Finding a safe home after hospital:

Case study research on supported housing and healthcare partnerships

February 2025

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Executive summary

This research explores existing evidence on the impact of housing-related delayed hospital discharges and the important role that supported housing can play in preventing delays and alleviating pressure on the NHS. Drawing on a series of case studies, this report showcases how the NHS and supported housing providers are working together to remove barriers to finding a safe home and support people leaving hospital at the right time for their recovery.

How do housing challenges affect people leaving hospital?

The evidence demonstrates that a lack of supported housing and suitable homes for people to move into when they're ready to leave hospital is a factor preventing people from being discharged. Longer hospital stays can be detrimental to recovery and people's health. This creates more strain on oversubscribed NHS waiting lists, preventing people from accessing treatment that they need.

7,239
additional hospital bed days due to a lack of supported housing in September 2024.

In September 2024, waiting for supported housing was the single largest reason for delayed discharges from mental health inpatient settings. This equated to 7,239 additional hospital bed days, making up 17% of all delayed discharge days in September.[1]

In acute trusts, the average number of patients per week who had a hospital stay longer than 14 days and a delayed hospital discharge due to housing-related reasons has more than tripled since 2021, from 49 to 153 patients per week in 2024.[2]

Longer stays in hospital can result in poorer health outcomes for people once they leave hospital, as well as an increase in their care needs.[3] Delayed discharges from hospital also cost the NHS more money. For mental health inpatient settings, we know there were 109,029 days of delayed discharge because patients were waiting for supported housing in 2023/24[4], costing the NHS an estimated £71m.[5]

Savings could be made to the public purse of between **£53-£65 million per year.**

As well as offering improved health and wellbeing outcomes for individuals discharged from hospital, supported housing also costs significantly less on average than a stay in hospital, even with more intensive care and support packages that come at a higher cost (such as for individuals with a learning disability and autistic people). When considering the average costs of rent, care and support for different client groups in supported housing, we estimate that if we had enough supported housing to make sure everyone in a mental health setting could leave hospital at the right time for their recovery, savings could be made to the public purse of between £53-£65 million per year (see appendix for further detail).

How are housing and health providers helping people leave hospital?

The innovative services featured in this research were all driven by a pressing need to reduce delays to hospital discharge due to housing. These services reduce costs, alleviate resource pressures, and prevent people needing to be in hospital longer than needed. Many of the schemes also aimed to address repeated readmissions from people who were discharged when they did not have a home that met their needs, including those discharged to the streets.

Often starting out as a pilot, they were driven by individuals determined to try something different to address the issues that they were seeing. This led to new partnerships across sectors, with Integrated Care Boards (ICBs) and housing associations at their heart but with local authorities and other voluntary sector organisations often playing a critical role. Through building trust in each other's expertise and capabilities, a willingness to take risks, and a shared vision and strategy, the partners we spoke to felt they were able to deliver a higher quality service and better outcomes for the people they support.

There is evidence of the positive impact these schemes have on the NHS and local systems, including significant cost savings, reduced readmissions and reduced use of more expensive private sector mental health beds. This was alongside often life-changing impacts for the people supported to leave hospital into a home that meets their needs.

However, there were some common challenges faced by the partnerships delivering these schemes. Many felt that difficulties securing long-term revenue funding and capital grant funding poses a barrier to the sustainable future of the schemes and their capacity to meet future demand. A lack of local affordable housing options affected some of the schemes' ability to move people on from short-term supported housing when they were ready.

Our recommendations

Any hospital discharge should not only consider a person's health and care needs, but also their need for a secure, safe and affordable home. To achieve this:

- **Integrated Care Boards and housing providers should work together** to remove barriers to safe, appropriate housing so people leaving hospital can leave at the right time for their recovery.
- **The government should set a national strategic direction** for health and housing providers to work together. Integrated Care Systems, local and combined authorities and housing providers should agree a local assessment of need and plan for how this need will be met.
- The government's upcoming **National Housing Strategy and NHS 10 Year Plan should integrate health and housing**. If this happens, we can make sure that policy looks beyond just the numbers of new homes and assesses local need to plan and deliver the right homes in the right places.

There is a pressing need for greater capital investment in supported housing, as well as secure, long-term revenue funding for hospital discharge schemes. Decisions about funding should consider how services are funded during and after discharge from hospital, to deliver better value for money in the longer term.

- **Capital grants need to be sufficient** to ensure schemes, including Specialised Supported Housing, are financially viable, affordable for residents and value for money for the benefits system.
- The **£300 million Housing Transformation Fund announced should be reinstated**.
- The planned **longer term financial settlement for local authorities should be used to drive better strategic planning** and long-term commitments on revenue funding for supported housing.

Key definitions used in this report

Acute Trust and acute inpatient settings (see also: NHS Trust)

According to NHS data submission guidance, acute discharge delays are submitted from acute hospital trusts with an A&E department. There are 119 NHS Trusts that offer acute services, meaning they make up most of the NHS Trusts in England. Acute medicine also covers a broad range of treatment, and is separate to specialist services. For these reasons, we also refer to acute inpatient settings as 'general' hospitals in the report.

Capital grant

An amount of public money awarded for building new housing or infrastructure and (for the NHS) updating equipment or facilities.

Clinical Commissioning Group (CCG)

CCGs were a structure of NHS services responsible for planning and delivering a wide range of local health services. They were operational from 2013 until 2022, when they were replaced by integrated care systems (ICS).

Commissioners

Commissioning generally refers to sourcing and purchasing of services. In the context of supported housing, local authorities and NHS ICBs may commission care, support, housing, or a combination of these services together.

Delayed discharge

When a person is clinically well enough to leave hospital, but they stay in hospital longer than they need to. The NHS reports on delays when a person has not been discharged by the end of the day they were ready to leave hospital.

Forensic patients

A patient with a mental health disorder who has been admitted to a hospital and/or secure setting to keep themselves and/or others safe. They may have committed a crime or been seen as capable of committing one.

We use the term "disorder" in this instance as this reflects the language used in the relevant parts of the Mental Health Act. We refer to mental illness in the rest of the report. Further guidance is available from the Equality and Human Rights Commission.

General hospital

See: acute trust/acute inpatient settings

Integrated Care Board (ICB)

Integrated Care Boards replaced CCGs in 2022. They are NHS organisations that bring together health-related services (such as GP surgeries and hospitals) in one local area.

Integrated Care System (ICS)

This is a wider group of partners including upper tier local authorities, community organisations and, in some instances, housing providers. Each Integrated Care System in England will contain one ICB.

Mental health inpatient setting (see also: NHS Trust)

A mental health delayed discharge is reported to the NHS for patients who are in hospital for a mental health reason and cannot be discharged when they are ready to be. All providers of specialist secondary mental health, learning disabilities and autism spectrum disorder services must submit their data (including discharge delays) to the NHS. This may include NHS Mental Health Trusts and other providers, such as private hospitals. To encompass these scenarios, we have used "mental health inpatient settings".

NHS Trust

NHS Trusts and NHS Foundation Trusts are part of the NHS structure and deliver NHS services at a local level. A trust may provide just one service, such as specialist treatment, or a mixture of services. These services can include transport by ambulance, Accident & Emergency (A&E) care, other hospital treatment and community care.

