent and does not happen for everyone (please see the need for longer term support in the challenges section)

> *"…if I got a referral, I did what I needed to do, but I kept it open, and every week I used to ring that patient up on a Thursday because this is what to me part of the housing support role is supporting that patient until they're discharged, so if they're in for 6 months, then you support them the whole 6 months."* (HSC1)

**Facilitating referrals to other agencies and services**

A key part of the HSC role was referring people onto other services and support, both to help address housing but also other needs such as debt management advice. This could be referrals for help with financial management, or health and wellbeing support. The links with WDH Estates team also appear to be invaluable with helping tenants on a more ad hoc basis, or simply keeping an eye on them.

> *"it's making sure that the right services are involved with them to have a successful tenancy. Erm there is no point in just giving them a tenancy erm and then them failing because they don't know what to do, how to sign up for things erm so making sure that they are falling then onto the supporting services erm that are then available."* (HSC2)

Knowing which agencies to engage with for issues such as repairs or the cleaning of properties is of key importance in preventing delayed discharges, when the issue is not lack of accommodation, but ensuring accommodation is safe and suitable. Awareness of, and links with, charities able to support the homeless, or those needing supported accommodation are also referred to throughout the interviews.

These links with other organisations are reflected in that over three quarters of services users were referred by the HSC to other services (n=376, 77.7%) (Table 9). Referrals included to the Independent Living Team, the Neighbourhoods team, the Cashwise service and Adaptations team. In both the mental health and acute settings, the greatest number of referrals were to the Housing Needs Service (council homelessness) team and the WDH Neighbourhoods Team. Amongst Fieldhead service users, almost half of service users were referred to the HNS specialist housing team. As demonstrated in the table and not unexpectantly, there were some differences between HSCs in which services they referred to. For example, it was only in Pinderfields that HNC make referrals to the adaption team. Interestingly there are also referrals to services outside of the HNCs geographical area, reflecting that some service users are supported to move to different geographical areas.

The range of services people were referred to highlights the holistic approach the HSCs take- not just supporting with accommodation but also ensuring people get the support they need to sustain their home and to improve their wellbeing for example, referral to wellbeing services and getting debt management support. In this sense, the HSC is also acting as a ”social prescriber”; helping people access the support they need to meet non-medical needs.

Further reflection is needed on the impact on WDH as a whole in terms of the referrals from HSCs to the WDH services and whether these referrals would have been made anyway, but by different agencies or if having the HSC has resulted in increased referrals to other WDH services and whether they have the capacity to manage these. It also indicates that hospital staff would benefit from more training about the other services that WDH offers.

**Table 9 - Referral to other services**

| | Fieldhead (n=238) | Pinderfields (n=250) | Total (n=488) |
|---|---|---|---|
| HNS Specialist rehousing | 103 | 73 | 176 |
| WDH Neighbourhoods team | 116 | 38 | 156 |
| WDH Cashwise | 35 | 41 | 76 |
| WDH Estate Management | 28 | 38 | 66 |
| Housing application with other registered social landlords | 40 | 15 | 55 |
| WDH Independent Living Team | 18 | 27 | 45 |
| Housing needs service | 0 | 38 | 38 |
| WDH Adaption | 4 | 27 | 31 |
| Single Point of Access Service | 25 | 0 | 25 |
| Private Rented Accommodation advice | 20 | 3 | 23 |
| WDH Debt Management | 13 | 5 | 18 |
| Care Link | 0 | 11 | 11 |
| Connecting Care Hub West | 0 | 7 | 7 |
| ODA homelessness referral | 6 | 0 | 6 |
| WDH Wellbeing Team | 0 | 7 | 7 |
| Connecting Care Hub East | 0 | 5 | 5 |

| | | | |
|---|---|---|---|
| Other Local Authority Social Services | 0 | 5 | 5 |
| WDH Solutions | 4 | 0 | 4 |
| Home swapper | 3 | 0 | 3 |
| Kirklees housing solutions | 3 | 0 | 3 |
| LiveWell Wakefield | 0 | 2 | 2 |
| WDH Tenancy Advice Service | 2 | 0 | 2 |
| Calderdale Housing Support | 1 | 0 | 1 |
| West Yorkshire Fire Service | 1 | 0 | 1 |

Alongside onwards referrals, the HSCs supported two people to access financial help, for example, a grant to pay for a deposit to move into new accommodation.

Interview participants spoke highly of the HSCs going the extra mile to support them, for example one participant spoke about the HSC driving them round the new area including visiting the GP to help her settle:

> "*And she used to sit me down every week, she used to come every week and sit me down and go through the housing applications or if anything is updated and she even took me in her car to come in to the GP around here to know the area, she even took me in the car... She was a nice lady*" (SU1)

Examples like this highlight how much the HSCs tailor support to meet the needs of individual service users, this is discussed further later under Mechanisms of Success.

**Length of support**

The length of support provided ranged considerably between individual service users, demonstrating how the HSC tailor their support to specific circumstances (Table 10). On average, service users in Pinderfields received support for 6 weeks compared to 4.5 weeks in Fieldhead. In Fieldhead the intervention ranged from supporting people for 1 day to 255 days, with the mean being 32 days (so about a month). Over two thirds of people (n=162, 70.1%) were supported for a month or

less. This indicates that for many service users, the HSC is a relatively short-term service. In Pinderfields, the mean amount of support was higher at 46 days, just over half (n=134/248, 54%) received the intervention for 31 days or less. This is because in Pinderfields, some support may be provided after discharge. The differences may have implications for case load capacity. About 10% of service users required support for over 3 months (n=48, 10%). This links into a finding discussed later in the report about some people needing longer-term support from an HSC type of service in relation to sustaining their housing.

**Table 10 - Length of support**

| Length of time | Fieldhead (n-231) | Pinderfields (n=248) | Total (n=479) |
|---|---|---|---|
| **1 week (7 days)** | 54 (23.4%) | 57 (23%) | 111 (23.3%) |
| **1 week - 1 month (8 days - 31 days)** | 108 (46.7%) | 77 (31%) | 185 (38.6%) |
| **1-2 months (32-62 days)** | 37 (16%) | 48 (19.4%) | 85 (17.7%) |
| **2-3 months (63-94 days)** | 15 (6.5%) | 35 (14.1%) | 50 (10.4%) |
| **3-6 months (95-186 days)** | 14 (6.1%) | 23 (9.2%) | 37 (7.7%) |
| **Over 6 months (187 days)** | 3 (1.3%) | 8 (3.3%) | 11 (2.3%) |

It was apparent that the HSCs feel that their role includes a duty of care to ensure that there is some kind of ongoing support to facilitate a successful discharge and to prevent readmissions. What is less evident is what form this support should take and for how long.

The processes for onward HSC support differ in each trust, with Fieldhead providing support up until discharge, and Pinderfields providing some onward support post discharge if required. This is in part because Pinderfields is an acute hospital with a high proportion of elderly patients discharged to care homes or interim care beds, and the HSC may support people to transition into more permanent accommodation. All HSCs recognised the importance of follow-on support from external services to continue support in the community and reduce chances of hospital readmission.

*"…..I used to go see them at discharge meeting and then I used to say right I'll make an appointment and I'll come to your house next, in a weeks' time, and I used to meet the care coordinator there, and then I used to go to the property, meet the care coordinator, make sure everything were ok, erm and then I would discharge then, close it all down."* (HSC1)

*"….making sure that their supported once they have left hospital for whatever they might need once they have got a tenancy so obviously my work stops when they are discharged but they, they probably, more than likely, need support to carry on, so its making sure that the right services are involved with them to have a successful tenancy."* (HSC2)

*"Yeah well this is something that I've raised erm, sort of, I probably raised it at the very very beginning of the role, because I mean I wanted clarity about, err, where my role should end"* (HSC3)

From a management perspective there is clear understanding that having the right support systems in place on discharge is key to ensuring that a discharge is as successful as possible. However, at present the role does not have the scope to provide HSC input for a substantial period post discharge suggesting an opportunity for potential developments to the service (please see developments to the service section)

**SUMMARY BOX**

HSCs contribute to a more comprehensive and multidisciplinary approach to patient care and discharge.

HSCs act as a bridge between clinical groups involved in discharge.

Effective communication and the timing of communication is key.

HSCs provide a gateway to lots of other available support and to WDH in house services, acting as 'boundary spanners' linking up different sectors.

There is an indication that for some SUs there is a need for longer term specialist housing support after being discharged from hospital

## 4.4 Outcomes and impact of the service

In this section we focus on the impact of the service - both on the system and individual service users.

**Impact of HSC role on the discharge pathway**

All HCP's felt that the role was having a clear positive impact on the hospital discharge pathway by supporting people into appropriate accommodation, which has mutual benefits for the wellbeing of the service user and the hospital. Many discussed how the introduction of the role appeared to have improved the overall hospital discharge system, reducing unnecessarily delayed discharges and average length of stay. In particular, the service had assisted in discharging service users who had received effective treatment and were feeling stable in their mental health, who otherwise would have had to remain in hospital for a longer period of time due to housing related issues.

> *"And it's just been very effective in reducing delayed discharges. Obviously when we have got someone who is presenting as stable, it can be quite frustrating that we aren't able to move these service users on because there is an issue with housing. It has been really effective in that area. And really proactive in like I say, reducing the admissions. And one of my colleagues just said we need more [HSCs]"* (HCP4)

> "*it helps us to, I suppose if you look at it from…like a bed management point of view is that, when the service user's ready to be discharged, erm, if, the quicker we're able to find them suitable accommodation then the quicker they can get back into living their lives back in the community or wherever it is that they're, is appropriate for them, erm, and that's good for the service user and it's also sort of like good for the hospital as well and…it's a positive impact on the role of patient flow"* (HCP5)

In discussions around the impact of the service HCPs discussed issues with the previous discharge system. Prior to the HSC role in Pinderfields, if a housing issue was identified during the process of discharging to respite/interim beds the hospital social work team would refer the SU to the community social work team and discharge them from the hospital team often without any progress being made towards resolving the identified housing related issues; this inevitably could result in lengthy stays in respite for individuals. It was noted by HSC3 that as they took up the HSC post there were several immediate referrals for people who had been in respite

beds in care homes waiting to be rehoused upwards of six months simply due to the fact that no-one from the social work team had been bidding on properties for them. Having a housing officer with specialist knowledge and whose remit was to deal solely with housing related issues meant that potential housing problems could be dealt with alongside social care issues whilst in hospital/after discharge to an interim bed, speeding up the overall process and allowing social workers to provide support in a wider context.

> *"my argument was is that, you know I sit with the hospital social work team, I think, I think they're the ones who had the greatest difficulty with the housing issues…so within your council you've got [homeless] services and then you've also got social services within Wakefield council, so despite they're all under that same umbrella of Wakefield council they don't work that well with each other or sort of really know what each other's roles are, so, what I've found is that the social workers didn't really understand the housing process or what needed to be done to move people on and, and, just the simplicities of bidding on properties, erm, you know they didn't have the time or capacity to support people with that, so what I found was some people were in care homes and they'd been there for 6, 7 or 8 months, waiting to be re-housed and actually nobody had been bidding on properties and it was just ones like that, and that's what I sort of noticed is they don't have that time to be able to give to people to support them with that housing element"* (HSC3)

In Fieldhead, Before the HSC was in place, those who were unable to locate appropriate accommodation were likely to have to present themselves to homeless services once they left hospital, increasing the likelihood of homelessness:

> ***"****They wouldn't want them to stay in hospital indefinitely, if there were problems finding accommodation. So, in those cases, that person would probably end up having to present at the homeless services. And for some people that would be quite inadequate. It wouldn't really meet their support needs. Or we would be looking at trying to fund a placement, which might not really be appropriate but it was the only way to get them out of hospital*" (HCP2)

**Impact on healthcare services and individual job roles**

Healthcare staff at all levels commended the service for alleviating pressure on overstretched healthcare services and dramatically *'lightening the workload'* (HCP7). Having a dedicated person with specialist knowledge of housing related issues was

very valuable for improving overall hospital services but also by reducing pressure and stress on individual clinical staff. As previously stated, before the job role was in place, the responsibility for housing related issues would fall to front line clinical staff, such as nurses or care coordinators, who do not have the knowledge of housing issues and systems or the time to appropriately deal with the issue. At times, dealing with housing alongside clinical issues would cause significant stress for individuals, as well as '*difficulties and delays'* to the discharge pathway (HCP1):

> *It's definitely a vital role. I think, I've just been speaking to the team before I came in, just getting their feedback…. I think everybody is saying it's really beneficial to have someone who specialises in housing. I wouldn't know where to start if someone told me that they were homeless… And it takes the stress off both staff and service users. You know we are in an acute ward. We are very busy and it is time-consuming to sit down with someone and make all these referrals to housing about properties. It is just nice to have someone there who has got that dedicated time."* (HCP2)

This led some staff to discuss how they felt the service should continue to be funded and increased if possible – with more HSC's working across different wards.

> "*Absolutely [it has had an impact] and something we need more of. I understand we have got one housing co-ordinator for like three wards within our unit and I can imagine she is very, very busy but it is definitely a vital and beneficial role within our trust*" (HCP4)

For social workers in particular, due to the broad scope of the health and social care assessments that the hospital social work team carry out it was observed that there was a lack of knowledge, time and capacity to deal with specialist housing issues (e.g., searching for properties, support for bidding and applications)

> *"it became apparent that you know there were nobody really within the hospital or the social work teams that had that knowledge or experience of housing pathways and where these solutions could really be found when there were housing issues. So I think when it were identified on their system that it were a housing related issue that were preventing their discharge, I think there was nobody in particular within the trust that they could go to with that specialist knowledge or understanding."* (HSC4)

A small number of participants also discussed how the role had '*strengthened*' (HCP4) joint working between housing and health services. For example, HCP1 discussed how joint working between housing and health through a multidisciplinary

approach was considered beneficial for the hospital discharge pathway and the wider wellbeing of service users:

> *"it's more of a multi-disciplinary more comprehensive approach to erm patient care with regard to recovery and progression for discharge. Erm I specifically say that this has helped us to present discharge early err because this in the past has caused quite a significant delay regarding housing…And that gap is sort of that delays definitely being reduced for having a proactive housing coordinator*" (HCP1)

Another participant suggested that having a member of staff dedicated to housing had reduced tensions between clinical groups involved in hospital discharge:

> *"I think it's taken the stress out of it and a little bit of the tension; you know if you don't fully understand somebody else's role and you've got different priorities and things it can cause a little bit of conflict. But when you've got an actual person that you know of by name, that you can work with, it more co-operative*." (HCP2)

This, in turn had improved joint working and "*built that bridge*" (HCP2) between housing/health by improving knowledge sharing between services:

> *"It kind of built that bridge between the acute services and the homeless service, I suppose….Not only that but again it is building the knowledge on both parts of what the other service does*" (HCP2)

Overall, the role was described as extremely beneficial for removing stress from individuals job workers, improving patient experience and the overall discharge pathway.

It was noted by HSC3 that as they took up the HSC post there were several immediate referrals for people who had been in respite beds in care homes waiting to be rehoused upwards of six months simply due to the fact that no-one from the social work team had been bidding on properties for them. Having a housing officer with specialist knowledge and whose remit was to deal solely with housing related issues meant that potential housing problems could be dealt with alongside social care issues whilst in hospital/after discharge to an interim bed, speeding up the overall process and allowing social workers to provide support in a wider context.

> *"my argument was is that, you know I sit with the hospital social work team, I think, I think they're the ones who had the greatest difficulty with the*

*housing issues…so within your council you've got [homeless] services and then you've also got social services within Wakefield council, so despite they're all under that same umbrella of Wakefield council they don't work that well with each other or sort of really know what each other's roles are, so, what I've found is that the social workers didn't really understand the housing process or what needed to be done to move people on and, and, just the simplicities of bidding on properties, erm, you know they didn't have the time or capacity to support people with that, so what I found was some people were in care homes and they'd been there for 6, 7 or 8 months, waiting to be re-housed and actually nobody had been bidding on properties and it was just ones like that, and that's what I sort of noticed is they don't have that time to be able to give to people to support them with that housing element"* (HSC3)

**Impact on housing outcome**

Based on the routinely collected data, there were a variety of housing outcomes that service users experienced (Table 11) and these differed in the acute and mental health setting. In Fieldhead, the most common outcome was people remaining in hospital after the support was complete (n=49/225) (21.8%) or people moved to temporary accommodation (n=35/225) (15.6%). The staying in hospital outcome partly relates to the HSC being involved earlier in someone's hospital stay to try and get housing issues sorted, so they can be discharged when medically fit. It also may reflect that SUs in the mental health trust are likely to experience longer term issues with their health. Within Pinderfields, the most common outcome was people going home to WDH accommodation (n=47/236) (19.9%) or temporary accommodation (n=42/236) (17.8%). Other outcomes include returning to their own home, moving between accommodations such as from non-WDH to WDH housing or moving into a care home. The outcome of being moved to temporary accommodation is partly because in the acute sector, people may be move to intermediatory care beds. Only a small number of people did not engage in the service (n=6), and these were all mental health service users, highlighting that the reasons may be related to it being a mental health related admission and the challenge people face engaging in services when unwell. The number of people having an outcome of temporary housing or going back home whilst awaiting a new property highlights how peoples' housing issues can continue after being discharged from hospital.

**Table 11 - Housing outcome following support**

| | Fieldhead (n=225) | Pinderfields (n=236) | Total (n=461) |
|---|---|---|---|
| Failure to engage | 6 (2.6%) | 0 (0%) | 6 (0.87%) |
| HSC intervention complete, patient remains in hospital | 49 (21.8%) | 24 (10.2%) | 73 (15.8%) |
| HSC intervention complete- patient remains in respite care | 0 (0%) | 5 (2.2%) | 5 (1.1%) |
| Home (non WDH) | 24 (10.7%) | 24 (10.2%) | 48 (10.4%) |
| Home (non WDH) – Awaiting suitable housing | 0 (0%) | 14 (5.9%) | 14 (3%) |
| Home (WDH) | 30 (13.3%) | 47 (19.9%) | 77 (16.7%) |
| Home (WDH) – Awaiting suitable housing | 0 (0%) | 17 (7.2%) | 17 (3.7%) |
| No intervention required | 14 (6.2%) | 0 (0%) | 14 (3%) |
| Passed away | 0 (0%) | 5 (2.1%) | 5 (1.9%) |
| Permanent residential home | 0 (0%) | 15 (6.4%) | 15 (3.3%) |
| Police custody | 1 (0.4%) | 0 (0%) | 1 (0.2%) |
| Returned to lodgings | 30 (13.3%) | 11 (4.7%) | 41 (8.9%) |
| Sign up to new accommodation out of area | 5 (2.2%) | 0 (0%) | 5 (1.1%) |
| Sign up from non-WDH to WDH accommodation | 12 (5.3%) | 18 (7.6%) | 30 (6.5%) |
| Signed up for supported accommodation | 4 (1.8%) | 0 (0%) | 4 (0.9%) |
| Sign up to new accommodation WDH-WDH | 7 (3.1%) | 6 (2.5%) | 13 (2.8%) |
| Sign up to registered social landlord or other rental accommodation | 8 (3.6%) | 8 (3.4%) | 16 (3.5%) |
| Temporary accommodation | 35 (15.6%) | 42 (17.8%) | 77 (16.7%) |

### The impact of housing on people's health

One of motivations for commissioning the service was because of the extent worries about housing or inappropriate housing can affect people's mental and/or physical health and we found that housing issues continued to have a detrimental impact of people's health and wellbeing. Earlier in the report, we described how their housing issues were detrimental to their health. In the questionnaires, we asked people how their housing was affecting their physical and mental health to understand whether the detrimental impact of housing issues on people's health reduced after receiving support. Within both Fieldhead and Pinderfields, after receiving support, half of people completing the retrospective questionnaire (n=10/20) still felt their physical and mental health was detrimentally impacted by their housing issues. This indicates that for about half of respondents, even after receiving support, their housing situation was still detrimental to their health. This may be partly because as discussed throughout the report, the HSC could try to, but were not always able to solve people's housing issues because of the constraints of the availability of housing and delays to getting other support organised.