NHS England reports on delayed discharges from hospital differently according to the type of care a patient is receiving. In this report we refer to delayed discharges from mental health and acute settings.

No Recourse to Public Funds

A condition related to a person's immigration status in the UK. They are unable to claim certain benefits, such as Housing Benefit.

Out of Area Placements (OAP)

Patients receiving inpatient mental health care in an area that isn't covered by their local health services because there wasn't a space in an appropriate service closer to home.

Revenue funding

Funding for ongoing services to ensure that someone can manage in their own home and the home is safe and well maintained. Revenue funding may include funding for care and/or support services from a local authority, the NHS as well as housing benefit to cover individuals' rent.

Service Level Agreement

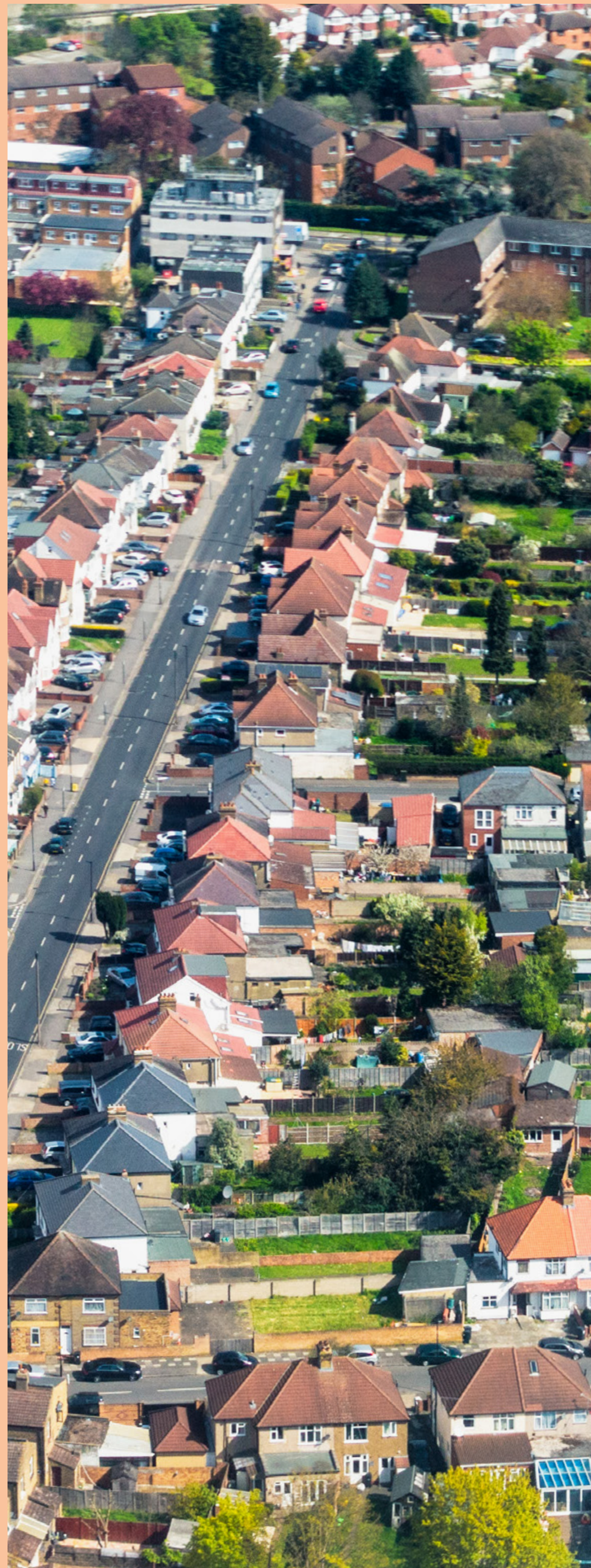
A contract between an organisation commissioning services and the organisation providing those services.

Step-down

An initiative providing short-term transitional support and accommodation for people who have been discharged from hospital.

Voids

A period of time where a property is ready to let but remains empty and no rent is being paid.



Introduction

Good quality, suitable and affordable housing is vital to a person's resilience, health and wellbeing. For people leaving hospital, it becomes even more critical. A home that suits a person's specific needs and has the right support at the right time is key to keeping them out of hospital and living a healthy and independent life.

With the NHS facing chronically oversubscribed waiting lists, delays for treatment and funding pressures, supported housing plays a critical role in relieving pressures on our health system. Throughout this research, we'll explore compelling evidence on the links between a lack of suitable housing and delays to hospital discharge, and the negative effects on both wellbeing for patients and on NHS waiting lists.

In this report, we'll also draw on case studies from supported housing providers working to solve this problem together with the NHS. By working in partnership, the barriers to housing for people leaving hospital can be broken down, freeing up hospital beds and promoting better physical and mental health outcomes.

The schemes featured in the research show how supported housing can improve hospital discharge for the main groups of people affected by delays: people experiencing homelessness, people experiencing mental health illness, people with a learning disability and autistic people and older people.

We spoke with housing providers and NHS commissioners to explore what we can learn from the case studies about:

- Why these approaches are needed.
- How the schemes are developed, delivered and funded.
- How partnerships are formed and sustained.
- The positive impact that they have on the NHS and people supported.
- Challenges in delivering the schemes and how those could be alleviated.

What is supported housing?

Supported housing is accommodation where housing, support and sometimes care is provided. It's an umbrella term that includes a wide range of homes for people who need support to live independently, including retirement communities, extra care housing for older people, homeless hostels, mental health step-down units, domestic abuse refuges and housing for people with a learning or physical disability and autistic people. It can be a permanent home or part of a pathway to housing with less or no support. Specialist schemes can support people who have experienced significant trauma[6] or after long stays in institutional or forensic services.[7]

What all types of supported housing have in common is a focus on independent living, choice and control in a home environment. Support services help people settle into a new home, maintain their tenancies, stay safe, learn life skills, find employment and training, connect with health and social services, remain active and access their community, leisure and cultural resources. On-site care services in some schemes means there can be a flexible response as a person's care needs change.

There are about 535,000 supported homes for rent in England, and the great majority are owned and/or managed by not-for-profit providers registered with the Regulator of Social Housing.[8] Registered Providers must comply with consumer, governance and financial standards, including the Rent Standard that sets maximum levels for rents to ensure that they remain affordable and below market rates. Registered Providers can bid for capital grants to help subsidise the cost of building new social rented homes.

In recent years the amount of grant funding per home has diminished, making the development of new specialist schemes more difficult. To partly fill this gap, there has been an increase in lease-based models where not-for-profit housing providers enter long-term leasing arrangements with for-profit private landlords, property investment companies or equity investment firms.[9] In this model, the provider acts as the landlord but needs to cover the lease fee levied by the owner of the building.

Specialised Supported Housing is a financial model defined by the government's policy statement on rents for social housing.[10] Properties are bought on the open market or purpose built with 100% private finance. The property is owned or leased by the Registered Provider and rents are exempt from the Rent Standard and so can be much higher than social or affordable rents. Specialised Supported Housing must:

- Be specifically designed or adapted for people who require specialised services to enable residents to live independently in the community.
- Provide a high level of support, to an equivalent level to the services or support that would be provided in a care home.
- Be provided under an agreement with a local authority, or the NHS, and the rent charged to comply with this agreement.