For individuals within Pinderfields who completed a prospective and follow-up questionnaire (n=7), 4 service users remained feeling that both their mental and physical health was detrimentally impacted from their housing issues. One person felt the impact of their housing issues on their health had increased during the period of getting support. There were only two people who felt the impact of their housing issues had decreased whilst receiving support- these people had their housing issues resolved. Whilst small numbers, it indicates that further exploration is needed about what further support people need to try and reduce the detrimental impact people's health is having on their housing, we discussed this further later in the report when we discuss post discharge support.

### Satisfaction with support

Generally, service users found the HSC helpful and were satisfied with the outcome of the service, even if their housing issues were not resolved. Of the 21 retrospective questionnaires completed, over three quarters found the HSC very helpful or helpful in their support (n=16/21). Two people, one in each service found the HSC unhelpful. Furthermore, the majority of people (n=6/7) completing the Pinderfields' follow-up questionnaire felt the HSC was helpful. One person was not satisfied as they felt sufficient support such as with the housing bidding process had been provided. People were generally satisfied with the support they received, for example, of the 11 people who completed the retrospective questionnaire, the majority were either

very satisfied or satisfied (n=7/11). Four people were very dissatisfied because they still had housing issues that had not been resolved.

Some participants provided feedback to emphasise their gratitude to the HSCs and satisfaction with the service:

*I am almost sure that without this help I would have lost my home*

*Very happy with the help I received. Amazing.*

*Was always very helpful and did everything she could to help*

*Everyone was kind and helpful*

*Felt safe and cared for*

*Because it's a nice flat*

*Helped me remain in the home I worked for & love*

*I was given lots of advice and support*

*Provided support and practical help that I would not have known about without her help*

*Fantastic feedback from my daughter about the service*

In the interviews with service users, it was clear that although the outcomes from the service had been mixed, the service has had a positive impact on the lives of some service users. For example, some participants acknowledged that they wouldn't have been able to access the support they required without the assistance of the HSC due to their ongoing mental health issues, including SU5 who was put on higher priority for council properties following support from the service:

> *"If I didn't have that offer and that service, I wouldn't have had a clue. Erm, where to start and where, were I'd be, I'd still be in bottom of the list. Er, not knowing, you know what I mean, erm, where I should have been really. Erm, but she, it were her that raised the issues of me house, issues and the meds bit erm, and, and they realised where erm, I should have been and I wouldn't, otherwise I'd still be at the bottom of the list*" (SU5)

Likewise, SU2 felt the service had a '*massive'* impact and without it they would have had to *'stay in hospital'* over a longer period. They acknowledged the traumatic nature of staying in hospital when you are otherwise well but are experiencing other barriers to discharge:

> *"[Without the service] I'd have had to stay in hospital… being in hospital with other patients can be very, very awful and nasty. And when you're basically spending the last couple of months there when you're well, waiting for this house, it has a dramatic effect on you.*" (SU2)

Some questionnaire respondents provided more critical feedback. Often the criticisms relate to service users feeling that the HSCs were not clear enough about requirements or they needed to manage housing expectations better. For example, one participant was dissatisfied with the service because they were not being offered housing in their area of choice, even though they believed that suitable properties had become available. So, there may be an issue about how to have difficult conversations with people especially in terms of managing expectations and their responsibilities:

*I was told that I was expected to decorate my house before I could move and be considered for another property.*

*I was led to believe I would be getting support with my hotel bills but after moving into my new home, I was left with debt which I have to pay weekly*

*Not yet been offered a flat in the area that I want to live in.*

*Not yet received support*

Many service users felt that the HSC should continue to be funded to help people, with one questionnaire participant also feeling the service should be expanded.

> "*Definitely yeah [it should continue to be funded], as much as possible and not only to people who are homeless, people who they can deliver a fresh place to stay, a nicer place to stay, better housing conditions or at least help to refurbish it."* (SU2)

> *"Yeah, erm, like I say, if I didn't have that offer and that service, I wouldn't have had a clue. Erm, where to start and where, were I'd be, I'd still*

*be in bottom of the list. Er, not knowing, you know what I mean, erm, where I should have been really. Erm, but she, it were her that raised the issues of me house, issues and the meds bit erm, and, and they realised where erm, I should have been and I wouldn't, otherwise I'd still be at the bottom of the list*." (SU5)

**Whether the service resulted in housing issues being solved**

Questionnaire participants were asked whether their housing issues were solved following support from the HSC. Amongst the retrospective questionnaire respondents, just over half of respondents felt their housing issues had been fully resolved (n=9/19) and 6 felt some had been resolved but there were still some outstanding issues. A small number of respondents people (n=4) felt none of their housing issues had been resolved. Amongst follow-up respondents in Pinderfields, whilst people were generally satisfied with the service, almost half of people felt their housing issues had not been solved (n=3/7). For example, one person was still in a temporary care home, another is waiting for repairs to be made to their accommodation and one has struggled to received support from further services that the HSC was organising. This indicates that people can feel the HSC support has been beneficial despite their housing issues not having been resolved.

Participants gave a variety of reasons for why their housing issues had not been solved:

- Someone's ill health contributing to continuing issues with housing
- One person has not been provided with the housing that they need as they are still on the waiting list and are unsure why they have not yet been offered a property.
- Still in a temporary care home because their old house is not wheelchair accessible.
- One person is still in their previous housing, which is not suitable for their needs, but no decorating has been done, which makes it difficult to move.
- Financial challenges to sorting accommodation
- Difficulty meeting WDH standards of keeping a property especially when health and financial barriers
- Not received further support from other agencies.
- Not yet been offered the accommodation need,

There were some participants who were satisfied with the service despite their housing issues not being resolved. Given this, it appears there are three potential outcomes for the service:

**Type 1 - Service users are happy with the service because their housing issues were resolved**

In these cases, the HSC had managed to get any housing issues sorted and the service-user was satisfied with the housing outcome:

> *"I ended up with this bungalow in [name of area]. It's the best bungalow on this block, block of eighteen and it's also one of the best properties you can imagine personally, to be honest it's a massive bungalow…it was the start that I needed. She arranged it, yeah." (SU2)*

**Type 2 - Service users who feel the service has been supportive even though they still have issues with their housing that are yet to be resolved.**

In these cases, participants were happy with the support provided by HSC, but their housing issues had not been fully resolved. For example, one interview participant who applied for a property through the service was now living with family as the application fell through after their discharge from hospital, and their previous property was no longer suitable due to its condition. They were not happy with their housing situation and wished for ongoing support from the HSC to locate suitable accommodation. However, they acknowledged that they were happy with the HSCs support and wished for the support to continue:

> "*It's, it made me, well, to be honest I thought I could do with her back right now the way things are, you know what I mean? But erm, so erm, do the same as what she were doing in the there because I know she didn't mess about and there were houses available. But erm, she, she cos she that's what she did, she, she, I wasn't at the top list but she made sure that I got, I'd got some, there was places and that available. So, I know when she were doing it erm I was getting offered some. But it were the housing situation that I was in that was stopping us so, so I could really do with her now that it's annoying if they'd passed erm, the property, you know what I mean, so sent is passed so I couldn't start bidding*" (SU5)

**Type 3 - Service users are dissatisfied with the housing service because they did not feel their housing issues had been sufficiently sorted by the HSC.**

There were also interview participants who were dissatisfied with the service because their housing issues were not resolved. As has been discussed, HSCs were constrained in the solutions they could provide, meaning despite their best efforts they could not always fully resolve people's housing issues in a way that the service user would like. For example, two of the participants who had moved properties due to help from the HSC service were not satisfied with the new housing because they felt they had lacked control and choice over their housing options. Both participants were particularly vulnerable and desired further support with their mental health. Another participant has declared themselves homeless as the HSC was unable to provide them with alternative accommodation and they refused to go back to the property they were in prior to their hospital admission.

> "*Well it turned out to be shared living …… and people were screaming and shouting and I came back out. I came back up here and that's when I had to put mesen on homeless…. I was expecting a flat, not a what do you call it? Not sharing*." (SU3)

**How the service impacted on people feeling they had choice in their housing**

We explored within the questionnaire whether people felt they had choice in where they lived and how this may have changed through receiving support from the HSCs. There were similar findings across both mental health and acute settings. Amongst the 18 people who completed the retrospective questionnaires, two-thirds of service users (n=12) felt they had choice in where they live. Eight of these felt they had some choice in deciding where they were living, and four people felt they had lots of choice. In contrast, there were 5 people who felt they don't have any choice in where they are living. Some of these respondents were unhappy with the service and the outcome, but not all were.

We also considered how people's sense of choice compared between and after receiving support from the HSC. We could only do this in the acute setting and the numbers were small, but it appears over half of service users did not feel they had choice in where they lived (n=4/7), two of these people felt they had less choice after receiving HSC support compared to beforehand. The lack of a positive change may be because after speaking with the HSC, service users realised that when relying on the social housing/social care system that there are more limited options than they had hoped for. However, despite this, participants were complementary of the

support they received from HSCs. They felt that the support helped them get on waiting lists for housing and got them moved into temporary solutions.

The issue of choice was also explored through the interviews. This came out strongly in two interviews with particularly vulnerable service users who were struggling with their mental health and felt they did not have choice or control over their housing situations, which exacerbated their mental health issues. One participant requested to be in a supported living facility to support their mental health but were instead put in a shared living facility, they subsequently declared themselves homeless in an attempt to access more suitable accommodation. In contrast, the other was put into shared living but desired to live independently and closer to family. One challenge is that the lack of housing stocks and external factors options means for some service users, there are limited housing options. Thus, for some service users, there is little the HSCs can do in improving the choice and control service users have in relation to their housing.