Housing for people with long term high care or support needs may also be referred to generically as "specialist" housing, however other financial models besides the SSH model can be used to supply housing for people with similar high needs.

Capital funding is available from NHS England to buy or develop housing for people with a learning disability or autism.[11] This funding is managed nationally, working in partnership with Integrated Care Boards (ICBs) and NHS regional teams. Grants can only be made to local authorities, voluntary organisations or Registered Providers.

How do housing challenges affect people leaving hospital?

The evidence shows that addressing supported housing shortages could play a crucial role in reducing delays to hospital discharge and help tackle capacity issues and cost inefficiencies in the NHS. Right now, a lack of supported housing and appropriate homes for people to move into can prevent somebody from leaving hospital, harming their recovery and health. It also puts further strain on already oversubscribed NHS waiting lists, preventing people from accessing the treatment they need.

In September 2024, waiting for supported housing was the single largest reason for delayed discharges from mental health inpatient settings. This equated to 7,239 additional hospital bed days, making up 17% of all delayed discharge days in September.[12] Delayed hospital discharges in mental health hospitals have knock-on effects, including an increased number of Out of Area Placements. An investigation by the Health Service Safety Investigations Body identified that during March 2024 alone there were 805 inappropriate Out of Area Placements, which may cause harm to patients and their families.[13] These harms included "dying by suicide, physical, psychological, distress and anxiety". Research by Rethink Mental Illness found that, for individuals waiting for support due to a lack of NHS capacity, four out of five experienced a deterioration in their mental health, and two-thirds experienced suicidal thoughts.[14]

Investing in supported housing presents us with a key opportunity to make progress on the NHS Transforming Care agenda. This aims to improve the quality of care for people with a learning disability and/or autism and reduce the length of time they spend in hospital, as well as reduce hospital admissions entirely. In March 2024, there were 2,155 people with a learning disability and/or autism on inpatient mental health hospital wards. This is only a 26% decrease compared to March 2015, despite government targets to halve this number during this period.[15] We know that a lack of suitable housing is a key barrier to discharging people with a learning disability and autistic people from hospital – it was cited as the reason for 56% of delayed discharges in March 2024.[16]

12,517

patients in hospital each week that do not need to be.

In acute trusts, there were **12,517** patients on average each week in September 2024 who stayed in hospital after they no longer met the criteria to be a patient there. From the week beginning 2 September to the week ending 29 September there were **at least 164 patients each week on average who had stayed in hospital longer than 14 days and whose discharge was delayed due to housing.**[17] This included:

- Being homeless upon discharge (72 patients).
- Having no recourse to public funds (35 patients).
- Having no housing provision ready (57 patients).

Prior to 27 May 2024, this data was reported under the category Homeless/no recourse to public funds/no place to discharge to. It is noteworthy that this figure has **more than tripled since 2021**, where on average 49 patients each week were homeless upon discharge (see appendix for further detail). This may reflect special measures relating to the Covid-19 pandemic, such as the 'Everyone In' program, which made sure people experiencing rough sleeping had a place to stay.

The number of people in hospital longer than two weeks **whose discharge was delayed due to housing-related reasons has more than tripled since 2021.**

An audit of 15 general hospitals in London by Homelessness Health London Partnership found that over half of homeless patients currently in hospital were considered medically fit for discharge, but did not have a safe place to go. Of the 42 patients, 12 were waiting for accommodation, and a further 12 were waiting for specialist accommodation.[18] Although this audit was conducted on a small scale, the findings show the extent to which a lack of supported housing prevents individuals from leaving hospital at the right time.

These figures do not include the many more individuals who are discharged from hospital to the street. A Freedom of Information Request to hospital trusts in England in early 2024 showed that at least 4,200 people were discharged from hospital into homelessness from 2022-23.[19] A study of homeless patients in 2020 concluded that they have a higher rate of readmission compared to patients with housing in place—regardless of the reason they were originally admitted to hospital. The study also found that homeless inpatients were less likely to have their readmission planned, which could indicate a lack of ongoing healthcare.[20]

Longer stays in hospital can result in negative outcomes such as a greater risk of infection and other illnesses, according to the NHS.[21] For older people, longer hospital stays can lead to worse health outcomes and an increase in their care needs after leaving hospital due to a loss of mobility, according to the National Audit Office.[22] The Care Quality Commission also found that a hospital setting did not provide a therapeutic environment, which could exacerbate patients' distress and even trauma. This was particularly true for autistic patients and could even result in inappropriate restrictions.[23]

For mental health inpatient settings, there were **109,029** **days of delayed discharge in 2023/24.**

Delayed discharge from hospital also comes at an increased cost to the NHS. In the case of treating older patients alone, the National Audit Office estimated that this cost the NHS around £820 million each year.[24] For mental health inpatient settings, we know that there were 109,029 days of delayed discharge attributed to waiting for supported housing in 2023/24, costing the NHS a total of around £71m.[25]

When taking into account the average costs of rent, care and support for different client groups in supported housing, we estimate that **enough supported housing to enable the timely discharge of the people experiencing those delays could generate cost savings in the region of £53-£65 million per year** (see appendix for further detail). While these savings may not be fully realised unless wards were able to close, the findings indicate the scale of wasted resource and opportunity for more efficient spending within the NHS. Further costs could also be recovered through reduced use of expensive Out of Area Placements and private hospitals.

Enough supported housing to discharge mental health inpatients could generate cost savings in the region of **£53-£65 million per year.**

How are housing and health providers tackling the issue together?

In some local areas, NHS and supported housing providers are working in partnership to remove housing barriers and support timely discharge from hospital for groups of people who are most impacted. This section highlights some of these schemes, which are working to improve hospital discharge for:

1

People experiencing homelessness.

2

People experiencing mental health illness.

3

People with a learning disability and autistic people.

4

Older people.

1 People experiencing homelessness

Unfortunately, there are well-established links between experiencing homelessness and poor physical or mental health. Research by Homeless Link found that 73% of respondents who had experienced homelessness had a physical health condition, while 80% had a mental health condition.[26] Conditions associated with homelessness can increase the likelihood of poor health. However, it can also be more difficult for people experiencing homelessness to access health services, which means they are more likely to present to hospital than services in the community.[27] Acute treatment costs the NHS more money than primary care, while earlier intervention could prevent individuals' health conditions from getting worse.

In 2022, the NHS issued a toolkit for emergency departments that aims to support them to provide "a consistent, patient-centred, and high-quality service to people experiencing or at risk of homelessness and rough sleeping" and covers the process from admission through to discharge.[28] Although the toolkit showcases good practice, including a case study from Gloucestershire Hospitals Foundation Trust, homelessness on discharge from hospital remains a pressing issue in some areas. A Freedom of Information Request to hospital trusts in England found at least 4,200 people were discharged from hospital into homelessness in 2022-23.[29]

People with No Recourse to Public Funds (NRPF) make up one-fifth of those whose discharge is delayed due to homelessness. We heard from housing providers that it can be challenging to support these individuals to access longer-term housing. Although some people with NRPF may be allowed to work, they will not be able to access state welfare support or housing through their local authority. This is a major barrier to accessing safe and secure housing.

At least

4,200

people were discharged from hospital **into homelessness from 2022-23.**

Move-on and the process of finding and securing longer-term accommodation for homeless individuals discharged from hospital is a significant challenge more broadly due to a shortage of affordable housing options and even temporary accommodation placements. However, step-down or short-term supported accommodation can reduce the number of individuals discharged from hospital directly to the street.[30] This also means individuals can receive intensive housing support to plan for and access suitable accommodation while in a safe, secure environment.

Gloria House

Gloria House is a six-bed supported housing scheme in Hackney, London. The Royal London Hospital refers patients to the scheme who are medically fit to leave hospital but have no home to go to. Since 2018, Gloria House has provided a home for 194 people after leaving hospital, where they have received housing-related support in a holistic environment. North East London ICB funds the scheme, with cost savings to the NHS reported of up to £1.8 million since the service began.

The development of Gloria House

In 2017, a conversation began between Peabody and Tower Hamlets CCG that was facilitated by Pathways, the homeless and inclusion health charity. Pathways and the CCG spoke of a "revolving door" situation where patients were leaving hospital and living on the streets only to return to hospital. This resulted in a considerable cost to the NHS and a lack of resolution for the individuals concerned. Over a series of meetings, the North East London ICB and Peabody set out their joint expectations for a housing-related support model and agreed outcomes for an initial one-year pilot scheme.

Peabody had identified an existing supported housing building where the service had previously been decommissioned and were able to work quickly to adapt the building. Gloria House accepted its first referrals in January 2018 and has since been recommissioned on a periodic three-year contract.

The Gloria House support model

Gloria House does not have exclusionary referral criteria, and staff are equipped to support residents with a range of needs. These may include mental health issues, substance abuse, fleeing domestic violence, gang affiliation, a history of offending, and individuals with No Recourse to Public Funds.

Peabody employs specialist staff at Gloria House who provide housing-related support through a psychologically and trauma informed approach. This includes three to four support workers alongside night-time concierge staff, which contributes to residents feeling safe and secure. Although Gloria House does not provide clinical support, staff may remind residents to take their medication or support them to register for local GP services. There is a communal ground-floor with a living room, kitchen and patio area for residents to use, and an ensuite bedroom in the scheme which is allocated to suit the resident's needs where appropriate.

Upon arriving at Gloria House, residents receive a welcome pack which includes bedding and toiletries to help them settle in. Residents stay at Gloria House for six weeks, and during this time are encouraged and supported to access local community services. Staff research and collaborate with colleagues and partners to signpost residents to the support services that will be most effective in helping them get back on their feet. This includes a partnership with voluntary sector organisations like food banks and a Providence Row Routes to Roots service, a project supporting single homeless people who have been admitted into the Royal London Hospital.

Working together for better outcomes

Referrals are made on a case-by-case basis, under a multi-disciplinary team (MDT) of medical professionals, social workers, voluntary sector professionals and Gloria House staff. Royal London hospital staff will flag when they become aware that someone is homeless. A Providence Row pathway worker will then assess the individual's suitability for the scheme and future housing options while they are still in hospital, with regular meetings between the MDT, which provides opportunities to highlight any issues and share expert help and advice. Gloria House and Providence Row work across London and beyond to connect residents with their home borough when looking at accessing local authority housing or other social housing.

The partnership working also extends to Gloria House's funding model. North East London ICB has an innovative approach of subsidising rent and support costs upfront. Gloria House staff support residents to maximise their income, and any housing benefit received is refunded as part of a regular reconciliation process. As well as providing financial security for the scheme, it enables Gloria House to support individuals with No Recourse to Public Funds, who may face greater barriers to finding a suitable home.

The initial pilot between the CCG and Peabody agreed a set of outcomes for the year-long programme. Since then, Gloria House regularly reports to North East London ICB to evidence the impact of the scheme. **It's estimated that the scheme has saved the ICB more than £1.8m since the service opened** (based on an average cost of a hospital bed across the Royal London Hospital wards), with low readmission rates to hospital (just 18 out of 192 individuals have been readmitted to hospital during their time at Gloria House). Gloria House also conducts its own survey as individuals leave the scheme, and it reports high levels of overall satisfaction and a feeling of safety.

Challenges

Although the contract allows the service to provide a bedspace for one individual with No Recourse to Public Funds, this is an increasingly challenging area of work. As people with No Recourse to Public Funds do not qualify for housing benefit, it makes finding a suitable long-term home more difficult. Staff report spending a significant amount of time supporting these residents to access a decreasing pool of services and resources in the voluntary sector due to funding cuts.

Other challenges include the knock-on effects of the financial pressures on local authorities and the NHS, with some below-inflation increases to funding. Combined with being a living wage employer and increased National Insurance contributions, it will become harder to generate funds that could be invested into creating further schemes like Gloria House and support more individuals.

Despite the challenges, Peabody have successfully opened a second hospital discharge service called Lowri House in 2022 which is also a six-bed shared house and operates in a similar way to Gloria House. This is jointly funded by the London Borough of Hackney and the NHS.

H.O.M.E Service

The H.O.M.E Service is delivered by Elim Housing and funded by Gloucestershire ICB for inpatients of Gloucester Royal Hospital, Cheltenham General Hospital and Wotton Lawn mental health hospital who are homeless or at risk of homelessness. The service also provides advice and support for other community hospitals and units in the county.

The service accepts referrals for any inpatients in housing need in Gloucester Royal Hospital, Cheltenham General Hospital and Wotton Lawn by clinical and nursing staff. They work with residents to identify housing options and create a personalised support plan with emphasis on identifying suitable accommodation for the patient when medically fit for discharge, reducing the risk of readmission and in turn relieving pressure on the NHS.

Purpose of the service

The H.O.M.E Service was borne out of the success of a pilot hospital discharge service based in Gloucester Royal Hospital. Hospital staff were concerned about the numbers of people being admitted to hospital who were identified as being street homeless. Without a home to be discharged to, many had nowhere to go except back onto the streets, the place that, in many cases, made them ill in the first place. As a result, the hospital was also experiencing high numbers of readmissions of people identified as homeless. **The primary purpose of the pilot and subsequent H.O.M.E Service was to reduce the amount of people who were discharged onto the streets and therefore the number of readmissions of people identified as homeless.**

The H.O.M.E Service is an extension of that pilot. Elim recognised that there was a gap in support for people experiencing mental health illness who were being discharged from hospital. They put forward a business case to Gloucestershire CCG (now Gloucestershire ICB) to extend the service to cover Cheltenham General Hospital and Wotton Lawn, a mental health hospital in Gloucester. Without access to official data, Elim built their case by collating information from the outreach service in the county about the people they were meeting who had experience of being in hospital and being discharged to the streets. The Commissioner was hugely supportive of the work they were doing and agreed to the extension to enable more people across Cheltenham and Gloucester to access the service.

How they work collaboratively to deliver the service

Gloucestershire ICB fund two project workers, who are powerful advocates for the people that they work with. One worker is dedicated to the general hospitals, and one works in Wotton Lawn, with people who have mental health challenges.

Patients can be referred to the service by a range of hospital staff and clinicians, including the Trust Safeguarding Hub and Onward Care Team, or members of the alcohol liaison and mental health teams. The project workers will work closely with the patient and hospital staff to identify what housing options the patient would like.