**Impact on wider outcomes**

As well as moving properties, service users discussed other outcomes relating to their health and wellbeing, which included successfully navigating the online housing system, receiving assistance with financial issues, and gaining higher priority when bidding for houses due to medical need. Providing support with complex housing systems and bidding are examples of the specialist knowledge provided by the service which health care professionals would not have the knowledge or time to provide.

> *"I wouldn't have been able to do it myself at that time. Erm, so she just basically said right, we'll figure out your finances and do your financial forms, we'll figure out, cos they needed that, er, to figure out the housing side and put, put, put me in where you need to be because I was on a low priority, then they, they'd put me on a higher one. So, she did that for me as well and then filled all the forms out erm, to do it anyway and now I can do it online, so I wouldn't have been able to figure that out myself."* (SU5)

In regard to wider outcomes, one service user who was struggling with mounting debt was supported by the HSC to access debt advice services. Through this support they were making progress rectifying their debts and were very thankful of the support they had received.

## SUMMARY BOX

HSCs provided a vital service which helps reduce workload and stress on other HCPs and services.

The HSC could provide specialist knowledge and support which were beneficial in terms of SUs health and wellbeing.

There were a range of housing outcomes following support which shows the diversity of skills and knowledge required from the HSC.

Most SUs found the HSC service helpful and were satisfied with the service, even when housing issues remained unresolved.

The HSC is not able to solve all housing issues as they are often limited in what solutions can be offered because of limited housing stock and other external factors.

## 4.5 Mechanisms of success, challenges faced and suggestions for service development

Building on the impact of the service, in this section we consider the strengths and weaknesses of the service and discuss how the service could potentially be developed.

# Mechanisms of success of the HSC role

Through the evaluation, we were able to identify several mechanisms that enabled the service to be successfully delivered. As well as assisting in the development of the service we hope the results will have relevance for other services wishing to implement similar interventions.

**Having skilled and experienced HSCs**

A key aspect of the success of the HSC role was the background of those holding the position, specifically in relation to relevant housing and service-user support experience. When the role was initially envisaged, and the subsequent job description developed, the management team had anticipated that knowledge of the housing process, and partner agencies would be beneficial.

> *"So we were looking for experience around partnership working, customer care and having that understanding and knowledge about housing but not just housing, housing within the wider context of what services were available in Wakefield as a whole."* (HSC4)

The interviews with the HSC demonstrated that this knowledge and experience was at the forefront of successful implementation of the HSC role. Each of the HSCs had come from customer facing roles within the housing service and had previous experience of supporting tenants with issues that were wider than those relating solely to housing. The current HSCs reflected that this experience had drawn them to the role and had been instrumental in its successful delivery. In addition, the previous experience of working within the housing sector also meant that there was a degree of knowledge regarding which other agencies may be linked to housing services. Experience of working within, or with, the WDH Estates Team also proved helpful as it gave an insight into the management of housing stock and previous tenant behaviours which may impact on their application for new housing, such as whether they had previous issues with violence or rent arrears.

> *"I think the background that I've got in the teams that I have worked with in the housing, so probably to, in particular the Home Search team erm that's really helped because I got a full understanding about who we let our properties to and how we let our properties erm how they are advertised so that I think that has really helped erm and also the Estates background erm in sort of knowing what is erm what we would class as an issue and what we would accept so in terms of how someone conducts a tenancy erm its about knowing how, what would be accepted, what, what would be managed and what would we wouldn't tolerate erm so that's definitely had a big helping hand."* (HSC2)

> *"I've worked for them for quite some time but erm, in a customer service role, so I started as a housing assistant which, that role was erm, customer facing in service access points, supporting service users, erm, tenants with housing applications with tenancy enquires, signing people up for their tenancies……and it was just all about being that first point of contact with any sort of housing related issue that sort of tenants or people who were looking for housing had."* (HSC3)

In addition, all HSCs highlighted how their previous work had benefitted their ability to perform in the role, more than one HSC talked about how they felt they had learnt a lot in the role and would be taking forward that experience into another work position.

> *"I can continue to do what I've experienced in housing support role I can carry it on in me job what I'm doing now you see."* (HSC1)

**Development of effective relationships between different organisations**

The importance of organisational partnerships and developing effective relationships was an essential aspect of the role in both trusts. This requires bringing together the right people to understand the remit and priorities of different agencies and promote cross-multidisciplinary support at a strategic level.

> *"I feel they will need to have formed good partnerships with the respective organisations because it kind of starts there really. I think they need to be clear on what the priorities are for the respective partnerships, for the respective organisations. What are their priorities and what are the issues for them at the moment? I think the need first of all if they haven't got them, to*

> *develop those patches but at a strategic level I think it needs because I don't think, I think that's what we learn from this, is to once we got around the right tables with the right people things started to happen. And I think we could talk all day at informational level and say that would be good, this would be good. But I think it's getting those discussions at a strategic level.* (HSC4)

It was clear that the HSCs had been proactive in developing successful working relationships with members of the healthcare teams, both in hospital and in the community, to ensure that people are fully aware of their role and what it encompasses. For example, HCPs in Fieldhead reiterated how the HSC was widely embedded within the hospital discharge system and was considered a valued member of the patient flow team. Joint meetings with housing/NHS colleagues were considered helpful for the HCPs as they were able to discuss individual cases and potential referrals on a weekly basis, and the HSC could keep up to date with wider discharge planning activities. This helped in facilitating joint working between organisations and improving the overall hospital discharge pathway.

HCPs also discussed how the HSCs are open to involvement in different aspects of housing issues, whether or not it is answering enquiries, helping with minor housing issues or responding to full referrals, and they have tried to ensure that other members of the MDT are aware of the many different ways in which they are able to help.

> *"Yes I feel so erm as soon as they have identified a housing related issue erm there's contact with me….they will ask and they don't just sort of ignore it so someone is identified….whether it is a full referral that is needed erm so yeah I think it's all, every, it's all linked in as it should be erm and they, they should be, they know when they need to be contacting me, erm and for what reasons erm so I do think that it all links in as it should and everyone is aware erm that I'm there and erm that's both in the community and in in-patient settings."* (HSC2)

**Onward referrals**

A key mechanism was HSCs spending time support service users to be referred and support by other appropriate agencies such as homeless services, debt support, wellbeing support and repair services which SUs/HCPs may not have been aware of or able to access. This is especially important in terms of helping people to transition post discharge from both the hospital and HSC support. In this sense, the HSCs plays a 'social prescribing role', helping people to get the necessary support for non-medical needs.

**Being embedded within Wakefield District Housing**

It was apparent that having HSCs who had an excellent knowledge of housing was a strength of the service. Awareness of how WDH worked, and the other agencies that may be involved with the SU due to their often-complex needs, was essential to help the HSC negotiate the often-complicated process of what housing options were appropriate for SUs, what housing options were available, and with which other agencies they may need to liaise. The HSC used their role to be able to support service users access other support provided by WDH including debt advice. This 'added' value of having one provider deliver several housing related services within the region was beneficial not only in terms of facilitating referrals but also provided some stability for service users in terms of not being signposted to multiple different organisations. From the qualitative interviews it was also clear that having HSCs with knowledge of WDH systems and who are embedded within WDH through previous roles was beneficial for understanding what services exist and which ones may be appropriate.

**Improving housing knowledge for HCPs**

In the sense checking workshop HSCs discussed how they had observed an improvement in the housing knowledge of HCPs since the start of the service – with HCPs taking more ownership and having more confidence to deal with housing related issues than previously. This is a key mechanism of success and shows how the HSC role could have a wider impact on the hospital system over time.

**Providing person centred support**

A major strength of the service was how each HSC tailored their support according to the population and individual need. During the interviews we asked the SU participants about their personal stories to provide context to their experiences with the housing support service. It became clear that each participant had very individual, and often quite complex experiences, and that no two stories were the same. The wide-ranging support provided by the HSC was also apparent from the routine/questionnaire data and shows how HSCs have extensive knowledge on the issues faced by service users and tailor their support accordingly. Patient centred approaches are a recognised component of high-quality care which involves putting the patient at the centre of the service to focus on their individual needs.

### Support for homelessness and other complex cases

Although supporting homeless individuals was extremely challenging (please see next section), the specialist knowledge and support provided by the HSC to supporting complex cases was also a clear mechanism of success. The complexity of homeless cases required specialist knowledge of housing systems and a flexible, patient centred approach tailored to the circumstances of each individual. Supporting complex cases such as homelessness is where the HSCs felt they had the most added value to the service. The HSC acted as an important liaison between the SU, the council homelessness team and WDH, remaining engaged with the SU as they move through the process. Before the HSC was in place, the hospital or community teams would make a referral to homeless services with no further follow up. Having a dedicated housing specialist involved with the homeless individual from the start meant that they provided consistency of support through the discharge pathway and beyond through referral to more specialist support if required.

## Challenges experienced by the HSC service

There were several challenges experienced in delivering the service.

### Organisational differences

Although both HSC roles are employed by WDH the two positions work differently because of where the role sits in each trust. Within Fieldhead, the HSC sat within the Patient Flow healthcare team with access to the same IT systems as the rest of the hospital MDT and is managed by a Healthcare Patient Flow Manager.

In Fieldhead it appears that the HSC has much closer links with the MDT on the wards that they cover. Prior to the introduction of homeworking due to Covid-19, HSC2 also physically shared an office with other members of the MDT such as occupational therapists and had more face-to-face contact with the rest of the MDT, attending ward rounds/case meetings regularly. HSC2 reflected that this helped in making people aware of their role, and that they felt part of the team, a view which was also shared by healthcare staff.