In collaboration with Gloucestershire local authorities, they identify the best housing solution for the patient on discharge. For people being discharged from the general hospitals, these tend to be temporary solutions, including B&Bs, while a more permanent solution is found. This is because the service must work at pace, as people are usually involved with that service for a matter of days, up to a couple of weeks. The team often have longer to work with patients in Wotton Lawn – weeks, months and, on some occasions, more than a year. This means that there is time to go through the council's allocations process for social housing, or to identify supported housing if they have ongoing support needs.

On a wider level, they work closely with hospital social workers, care navigators and community teams, as well as other third sector organisations to ensure the right support is in place. The H.O.M.E Service will refer to community-based support services that the person needs, such as charities that provide clothing or food. In some cases, they need to work with safeguarding teams, the police, and charities, for example, when they identify that someone has been trafficked. **Relationships with partner agencies across the county are crucial.**

Impact

Most residents were successfully moved onto accommodation options – in 2023 these included bed & breakfast (32%), private rented housing (11%), friends & family (8%), social housing (6%), supported housing (6%), sheltered housing (1%) or other accommodation options (14%).

There is a clear indication that the service is achieving its aims. **Following the collaboration, there has been an overall reduction in homeless readmissions over a 5-year period:**

- In 2019, 188 people identified as homeless were admitted to Gloucester Royal Hospital, 41 of these (22%) were readmissions.
- By 2023, the number admitted had more than halved to 77 people identified as homeless, and the number of readmissions was reduced to only 8 (a fifth of the 2019 number).

The outcomes also show that the service is effective in connecting people to support services, preventing people from falling through the gaps in provision. In 2023/24, 100% of residents were assisted in establishing contacts with external services and groups.

This included, for example, an individual who had been living in a residential rehabilitation service. After relapsing, they were asked to leave the service, despite no other breach of their license agreement, such as anti-social behaviour or not maintaining property. Therefore, they were facing homelessness on discharge. The H.O.M.E service completed a duty to refer to the council and their homeless application was accepted as a priority need. This meant they could be discharged to emergency accommodation. The service made sure they were referred for community-based support so that they could continue to be supported going forward, they then checked on them once they were settled into their accommodation.

Challenges

The H.O.M.E Service has been impacted by changes in the availability of housing since the pilot began. The cost-of-living and housing crises have contributed to an increase in homelessness and, therefore, an increase in referrals to the service and challenges in managing a larger caseload. For people in mental health services, it has become increasingly hard to mediate with their family and negotiate returning to their family home. This is thought to be at least in part due to challenges in accessing community mental health services, which are lacking in the Gloucestershire area.

There are also reduced housing options for the people they support. Fewer private landlords are willing to work with the service to provide permanent housing for people to move into and Local Housing Allowance rates have not kept up with rising private rents. Due to cuts, supported housing options for people with lower support needs are no longer available in the county. And there is a severe shortage of supported housing placements for wheelchair users. There is also minimal housing for individuals who are experiencing mental health illnesses. For individuals who have been in hospital for many months, going into temporary accommodation can be daunting, causing hospital re-admission due to mental health relapse.

2 People experiencing mental health illness

Demand on mental health wards is extremely high, with bed occupancy rates at 94%, well above the 85% safe standard rate.[31] This is known to cause increased pressure in other parts of the health system.[32]

Pressures on mental health hospital beds drive up inappropriate use of Out of Area Placements.[33] These placements have long-lasting consequences on people who are placed far from their home and their friends and family, where they receive fewer visits and more feelings of isolation and emotional distress.[34] In 2021/22, the NHS spent a total of £102m on inappropriate Out of Area Placements which, according to the Royal College of Psychiatry, will continue as "there aren't enough properly staffed beds or alternative specialist intensive provision locally".[35]

Yet there are people in mental health hospital beds who no longer need to be there. Our analysis identified that over 100,000 delayed discharge days in 2023/24 were caused by patients waiting for supported housing, costing the NHS around £71 million (see appendix for further detail). We know that being detained under the Mental Health Act can have a profound impact on people.[36] Therefore, we need to make sure there is enough supported housing to prevent anyone having to stay in hospital any longer than is clinically necessary.

over

100,000

delayed discharge days in 2023/24 were **caused by patients waiting for supported housing.**

As well as improving patient outcomes, supported housing for people leaving hospital with a mental illness can play a crucial role in alleviating pressures on mental health services, freeing up beds and reducing use of inappropriate Out of Area Placements.[37]

The next two case studies demonstrate how supported housing providers can work collaboratively with the NHS. By working together to meet the needs of people leaving hospital with a mental illness, we can reduce pressure on mental health wards and save the NHS money.

Ibis House

Ibis House is a supported housing scheme in Newham that provides a short-term step-down service for people discharged from Newham Centre for Mental Health—a psychiatric ward with 112 beds. The scheme is funded by East London Foundation Trust on a one-year basis.

The scheme has ten self-contained bedrooms and accepts referrals from East London Foundation Trust for individuals who have no clinical need to stay in hospital but could benefit from the housing support that Look Ahead provide.

Purpose of the scheme

The scheme was jointly developed by Look Ahead, East London Foundation Trust and the London Borough of Newham, who saw that a high number of patients were being placed out-of-borough or in private hospitals. The Trust put forward a business case, showing that hundreds of pounds per week could be saved per person and the flow through the inpatient unit could be improved. **Crucially, Ibis House supports individuals who no longer clinically need to be in hospital, freeing up much needed bed spaces in Newham's mental health inpatient unit. The scheme offers a better use of resources and positive outcomes for individuals.**

The Ibis House support model

Ibis House works on a flexible model, taking referrals from East London Foundation Trust based on the needs of the hospital wards. However, the referral process ensures that individuals are well-matched to the scheme and can benefit from the short-term support offered. The ethos of the scheme's partners centres on clinical care provided in the community rather than a hospital environment, with a framework of housing support.

Ibis House provides 24-hour staffed support service from a team of support workers, with tailored support and risk-management planning. The house operates a psychologically informed environment and connects individuals with any ongoing clinical support they are receiving, as well as services in the wider community that support their recovery journey.

The step-down service offers a stay of up to three weeks, and the referral process ensures there is already consideration and planning for the move-on process at the time of being admitted to the service.

Development and funding

Ibis House used to be a supported housing service for young people but was decommissioned. The scheme had been purpose-built with support services in mind, and had an office, reception area and safety features such as CCTV. This meant the new project could take shape at pace. However, Look Ahead reflected that developing a new scheme could have optimised the space, supporting more people than a repurposed existing building.

The ongoing costs are currently funded by East London Foundation Trust under the Hospital Discharge Fund—a two-year initiative aiming to support Integrated Care Boards and local authorities to facilitate better flow through hospitals. The partnership want to secure long-term funding, to maintain the high quality of the service through stable working relationships and improved staff retention. **Most importantly, longer-term collaboration and a funding commitment will result in better strategic planning to ensure supported housing can meet local needs now and in the future.**

Impact

At the heart of the scheme's development was a goal to reduce the negative impacts associated with a high number of Out of Area Placements, a high use of private hospital beds, and a high number of patients who did not clinically need to be in hospital. East London Foundation Trust observed a clear link between a lack of appropriate housing available and delayed discharge from their hospitals. In February 2024, 58% of clinically ready for discharge cases were related to housing. In the previous December, 24% of people on wards were recorded as "clinically ready for discharge". In the same month, the Trust recorded 31 instances where someone waited in A&E for longer than 12 hours to be admitted to a psychiatric bed. This shows the knock-on effect of delayed hospital discharge on admissions to hospital, meaning that Trusts often resort to paying for private sector hospital beds to treat patients urgently.

From a cost savings perspective, in the first 6 months of 2024 (January-June) the Newham directorate of the Trust spent on average £376,471 per month on private mental health hospital beds. **At the peak of these beds being used, the Trust estimates they spent the same amount of money in one month that could have covered the cost of running Ibis House for one year.** Fortunately, since August 2024 the Newham directorate has been able to stop the use of private hospital beds—which is a significant step in patient wellbeing and a more optimal use of the Trust's resources.

This improvement in resource management means that individuals can go to the place that best suits their care needs—whether that is a quicker admission to hospital, or being in a hospital close to their support network as opposed to out-of-area (the Trust is aware of the evidence base around increased risk of suicide following a discharge from out of area inpatient units). A supported housing pathway such as Ibis House means that individuals do not stay in psychiatric wards longer than they need to and offers an alternative to less suitable "bed and breakfast" placements. Although the scheme is still new, partners are currently developing a joint evaluation framework to monitor these positive outcomes more closely.

Challenges

In the first half of 2024, the Newham directorate of East London Foundation Trust reported spending on average £8,641.36 per month on "bed and breakfast" for people who were clinically ready for discharge but did not have housing ready to be discharged into. According to the Trust, this group of people would be mostly reliant on general needs housing or the private sector because their needs did not meet those set out in the Care Act. Although schemes like Ibis House offer an important step-down service and transition into the community from hospital, residents' stays are short-term. **A lack of other housing or services for people to move on to afterwards means that Ibis House must take this into account during the referral process and ensure that individuals admitted to the service already have move-on planning taking place.** Look Ahead reported that it can also be difficult for residents to adjust to leaving the service when the standard of the accommodation they will be going to is not of the same quality.

Working together well is critical to success

Another challenge to developing and running schemes like Ibis House is getting commissioners to understand the role that supported housing providers can play and the expertise they can offer. Without this awareness, local authority and NHS staff may feel that passing on funding to an external partner carries significant risk.

All partners involved in Ibis House valued the importance of relationship building. Look Ahead and East London Foundation Trust gave examples of previous pilot schemes that had not worked due to a relationship barrier. For example, individuals being placed in a scheme they weren't suited to because the referral process wasn't working.

Fortunately, Newham Council's flexibility and the willingness to take and share risk between East London Foundation Trust and Look Ahead meant that the scheme was possible. They continue to maintain a trusting relationship and believe in one another's expertise. For example, Ibis House intentionally does not have clinical infrastructure out of a preference to work in partnership with health colleagues. On the other hand, clinical colleagues are not best placed to navigate an individual's complex housing situation. By working together and understanding the connection between housing and health, this partnership can provide better outcomes for each service as well as individual residents.

South West Yorkshire Partnership Foundation Trust (SWYPFT) Hospital Discharge Service

The South West Yorkshire Partnership Foundation Trust (SWYPFT) Hospital Discharge Service provides transitional housing support for individuals being discharged from care, ensuring a smooth transition back into the community.

As part of this, West Yorkshire ICB commission three (soon to be four) properties for patients leaving Fieldhead Hospital in Wakefield. The properties, which are provided by Wakefield District Housing (WDH) and managed by Inspire North, accommodate people who are ready to be discharged from Fieldhead Hospital but have no safe place to go. They receive a high-level of support from Inspire North to live independently and live in the community.

Purpose of the service

The service was introduced to **address delays to discharge because of a lack of appropriate housing**, by providing a safe place to discharge people to. This means people don't need to stay in hospital any longer than necessary and can continue to receive the support they need in the right environment for their needs.

Beyond housing, the service offers funding to address various housing-related challenges, including rent arrears or necessary remedial work on properties before individuals can safely return home. It also provides small personal budgets for other housing needs and arranges short-term hotel accommodations when required. This comprehensive approach helps to remove housing barriers and support individuals in achieving stability and independence.

Through this, the service also aims **to reduce pressure on the hospital and free up bed space for people who need hospital treatment.** This is crucial for the hospital, with growing pressures due to increasing, and increasingly complex, demand.

How they work collaboratively to deliver the service

The pilot is commissioned by West Yorkshire ICB, who cover the housing costs for the properties, which are owned by WDH and managed by Inspire North. Residents can then claim Housing Benefit to cover their rental costs and are supported to apply for that. The ICB will cover housing costs where this is not the case and in between tenancies. The ICB also pay for furnishings to make sure they have a homely feel and give people the best possible start when they leave hospital. People can stay in the property for up to 12 months, with a high level of support provided by Inspire North to help their continued recovery and to build or regain the skills and confidence they need to live independently.

The ICB recognised that many of the people in their care, who are deemed clinically fit for discharge, still need further support to prepare them to live independently. Some of the people supported by the service have been hospitalised for several months, they may have histories of behaviours like damage to property, which make it challenging for them to find or retain general needs social housing or housing in the private rented sector. Inspire North have significant experience of supporting people who have been in similar circumstances, building important life skills, including how to maintain a tenancy.

Residents are proactively identified for the service through the NHS trusts' weekly Multi-Agency Discharge Event (MADE) meetings where they discuss patients who are likely to have a delayed discharge. Where homelessness is an issue, they can flag this as soon as they are admitted and begin putting plans in place for a timely discharge. The WDH hospital co-ordinator is a member of the MADE panel and plays a vital role in identifying housing for people to be discharged to, including who is likely to benefit from this service.

Some people need a slower transition from hospital to a step-down home. Inspire North have worked with the hospital to support someone with a transitional discharge, who spends their days at the property but returns to the hospital for the evening. This would be much more difficult, or even impossible without the funding to cover the costs of the property.

Impact

According to the ICB, the service has likely saved months of additional bed days, given the time it would usually take to identify a social home. This means significant amounts of money saved, with a specialist mental health hospital bed costing between £500 and £700 per day.

By supporting 8 to 10 people to reduce their length of stay by 2-3 months, the SWYPFT hospital discharge service could save between £113,520 and £344,100 per year.

But bed flow is also really important to the ICB and the service has meant that beds have been made available for someone waiting to receive hospital treatment.

Pressure is also relieved through reduced readmissions. An alternative to the scheme, might also be discharging the person to the local authority for emergency accommodation. But this is a situation which is likely to result in crisis almost immediately.

Although the service is relatively new, they have had a huge impact on the first people supported through the scheme. One resident with complex mental health needs had experienced a decade of cycling through admissions, discharges, crises and readmissions. In a relatively short space of time, they have been supported to move into their own accommodation. This has therefore resulted in huge cost savings, while also **providing the right environment for someone to break the cycle and truly begin their recovery.**

Challenges

The service requires the ICB to secure buy in from all partners, including those providing the housing and managing the service. **Housing associations can have reservations given the levels of risk.** With pre-tenancy checks handled by Inspire North, and the possibility of housing people with histories of violence, there was some initial hesitance within WDH. However, they were reassured by the detailed risk assessments and robust support provided Inspire North.