> *"I'm not a nurse or you know part of the nursing staff but I am part of the team and if we work together we get the outcome that we all want erm and that's someone to be discharged well and into the right accommodation."* (HSC2)

> *"Yeah, so, erm the [HSC] calls into our, well she's part of our team, the patient flow team so she attends sort of daily meetings with us, so we discuss any issues that we've got…"* (HCP5)

In contrast at Pinderfields, which covers a wider region, the HSC is based within the hospital social work care team and does not have the same closer links with the hospital MDT that they work with. HSC3 does not have access to the hospital IT systems and is not managed at a healthcare level. It appears that as HSC3 is not as embedded in the hospital trust, does not have the same support at a trust managerial level, and that their role is not as widely known, or as utilised as it could be.

> *"I've sat with a team, the hospital social work team and work on one of their laptops I have access to all their recording systems, so, for me, my role is probably sat more with them, but I've made myself available to the whole hospital because some people wouldn't come under the social work remit, erm, but I don't take any kind of direction or leadership from anybody there, which can be confusing."* (HSC3)

HSC3 is aware that there is perhaps a lack of prominence of the HSC role with some members of clinical teams in the trust due to her position within the social work team and has tried to improve engagement by sending reminders that they are there via email and presentations at meetings. However, the different way of working indicates that there may be a lack of awareness of the significance of the HSC role in facilitating discharges if they are not a visible presence on wards and in meetings.

> *"I think yeah it does definitely help erm, the health professionals I probably don't think the health professionals even know I'm involved sometimes though, I think sometimes you know, doctors wouldn't really know much about my role I don't believe I think it's the discharge team 'cause, you know the discharge coordinator sits on every ward they are sort of ultimately, erm, responsible for the discharge…chances are sometimes the housing issues wouldn't really become a doctors' concern necessarily."* (HSC3)

Historically for healthcare teams as the focus is on the mental or physical health of the SU it is clearer to see how HSC2, who is based within a healthcare team, can help relieve any housing related discharge problems as it would not necessarily be expected to be within a healthcare professionals' remit.

As previously noted, there are timing implications for the HSC based within the social care team as they often receive referrals late in the discharge pathway and close to

the time that the SU is due to be discharged from hospital. In addition, the length of support provision differs as for this HSC it often runs post hospital discharge, where the SU may be in an interim care bed, to support the work of the social care team and to prevent hospital readmissions caused by an inappropriate or unsuccessful discharge.

> "*so what the social workers do, they work really quickly to find this person a bed in the care home, they move into the bed in the care home and that's where their assessments take place and often the housing issue becomes a bit more apparent as well, 'cause it might be that they've been self-neglecting or it might be that they had a stroke erm, and they're now needing a care package but actually the property is also unsuitable so they need re-housing, so my role, I carry on work, I will work with that person and I'll take a referral 'cause they have been in a hospital setting, social work team have supported the discharge to move them on out of hospital but there is still this housing issue and part of the role is also to prevent re-admission, by resolving the housing issue straight away*" (HSC3)

After reflecting on where the HSC role would be ideally placed, either within the hospital discharge team or the social work team, both HSC3 and HSC4 suggested that the HSC as part of the hospital-based team appears to be a better working model due to a key element of the role being to facilitate effective hospital discharge. This would also require line management from healthcare staff to promote the role across the different health care teams.

> *"if they were to sort of introduce it into other areas, I think more presence up on the wards would be, would be beneficial, and whether it, you know does it need to sit with the hospital social work team, you know I would maybe question that maybe, you know if it did sit more with the NHS, erm, it might sort of change things a little bit"* (HSC3)

> *"my view is it needs some line management within the trust that can really promote the role. And I am aware there is a hospital discharge team within the trust. Now my thoughts are that's ideal where it would sit you know. It's about hospital discharge. It's about facilitating the discharge. All the wards have discharge co-ordinators and care co-ordinators. Again my understanding is that they are all managed as part of one team. Now my view is that [HSC] would be ideally placed within that team."* (HSC4)

Although HSC3 felt that their role would be better placed in the healthcare team, it was clear that the role had obvious benefits to the social care team, as they provided

housing knowledge and a capacity to deal with purely housing related problems, something that was missing from the team before the HSC appointment.

**Availability of suitable housing and external services**

A lack of suitable housing was identified as a key issue, particularly as it had an impact on delayed discharge or revolving door admissions. Our evaluation identified that there was a lack of post-hospital supported housing for mental health service users to support them with living independently. Furthermore, there was a need to continue the Covid-19 policy of housing people experiencing homelessness in accommodation. HSCs often referred people to complementary services like debt management. Locating this additional support was vital for people to be able to sustain their housing post discharge but this is dependent on the services being available. The interdependency of services is important when making commissioning decisions in terms of considering the impact of changing service provision on other support services and is considered further in the recommendations section.

HSCs raised the issue that a lack of suitable housing meant that service users were often discharged to housing that was not suitable for their needs. For example, discharging someone who was homeless with a history of dependency problems into a shared housing and the likelihood that this would lead to readmission.

> *"they want them to be discharged, there's nothing we can do so basically setting them people up to fail again because housing needs service just can put them anywhere, so they're amongst the people with alcohol, drugs and all that, so, so yeah, so…… there was the odd few that came back in, discharged, come back in, and it's a reoccurring, but then you see they start to look at the fact, why are they coming back in and half of the problem is they're in shared houses got back on the drugs and the alcohol because they're free of that when they're in hospital, and that's the reoccurring thing that causes it, so. …"* (HSC1)

In other situations, it can be the lack of a specific type of accommodation for physical needs.

> *"a gentleman I have just been supporting he was awarded a priority for a ground floor property with a level access shower and level access into the property, so no steps into the property. So he is only eligible to express an interest in that type of accommodation so if there isn't that type of accommodation then there isn't anything for us, for us, to bid on"* (HSC2)

The HSCs were often frustrated by the lack of housing available for those with particularly complex needs and people with mental health issues who needed supported housing after discharge.

> *"it's definitely the inaccessibility, erm, so then on the homeless side of things it's, again, the homeless people who have got, who are wheelchair users I think that's quite a big factor as well. Again, you know, amputees who are homeless who, you know, it's quite a big issue but there's no, there's no accommodation…"* (HSC3)

Service users also expressed frustration at the lack of suitable housing, and this had a detrimental impact on their experiences of the HSC service. For example, a lack of suitable accommodation to support mental health was a contributing factor in SU3's experiences of the service. Others expressed concern over wanting to be closer to family and living independently.

> *"I think it should but I think you should prioritise it in anywhere that's shared. I mean shared places they are alright but at least you have to share everything. You have to mix with people you know like can be scared of or summat and it's not good*." (SU3)

It was also apparent that service users expressed little understanding or acknowledgement of the external factors which may be impacting on what housing solutions could be arranged by the HSC. This has implications on the levels of satisfaction of the service and HSC's need to carefully manage expectations from the outset.

**The complexity of people's housing and personal situations**

The complexities of the characteristics and background of SU was often one of the greatest challenges to the success of being able to work with the HSC. Some of the barriers may be past behaviours when SUs were previous tenants, such as difficulties with rent arrears or previous histories of violence, which then go on to preclude the SU from getting further tenancies. For example, one service-user had their WDH housing application rejected due to a criminal convictions and previous rent arrears. It was challenging for HSCs because service users would not also understand the impact their background could have on the potential housing solutions. One HSC explain that:

> "*So probably the biggest challenger for me erm is around someone's previous behaviour. So if someone is wanting support and they are ineligible for accommodation with WDH erm due to behaviours it makes it really difficult because it's not only WDH it will be the same with the majority of all social housing providers so anyone that has been evicted from previous accommodation providers or social housing erm criminal convictions that are not spent erm makes them ineligible erm so that obviously really really reduces the amount of accommodation that is available to them."* (HSC2)

In other situations, people may not like the area, or the place that they are currently housed and so refuse to leave hospital as do not want to return to their previous accommodation.

> *"I've worked with people that have refused to go home, that's a big one that I get called in to do, as well, so, I've had people, you know where their properties actually been assessed as suitable, you know they can manage in the property, they don't need carers but they just don't want to go back."* (HSC3)

Due to the complex nature of the SUs personal circumstances some would also not engage with the service or would begin support before eventually stopping engaging with the HSC.

> *"we do get a lot of problems with like disengagement, you know, some people just want to be out and they'll just go and that's it they don't want any more involvement"* (HSC3)

**Supporting people who are experiencing homelessness: navigating challenges in the system**

Although supporting homeless individuals was considered a mechanism of success, the challenge of supporting SUs experiencing homelessness was highlighted many times throughout the interviews. The difficulties HSCs experienced in supporting homeless individuals were varied and were a result of several different contributing factors such as SU past behaviour or circumstances, lack of appropriate housing or SU disengagement. Even something small such as a SU lacking appropriate identification caused great difficulty when trying to register them on the housing system. It was clear that supporting people experiencing homelessness was incredibly complex and required knowledge of the housing and homelessness system, strong links with the council homelessness team and wider agencies, as well

as broad knowledge of health and wellbeing issues and the contributing factors which may lead to homelessness (e.g., such as substance abuse, family breakdown etc). It was also clear that support for the homeless through the housing system could be improved to better streamline the process, such as removing the need for identification for homeless individuals if the housing team can verify their identity.

> *"With the homeless cases, they are complex again by nature, erm, the fact that they're homeless suggests they may have had sort of drug or alcohol issues, criminal convictions and all those then add to the barriers of getting registered with WDH as well so, you know, to get through a DBS check with somebody who hasn't got any ID, is just, it's a battle in itself so to get them moved on out of hospital the option is to go to the housing needs service and to go to a hotel and then do the signposting to other services in the hope that that will then support them to look for permanent accommodation."* (HSC3)

> *"We have issues where people have been in temporary accommodation and they may have not paid the rent or applied for housing benefit to support the rent. Erm they may have trashed the property, the hotel rooms so they are not able to go back erm so that then also reduces the options that the homeless team then have. You know they have a certain amount of properties and hotels that they use for temporary accommodation and if there has been ongoing issues throughout a number of those it really limits what is available."* (HSC2)

The barriers associated with supporting homeless individuals sometimes meant that the HSCs were unable to locate appropriate housing before people were discharged, or that the individual became homeless again even after housing was identified due to SU disengagement with the service.