The pilot has funding for two years, but all partners were keen to continue and expand the service, recognising that there is more demand than the four properties can meet. However, if the service were to continue beyond the pilot, procurement requirements mean it would need to go out to the open market. This makes it **challenging to maintain relationships which are so key to delivering this kind of service.**

Another challenge which impacts on the flow of the service, is a **lack of suitable accommodation for residents to move on to.** While the people going through the service tend to have the highest priority status on social housing waiting lists, they may have specific requirements due to their mental health challenges, such as a self-contained property with its own front door. And social homes like this are in high demand.

3 People with a learning disability and autistic people

Supported housing offers people with a learning disability and autistic people an opportunity to live independently, in their own home and close to their friends and family.

However, too many people with a learning disability and autistic people remain in more restrictive settings such as residential care or hospital, on mental health wards sometimes far away from home, due to a lack of supported housing. Mental health wards are not appropriate environments to meet their needs, with negative impacts on sensory perceptions such as lights, noise and temperature being a particular concern for autistic people.[38] Moreover, some people with a learning disability and autistic people can experience intolerable treatment in inpatient facilities, including abusive and restrictive practices.[39]

The government's recent Supported Housing Review calculates how much unmet need there is for supported housing and how many homes are needed to meet unmet need in the future. More than half of the commissioners surveyed said that there was unmet demand for supported housing for residents with learning disabilities and autistic people in their area.[40] A lack of suitable housing is a key barrier to discharging people with a learning disability and autistic people from hospital – it was cited as the reason for 56% of delayed discharges in March 2024.[41]

A lack of suitable housing was the reason for

56%

of **delayed discharges** in March 2024.

This affects the government's ability to meet commitments set out in the 2019 NHS Long Term plan regarding the Transforming Care agenda. The Plan committed to reducing the number of people with a learning disability and autistic people in mental health inpatient facilities to less than half of 2015 levels by March 2023/24. The CQC report that this commitment, alongside others made in relation to the Transforming Care agenda, have not been met. In March 2015, there were 2,905 autistic people and/or people with a learning disability as inpatients. By March 2024, the target's deadline, there were 2,155 inpatients. This is only a 26% decrease on the March 2015 figure.[42]

Therefore, supported housing is crucial to delivering the aims of the Transforming Care agenda, as well as to incoming changes to the Mental Health Act. These changes will mean that people with a learning disability and autistic people would no longer be able to be detained under section 3 of the Act unless they also have a psychiatric disorder. But there needs to be sufficient provision in the community to house and support people with a learning disability and autistic people, as we hear from commissioners that, currently, a hospital admission is the only option for many.

Hampshire and Isle of Wight ICB

The ICB have 30 specialist supported homes in their portfolio for people with a learning disability and autistic people who are eligible for NHS Continuing Healthcare (CHC).

These specialist supported homes are micro supported housing schemes, ranging from a few single properties to a scheme of eight flats.

They have taken an innovative approach to finding and funding these properties which has helped them to discharge people from restrictive hospital settings to living independently in the community, sometimes after very long admissions. These schemes have also helped to avoid inappropriate admissions to hospital.

The approach is built on a recognition of the importance of public services working together to create the right profile of housing.

Why was this change in approach needed

With a shortage of bespoke housing options in Hampshire and Isle of Wight, particularly for people with a learning disability and autistic people, a lack of suitable accommodation was being cited as the predominant factor in the length of stay, delayed discharge and admission to assessment and treatment units. It also meant there was a risk that people are placed outside of the county and/or in high-cost residential settings.

The ICB also recognised that housing need is growing for this group of people who may be overlooked in existing housing plans and end up in inpatient settings. In 2023/24, there were 475 people with a learning disability and autistic people in Hampshire and Isle of Wight who had complex support needs. The ICB estimated that there would be a need for housing and supported accommodation for an additional 250 people by 2027/28.

Hampshire and Isle of Wight ICB developed a Housing Strategy which aims to deliver sustainable, well-designed housing and support for people with complex needs, to reduce inpatient stays and enable people to build a life outside of hospital or to avoid admissions to restrictive environments.

How did they work collaboratively to address this need

The ICB started to build relationships with a new sphere of stakeholders, including developers, housing providers and investors. They put together a demand profile which contains information about the people in their care who are going to need housing. This signalled to the market what their requirements were.

The commissioners began to work with a specialist housing developer, Purpose Homes, to find suitable properties and to identify a funder to cover the costs of purchasing and adapting the property. This tends to be private investors who then own the property, although the ICB have a small number of capital grant funded properties.

In this model, the completed property is then leased to a registered housing provider who manage it, with rent paid via the housing provider using Housing Benefit. The schemes are designed as Specialised Supported Housing (SSH). SSH has higher development costs, due to the level of adaptions and space required. Where there is no public capital grant towards the building or purchase costs, the rent is normally higher than other types of supported housing. Rents must be set at a level that can be covered by Housing Benefit or else the property will not be affordable for people claiming benefits.

The ICB signs a voids and nominations agreement which means that if the property is empty between tenancies for more than three months, then the ICB will cover the rental costs. This would come out of a voids budget line within the ICB's budget. The agreement means that the ICB has guaranteed access and rights to nominate tenants for the properties in their portfolio when they become vacant. While this agreement commits the ICB to potential financial liability and risk, the nominations agreement and demand profile mitigates this by enabling them to rapidly match people on the waiting list to the vacant homes.

Social care support is funded through CHC. The ICB have a Supported Living Contract Framework with preferred care providers. They discuss the needs of the people within the scheme with the provider to ensure they can meet those needs and work with them effectively. A service level agreement is signed between the landlord and care provider to promote seamless care and housing for tenants.

The ICB aim to ensure the provision of housing is separate from the provision of health, care and support services. While they recognise there is an element of mixed services, they want to ensure security of tenure and to encourage choice and flexibility for individuals regarding personal budgets. Previously they would spot purchase homes via care providers, who source private leasehold and rented accommodation. These homes did not always have a secure tenure which meant that if the care provider broke down then the person lost their home as well and, without an alternative, they were much more likely to end up back in hospital.

Impact

The biggest outcome for the ICB is being able to support mostly young people to have a life outside hospital as a basis to build progress towards independence, for whom there was no alternative solution. This results in long term cost savings for the ICB and assurance that they will continue to make cost savings in the future. They can control costs over a longer period, as they now know what their costs for this cohort of people are going to be 5-10 years in advance. Moreover, accommodation costs, which have previously been paid for through a health budget, are now more appropriately covered by Housing Benefit.

Across the first 21 specialist supported homes they identified for people in their care, the ICB estimated savings on their All Age Continuing Healthcare spend of £1 million per year. Moreover, initial financial modelling of opportunity costs associated with this new approach indicates **cumulative savings over five years in the region of £10m.**

This starts to illustrate some of the significant benefits for the system. But there are also positive impacts for the people who can live in these homes after significant lengths of time in a highly restrictive environment.

One person, who had been in hospital from childhood through to young adulthood, initially stayed in their bedroom as they didn't realise that the rest of the house was theirs. Now they have formed a relationship with their neighbours, taken up gardening and cooked meals for their parents.

Another person who had been in hospital for over three years and has a history of extreme self-injurious behaviour and trauma is slowly transitioning into their new home. Their home has been designed with the support of a suicide prevention specialist to be a safe place for them to live. They are now showing confidence and a level of optimism that had not been seen for a long time.

These changes are also likely to improve the person's health and wellbeing and reduce the likelihood of readmissions and other costs on the NHS that result from poor physical and mental health.