> *"There was a lot of homeless come through yeah, a lot of homeless yeah. But we've got barriers you see then because half of the time, erm, the homeless people that come through it has a knock on effect because we can't just rehouse them just like that, so they end up getting discharged to the homeless sections and they're back to square one again, erm, I have raised that within WDH to say that the fact is that these sort of people do need to be looked at more or less straight away."* (HSC1)

> *"I was very much aware that this chap was then street homeless, but he'd already, but really he has, he was discharged to a hotel, you know, it's on the discharge notes, he was safely discharged, but then in a matter of 2 days*

*he became homeless again, street homeless, and that, and that, I mean, stuff like that just doesn't sit comfortably with me, you feel like you take on that responsibility that you've actually not done what you've supposed to do, so, we can refer to erm, the rough sleepers, so I've, you know, referred him to them, but then when they went out he wasn't where he said he was going to be, you don't, yeah, and ended up having to say to him, you're gonna have to go back to Bradford and present to Bradford and they will be able to accommodate you but, he didn't want to do that and again it's this about patient choice, if they choose not to do something that you're advising is the best course of action, then that's ultimately up to them to do that but….."* (HSC3)

**Some service users needing longer-term or follow-up support**

Some participants wanted longer-term of follow-up support from HSCs after being discharged from hospital, especially those no longer satisfied with their housing situations:

*"I think, I think, I think that erm she should have contacted me to see if I was happy in my flat to make sure everything was alright, she should have followed through her job to make sure that I'm okay."* (SU1)

*"I think maybe after you get discharged I think people should follow-up whereas they normally discharge you after you've been discharged it's weird and I think you need more support while you're in the community you know why would you need support while you're in Fieldhead and you've already got somewhere to stay in Fieldhead do you know what I mean I don't get why they'd discharge from the service after leaving*" (SU4)

Another participant who felt '*pressured*' (SU1) to take the property they were offered through the service was no longer happy with their housing situation had been told they would be contacted upon discharge but had not received any onward communication. They had tried unsuccessfully to contact the HSC at the hospital and were not clear who they could contact for onward support now that they were back in the community.

*"I've rung [the HSC] up to try and contact her because she said she was gonna contact me when I come out of hospital after the Covid-19 and she, she were always like it before and she hasn't."* (SU1)

Given these challenges, there appears a need for HSCs to be able to provide some support post discharge.

### Challenges to undertaking research evaluation

When designing the study, we anticipated collecting questionnaires from the majority of service users who accessed support. However, recruitment was really challenging as SUs have complex lives and the HSC service may be seen as just one part of their hospital experience. Furthermore, it was difficult to collect follow-ups from mental health service users as many had experienced a relapse. The NHS research teams had to put in significant time to recruit and support each person to a questionnaire. In contrast, the routinely collected data from WDH was comprehensive and recorded for the majority of service users. WDH have systems in place to both record and use their routinely collected data which if effectively used would result in more robust research evaluations in the future. This is explored further in the recommendations to the service.

## Developments to the service

Participants completing the questionnaires and interviews were asked about improvements that could be made to the service. The two main suggestions were about improving communication and developing the post discharge support. One person felt that the service should be expanded so that more people could be supported.

### Improving communication

Some of the suggested improvements to the service related to improving communication in terms of difficult conversations. For example, one person wished they had been told upfront about the accommodation costs they would incur. In another case, someone questioned why they had not been offered a certain property. In another case, someone felt they needed more time and support with ensuring their property was up to standard. These pieces of feedback highlight the importance of managing expectations, being transparent and having difficult conversations such as about what housing is available and why it may not have been offered to that specific person. There may be a need to consider how to manage these difficult conversations especially when not meeting face-to-face but also documenting what was discussed so that there is a written record for service users to refer to, and to provide an audit trail of the discussion.

One participant felt that there could be greater communication between the hospital, council and HSC. This links to the qualitative findings that an important part of the

service was facilitating the links between the hospital and housing/ other support providers.

**Providing support post discharge**

From the perspective of HSCs and managers, they felt a key improvement to the service would be providing support HSC support post discharge. A significant redevelopment of the role would be required to facilitate HSC involvement with a view to preventing housing related readmissions.

> *"So it's kind of very hands-on while they are in the Trusts, but then ensuring that when they do get discharged, if there's any continued support required. Because there were some evidence to suggest that there's quite high numbers of people that have a hospital re-admission quite soon after following a discharge because the support breaks down on the discharge or the supports not there. So yeah, the main focus is getting those barriers addressed to allow the discharge but then also ensuring that any continued support linked into any continued support of the community once they are out."* (HSC4)

Those in the HSC role itself also recognised the potential requirement for more specific housing related support post discharge to prevent readmissions that are more related to the service users housing situation rather than a medical requirement. Some further support from housing specialists is required, linked with the community teams, for some service users post discharge in order to help prevent readmissions for regular reoccurring individuals.

> *"I know err, the consultants used to get quite frustrated when you get your reoccurring ones that keep coming back in, keep coming back in, there's a reason for that so maybe by, a housing support worker being more erm, involved in community, it could be the fact that they've got err, they're living in a shared house, they don't like it, that is why because a lot of them think it's oh, it's a free bed isn't it, free bed and meals, but if they had somebody like a housing support worker that were visiting them and they were saying 'oh I hate it here I don't like living here', they could actually build on then getting them their own place rather than being shared house"* (HSC1)

> *"But I think maybe if they could, and I am not saying to give that support, because obviously there will be agencies out there who are there to*

*give it, but you know just to give that continued, for want of a better phrase, continue hand-holding."* (HSC3)

## SUMMARY BOX

The skill and experience of HSCs and their knowledge of the housing system and relevant support services is an important factor in the service's success.

The HSC role has been implemented differently across the two trusts which has impacted on the development of the role.

The HSC role appears to work best when based within a healthcare team, with access to their systems and support from healthcare managers.

The importance of effective relationships and communication with healthcare staff and community teams is a key component of the role.

The skills and experience of the HSC, including a background in housing, understanding of the different types of service users and knowledge of and ability to liaise effectively with several external agencies are essential to the success of the role.

Delivering personalised person-centred support, tailored to the individual's needs, maintaining open communication and managing service users' expectations are all key factors in supporting a complex population.

Having the service embedded in WDH enables easy access for SUs to a range of available in-house services and other support.

HCPs and the MDT need clear understanding of the role and remit of the HSC, and the referral process to ensure the role is utilised effectively and appropriate referrals are received.

Factors outside of the HSC's control such as the complex needs of service users, in particular those who are homeless, and the availability of appropriate housing impact on the resolution of housing issues and thus hospital discharge and satisfaction with the service.

Our findings support that SUs are likely to need some support after hospital discharge, but this is currently out of the current remit of the HSC role.

## 4.6 Impact of Covid-19

Much of the service delivery and consequently the evaluation has taken place during the Covid-19 pandemic. Consequently, it was important to consider the impact of Covid-19 on the service. Although Covid-19 had an impact on people's health, in contrast, somewhat reassuringly, the impact of Covid-19 on service delivery, hospital systems and service users appeared to be low. Whilst methods of service delivery had to change, for some service users the largest impact was finding it difficult to view houses or organise repairs. Furthermore, some of the changes made to the service during Covid-19 appear advantages and have been made permanent.

**Impact of Covid-19 on people's health**

It was acknowledged that Covid-19 has exacerbated pre-existing mental health conditions for some service users, particularly those who were no longer able to have face to face appointments with their clinicians. People found not being able to see family and friends increase their social isolation and loneliness, exacerbating mental health issues. Furthermore, the outbreak of Covid-19 has also resulted in new patients being admitted who have not had any previous issues with their mental health:

> "*We have seen a significant influx of admissions. Particularly people who have never been in services before. So we are getting a lot of people being admitted for the first time. And they could be within their fifties and they've never had any mental health issues…We are getting people struggling with the Lockdown restrictions and feeling isolated. We are getting people fairly paranoid, who have never experienced that level of paranoia before." (HCP4)*

**Impact on service delivery**

Despite some concerns from the HSC that not being visible on the wards would impact on relationships with HCPs, most health care professionals did not perceive the outbreak of Covid-19 as having a great impact on the housing service, wider hospital support systems or numbers of referrals. However, a staff member at a managerial level discussed the impact of Covid-19 on staff sickness and the hospital discharge pathway, although this did not affect the HSC service specifically:

> "*The second thing is because of the Covid-19 related sickness amongst staff, we're not able to err turn around patients quicker… and thirdly*

*because of Covid-19 related issues some of the wards within the organisation had to be closed down …So definitely Covid-19 has impacted in the duty of care and also on bed pressures."* (HCP1)

**Change in modes of delivery**

Several changes to service delivery were made due to the outbreak of Covid-19, including moving appointment with HCPs and SUs to online methods. From the HSC and HCP perspective Covid-19 does not seem to have impacted negatively on how the service is delivered. For both HSCs, but particularly for HSC3, who covers a large geographical area, working from home using online platforms has actually had the unexpected benefit of releasing time that was normally spent travelling.

*"it worked really well it really were like I were on all ward rounds, through zoom and it were like just worked so well I just didn't have my presence on the ward but I felt that erm, I felt though they felt that I was present because I, the patients would be talking to me through zoom it were like, so really there were nothing apart from proper face to face do you know what I mean but it worked really well, really, really well, I were surprised really."* (HSC1)

*"so yes it had a massive impact in that I don't see people erm face to face but the same amount of work gets done if not more and I can actually erm fit in a lot more. If erm if someone is in a ward round erm with the Consultant and with the staff and they have not previously mentioned anything about housing erm and then they just reveal that they haven't got any accommodation the Consultant can instantly invite me to be present in that meeting whereas before I wouldn't have had chance in time to get to the meeting erm so things like that are a real positive erm you can get, I can attend a lot more things now by being online erm"* (HSC2)

Although Covid-19 appeared not have a big impact on communication between the HSC and HCPs or "*on any referrals or the service that the HSC provides"* (HCP4), it was acknowledged that face to face meetings between the HSC and service users were sometimes more effective for dealing with housing related issues, particularly when paperwork is involved or if the patient is not comfortable using online methods.

*"So recently [HSC02] was struggling to get in touch with a patient so we just, erm, I met with the patient and set up a Teams meeting so they could discuss erm, the situation over there rather than not have a face to the name*

> *(yeah) I think that's true for as patients in not, you know, they were quite worried and apprehensive about talking to this stranger on the phone that they don't, don't know and I think sometimes it's, you know, they're like really reluctant to give information and things like that*" (HCP2)

In addition, HSC3 and HSC4 acknowledged that not seeing service users in person may have an impact on fully understanding the service user needs and building rapport, and that the personal contact was missed. HSCs had to be proactive in ensuring that they are able to speak with the SU and contact has been done over the phone, or virtually, with the help of staff on the wards so that there was still that personal contact as much as possible.

> *"but I think for me I missed, I missed sort of seeing people because I think you don't really fully, you don't get exactly what's going on do you when you're not seeing people erm, and it's easy to forget as well what condition a person's got if you don't see them face to face, erm, and yeah I've kind of missed that sort of side of it"* (HSC3)

> *"So I am just worried that during the pandemic it's lost its' personal touch which I think you know historically patients have really been thankful of, and really appreciated that kind of personal touch."* (HSC4)

Overall, however, HSCs felt that the new ways of working had not detrimentally affected contact with SUs:

> "*haven't had too much of an issue making contact with people, erm, I tend to find as long as I can get a care coordinator or a discharge coordinator to ring me at a certain time I'll usually sort of book a time in, and they'll go onto the wards and give the phone, 'cause the phone signal in Pinderfields is atrocious so even if somebody's got their own mobile phone you can't always get them on that, so usually I would ask one of the team to, to be up on the ward and then they'd ring me with the patient and then I'd do the over the phone, and that's actually worked erm, it's worked really well*" (HSC3)

From the perspectives of the SUs we interviewed, the impact of Covid-19 had been minimal. This is partly due to fact that there were only two service users who received support during the pandemic who were only able to comment on their own experiences. Only one service user discussed the impact of Covid-19 on communication with their HSC via online methods:

*"[We communicated] via text mainly…. would have preferred to have spoken in person. It's Covid-19, isn't it*?" (HSC1)

**Impact on integration with HCPs**

Although Covid-19 did not have a huge impact on referral rates, the difference in how the two HSCs are embedded within the healthcare teams has made transition to virtual working more difficult for the HSC in Pinderfields compared to the experience of the Fieldhead HSC. The Fieldhead HSC has not felt that there has been much change to the strong working relationships with other HCPs that were already in place; and suggested that they were now more automatically involved with cases since the move to virtual meetings.

*"for linking in with the consultants erm I, I, this is probably better because before erm they wouldn't necessarily send an invite round for somebody's ward round I was involved with but now because everything is done electronically they sort of, they instantly invite me to all meetings that I need to be there so I don't ever miss out on anything whereas before sometimes that did happen if an invite didn't get sent whereas now all the invites, all the meetings are electronic all the invites go out if that makes sense"* (HSC2)

For HSC3, who is not as intrinsically linked to the ward teams, maintaining links with the MDT after the move to remote working has not translated in the same way, although it has not led to a reduction in referrals.

*"I think it's probably, I think the hardest thing is not being there this last year I feel a bit disconnected now, erm, you know I used to be up on the wards you know quite regular, erm, so you sort of become a bit more familiar don't you to people when they see you walking up and down and, and what have you, so I think now I feel a bit, I do feel a bit detached but I think, like I said earlier, the fact that I'm still getting the referrals and the phone calls coming in, you know, they know that that service is still there and that I will still, you know, aim to deliver what I can in, you know, soon as I can."* (HSC3)

**Impact on housing**

There was some impact on housing during Covid-19, however these issues were often temporarily related to national restrictions. Longer-term issues related to economic impacts. The initial difficulty of the closure of Homesearch for three

months during the first lockdown did create problems as people could not bid for properties. Furthermore, there were also issues with service users not being able to view properties or struggled to get repairs done.

On the questionnaires, across the different types of questionnaires and sites, 8 of the 20 people who answered the question had experienced some problems to their housing situation because of Covid-19. There appeared a distinction between disruptions to support mechanisms which created issues with housing and difficulties with accessing new accommodation. Examples included:

Examples of disruption to support mechanisms:

- One person had to move from their home because carers could no longer come to the house to support them because of Covid-19.
- One person needed to move because they could no longer have visitors to support them in their housing such as helping their wheelchair in and out of the housing.
- Housing is 1.5 hours from family so they could not visit during lockdown which exacerbated social isolation.

Examples of difficulties accessing new accommodation:

- Concerns that when the £80 additional support from Universal Credit is removed, it will be detrimental to managing their housing financially.
- Being unable to view potential accommodation
- Needing accommodation that was ‘ready’ to move into because it was difficult to organise repairs/improvements.
- Delays to being able to submit housing bids
- No clearers available.

Some of these issues were temporary issues caused specifically by the lock down such as not being able to have visitors or view accommodation. However, a more permanent issue is the impact of the reduction of Universal Credit and the rising cost of living which may create financial barriers to people managing their current accommodation or accessing new housing.

There was a positive impact on the housing available for people experiencing homelessness. As part of legislation bought in because of Covid-19, there was a statutory duty to provide accommodation for people experiencing homelessness such as them being housed in repurposed hotels. This option was not available before the Covid-19 and has not been made permanent. However, whilst it was in

place, the HSC felt it was an advantageous policy which made a positive different for their service users:

One benefit was the change to legislation for housing the homeless, which meant that accommodation on a large scale, such as repurposed hotels, was now available for housing the homeless, whereas before Covid-19 this was not an option.

> *"…because of the Covid-19 the legislation changed for the homeless so the homeless service had a duty of care to rehouse anybody that turned up at their door, so luckily for me that's where they all went…"* (HSC1)

**SUMMARY BOX**

Whilst Covid 19 impacted people's health and exacerbated mental health problems for some, it had less of an impact on service delivery.

The change to virtual and telephone-based working did not adversely affect service delivery or affect referrals, although some SUs missed face to face contact. Some of the remote working changes will continue to be undertaken by HSCs as they free up time, which can be spent on providing support to other cases.

Covid 19 affected some SUs housing situation, but some issues were temporary and related to lockdown. Reductions in Universal Credit and cost of living rises are likely to create and increase barriers to accessing new housing and managing current accommodation. Providing homelessness people with housing was viewed as advantageous and there could be scope to provide this on a local basis.

## 4.7 Logic models

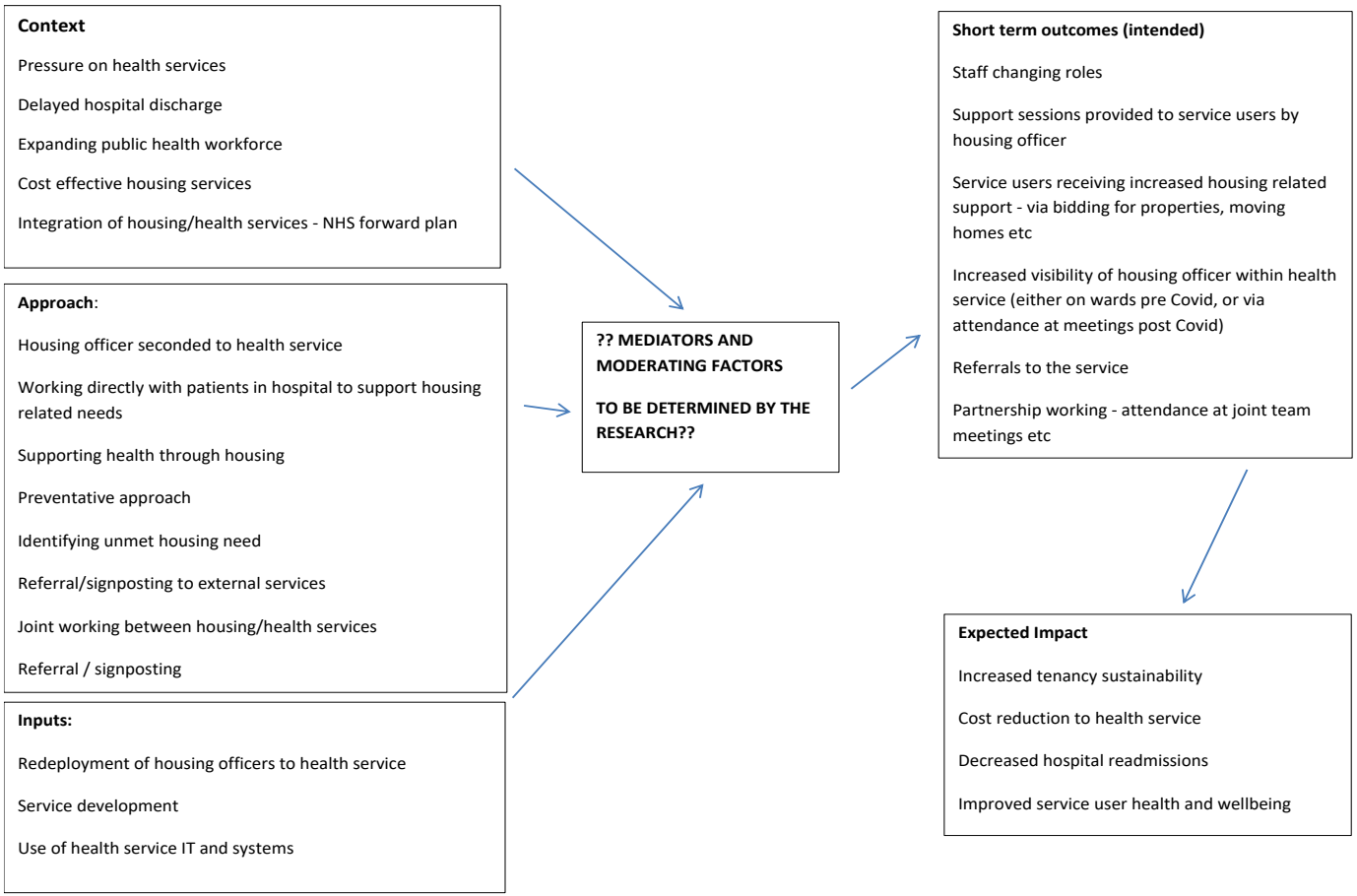
In this section we bring together findings from the qualitative and the quantitative parts of the evaluation to develop a project logic model which shows the links between the inputs and outputs/impact of the intervention.

Figure 2 shows the initial a-priori model developed at the outset of the project. Here the context in which the intervention is set, the approach taken and the inputs which the intervention was intended to consist of are outlined along with the intended short-term outcomes and anticipated longer term impact. At this stage the moderating

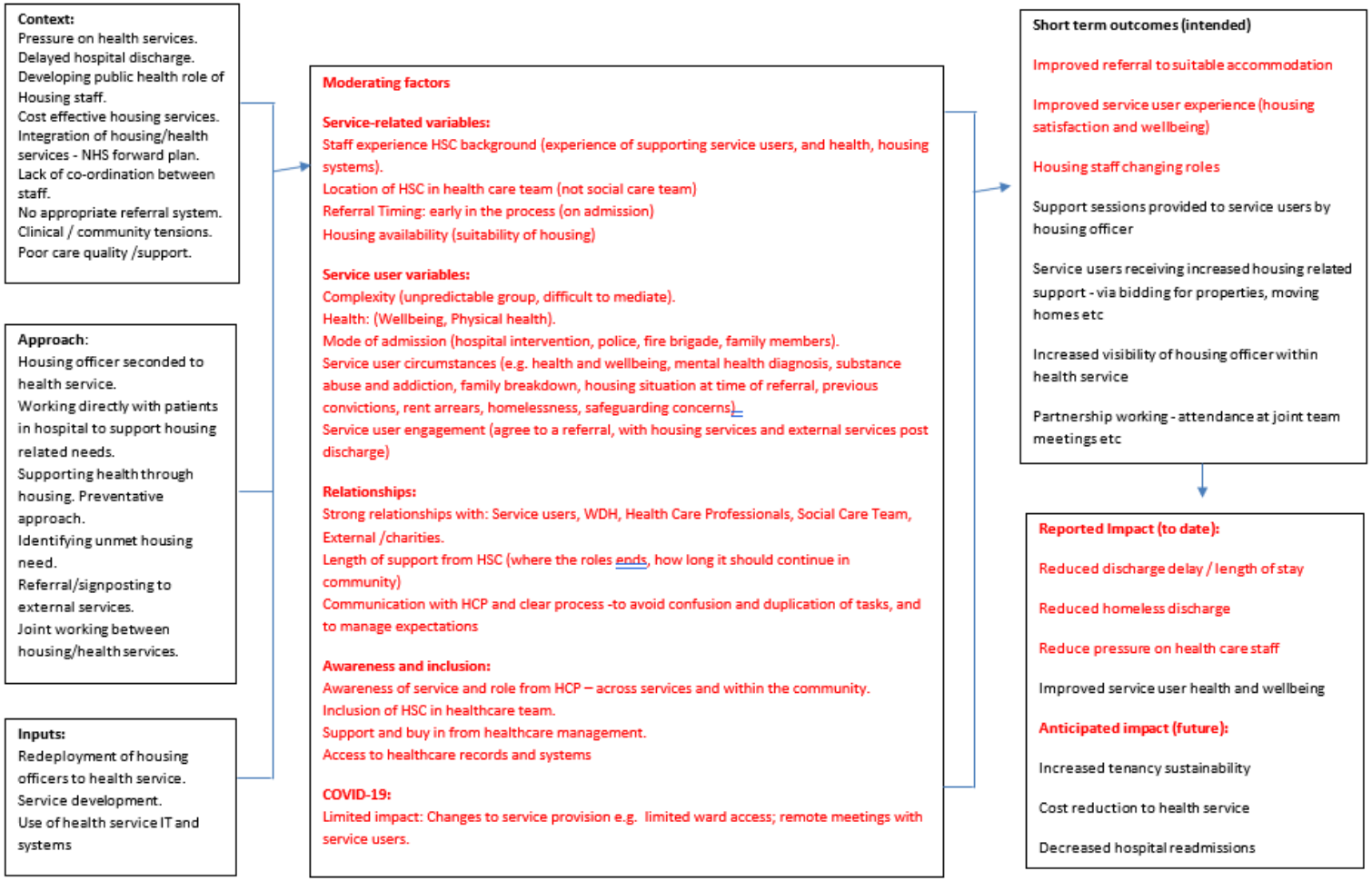
factors and the subfactors which mediate these are not represented as these were developed using the research findings.

Figure 3 show the final logic model with input from the research, published evidence and stakeholder involvement in the research. This final model outlines the context and input to the project, and the moderating and mediating factors which act to influence the short-term outputs and the longer-term impact (to date). Factors which have been added as a result of the research findings (changes to the a-priori model) are identified in red text.

## Figure 2: A priori logic model



## Figure 3: Final logic model



# Chapter 5: Conclusion and recommendations

## 5.1. Conclusion

This study sought to understand whether and through what mechanisms and to what extent, the HSC service has an impact on service user's health and housing outcomes, hospital costs and the process of hospital discharge. As well as demonstrating the impact of the service, our findings have shed important light on the mechanisms of success and challenges encountered by the service. In this section we provide recommendations for developing both this service and others wanting to implement integrated housing/health services aimed at improving hospital discharge.

## 5.2. Recommendations

**Organisational and Management**

- Our evaluation highlighted that for HCPs the service was vital and significantly reduced the time they spent trying to sort out service users housing needs, enabling them to focus on other tasks. Committing to funding the service permanently rather than on a short-term basis would be beneficial. This would provide reassurance to HCPs that the HSCs support will continue but also help to retain high calibre, experienced and effective HSCs who are at risk of leaving giving uncertainty of ongoing funding for the project.
- The working model should ensure that HSCs are placed within a healthcare team rather than a social work team, with access to healthcare IT systems, to ensure that there is the right awareness and support at a trust, managerial and ward level.
- HSCs need appropriate managerial support, within a patient flow or discharge team, from healthcare managers who understand the role, and can help promote it within the organisation.
- When establishing the HSC role, significant communication with internal and external agencies/charities will be required to ensure the correct people are involved, and that all involved understand each other's remits, priorities and what the service can provide. This includes working with ward staff and

discharge teams to develop understanding about what constitutes an appropriate referral and when referrals should be made.

- There is not a clear pattern to referrals. There may be scope for increasing referrals across a wider range of wards but there would need to be further HSC resource to accommodate this given the specialist knowledge required.
- A clear strength of the service was the HSCs being embedded within the housing association. Many of the service users were already WDH tenants and/or supported by the HSCs to access other WDH services. Being able to support service users within one organisation enabled streamlining of support. Given the benefits, a recommended model is having housing officers formally based within a hospital trust but with links into an external housing association.

**Background and experience of HSCs**

- It was clear that the background and experience of the HSCs were instrumental in the successful implementation of the role. Organisations need to appoint people who have experience in providing housing related support, have the ability to deliver person centred care, be pro-active in establishing relationships and have the ability to work independently. Appointing people with experience of supporting SUs with complex needs such as homeless patients, and an awareness of external services would be advantageous.
- Given the high skillset required to deliver the role, commissioners wishing to fund these types of services need to provide a pay scale which is appropriate to the role to attract senior level housing officers who are comfortable with autonomous working and undertaking service development without the support of a wider housing team.

**Providing person-centred support**

- HSCs need the flexibility to shape their support to the individual needs of each service user. This includes the amount of support, means of support and considering issues beyond housing that may need addressing to facilitate tenancy sustainability, such as signposting to debt advice.

**Impact of external availability of accommodation and services**

- Whilst HSCs provided support, they were constrained by what external housing options were available. Given this, commissioners need to consider

funding the HSC service alongside increased investment in wider housing options and other services across the healthcare system. Although our research demonstrates some positive impacts from the service, it remains the case that even with HSC support, service-users cannot be discharged quicker from hospital if there is not suitable housing available to meet their needs.

**Managing Expectations**

- HSC need to manage expectations of SU and HCP from the onset:
    - SU need to be informed of what housing options are and are not available to them and why.
    - HCP and the wider MDT need to be aware of likely timescales regarding discharges.
- Given the vulnerable nature of the service user population, it is likely that this information will need reiterating throughout the process. It may be useful to also provide written copies of information.

**HSC Support Post Discharge**

- It was clear that many service users desired support from the HSC after being discharged from hospital, particularly when their housing issues remained unresolved, and they did not know who to contact to resolve them. We recommend that the process of onward support is streamlined across the two hospital by introducing a system whereby the HSC follows up service users 6 months post discharge, checking in and providing patient centred support if required at regular intervals (e.g. at 1 month and 3 months and 6 months post discharge) and if needed, to refer the service user to WDH and other services if applicable. This process may help prevent future readmissions for the most vulnerable service users.

**Homelessness support**

- It was clear that the HSC service was highly valued in the support of homeless cases but practically support was challenging. Reducing or removing ID checks for homeless individuals if the housing team can verify their identity would be beneficial to help streamline the process.

**Future research evaluation and the use of outcome measurements**

- Given the difficulties in recruitment and the comprehensive nature of WDH routine data, there is scope to develop the routine data collected by the HSCs to potentially include some evaluation questions or outcome measures (e.g., on whether people's housing situations cause them stress) to be able to better track the impact of the service and to justify further funding. This will also enable the partners to continue to develop the evidence base once the formal university-led evaluation finishes. It is also recommended that similar initiatives may want to ensure that their front-line workers are collecting information such as demographics, service received, outcomes and the service users' perspectives to build up an evidence base on impact.

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