Challenges

The ICB reported that accessing funding for the purchase and adaptation of the homes is challenging. High demands on capital grants available through NHS England's (NHSE) Transforming Care programme has made it difficult to access this funding. Therefore, the homes are primarily funded using private lenders. This increases rent costs needed to cover repayments and, therefore, the ICBs liability through their voids and nominations agreement. While the risk is manageable with the small number and size of the schemes they currently have, it may limit how many more homes they can commission using this approach.

A relatively small amount of capital grant funding would make a huge difference. It would simplify and speed up the process of securing the property, and it would keep rent costs low, providing benefits across the whole system, such as through reduced Housing Benefit costs.

The approach has so far been developed somewhat experimentally. **The next step is to ensure there is governance and oversight within the ICB.** Commissioners recognise that their role is to deliver care, not housing, but there is the expertise within the wider ICB, such as in the team responsible for estates. They are working now to ensure senior leaders within the ICB understand the long-term benefits and cost savings for the ICB, whilst recognising that the ICB will be able to predict the long-term costs for this group of people in a way that is not possible in other areas of the organisation. The ICB is also building a regional approach with other ICBs and partners to generate a collective view of supply and demand to share with the market.

Gloucestershire ICB

Gloucestershire ICB commissioners found that a lack of suitable supported housing was having a huge impact on people with a learning disability and autistic people. This is through unnecessary admission, as well as delays to discharging people with no clinical need for treatment. The Commissioner told us that when a placement breaks down, while it is possible to find replacement care providers to support the person, finding alternative accommodation is more difficult.

They reported that all the ICB-commissioned people currently within inpatient units and around 25% of Gloucestershire people within secure hospitals are delayed discharges. They have been clinically ready for discharge for some time but been awaiting a suitable property in the community that they could call a "home".

Recognising that the system was not working, the ICB looked to develop an approach to ensure that the people in their care could be discharged into a home that meets their needs, supports their independence and breaks the cycle of readmissions.

Guiding principles of the approach

Gloucestershire ICB commission registered housing providers to develop supported housing schemes in the area for those people who are ready to be discharged. **These schemes are 100% NHSE capital grant funded, which the ICB feel is key to getting housing associations on board.** Compared to using private finance, grant funding also keeps ongoing housing costs, usually covered by Housing Benefit, to a minimum.

Where possible, the ICB prefer to develop new homes as this is cheaper than adapting existing homes, and it means that the homes are tailored to the requirements of those who will be living in them. However, building new homes is a longer process, often taking up to three years from start to finish. Without a housing strategy and forward planning, the approach tends to be more reactive, which requires buying a property off the market.

Gloucestershire ICB aim to ensure that the **accommodation and social care provision are commissioned separately.** This is opposed to a residential care home or supported living model where the care provider brings the housing, which they usually lease from a private landlord. By separating the housing from the care provider, they reduce the risk of the person losing their home if the care placement breaks down. The ICB have had situations in which someone was admitted to hospital or was at high risk of hospital admission because the care provider could no longer support a person, had staffing issues or were selling their business and the incumbent provider had different strategic objectives.

Impact

Although the homes often have a significant upfront cost, **the savings far outweigh the costs, with the upfront development costs paid back sometimes within a few years. Along with these savings, are even bigger impacts for the individuals themselves.**

For example, the cost of adapting a home for one individual was around £451k, entirely grant funded through NHSE capital grant, the ICB and a small amount from the local authority through the Disabled Facilities Grant. The process of searching for and adapting their new home took over two years. However, this home will save £207k across health, social care and Housing Benefit spend each year.

This individual, who had spent over 3 years of their young life in a highly restrictive Assessment and Treatment Unit (ATU), despite having no need for treatment, can properly start their adult life with support around them to develop skills for independent living.

Another person had been in hospital, in an ATU in a different county, for 20 years. Their treatment was costing around £434k per year. They were discharged a few years ago into specialist supported accommodation which costs the ICB and Department for Work and Pensions (DWP), through Housing Benefit, almost half of that - £253k a year. Therefore, this is a saving of £181k per year across the system.

For the person, the move provided new opportunities, including getting a pet and having their family over for dinner, the first time they have been able to eat together since they were admitted to hospital.

Challenges

A key challenge is finding housing providers who can develop this type of housing, which are very small schemes, sometimes only one or two-unit properties with staff space and usually very bespoke. The schemes within Gloucestershire ICB have been possible because of the 100% capital grant funding offer. However, this can't cover the development of the numbers of homes that are needed. Other privately financed solutions make the proposal less viable for housing associations, without a longer-term commitment.

Integrated Care Systems (ICSs) could help alleviate this challenge by developing the registered housing provider market. This requires ICSs to have a housing strategy, that reflects an understanding of the housing needs of people with a learning disability and autistic people within their community, and a proactive plan to meet those needs. A long-term plan like this assures registered providers they can step into this space and combined efforts at being creative with capital funding that is best value to the public purse.

4 Older people

Housing designated for older people makes up most supported housing, with the 2023 Supported Housing Review estimating this proportion at 65%.[43] This umbrella term covers a range of support needs, for example sheltered housing provides limited levels of support, while extra care (also known as assisted living) provides high levels of support.[44] It is widely understood that England has an ageing population. According to ONS population projections, people over 65 will make up 22% of the population by 2040.[45] This ageing population combined with improvements in average life expectancy will result in increased demand for supported housing for older people. Our research estimates that we will need an additional 167,329 units of supported housing (including housing for older people) by 2040, most of which will be for older people.[46]

65%

of supported housing is **designated for older people.**

In addition to significant cost savings to the NHS, supported housing for older people can offer improved wellbeing and quality of life as well as physical health benefits. This is especially true for supported housing that enables a timelier discharge from hospital. More than one in three 70-year-olds experience muscle ageing during a prolonged stay in hospital, which increases to two thirds of individuals over 90 years old. They may also be at an increased risk of infection, or "deconditioning", where an individual loses independence.[47] A Homes England study investigated the wellbeing and fiscal impacts of designated housing for older people. The economic analysis found that increased wellbeing associated with moving into sheltered or extra care housing could generate as much as £6,479 per person per year in social value.[48]

It is important that older people have access to the right housing. Older people can be particularly vulnerable to poor housing conditions that can affect existing health conditions, reduce quality of life or even result in a premature death.[49] A 2016 study found that sheltered housing saved the NHS at least £486m per year, with the largest part of this saving due to a reduced length of inpatient hospital stays. The study found that shorter hospital stays were made possible because residents of sheltered housing could more quickly and easily return to their home that was already adapted to their needs. Sheltered housing also prevented further hospital admissions as the accessibility features meant residents were less likely to fall and/or suffer hip fractures.[50]

The Discharge to Assess initiative in Bolton

Anchor, England's largest provider of specialist housing for older people, has worked in partnership with Bolton Council, Bolton Cares (the care provider), and NHS colleagues to pilot the Discharge to Assess (D2A) scheme in an Anchor extra care housing scheme in Bolton. Through this partnership Bolton Council and Anchor aim to help as many older people as possible to live well at home.

The scheme provides a more homely and appropriate setting for people who are unable to initially return to their previous homes following an admission to hospital. This includes patients who may be waiting for adaptations to their homes. The scheme aims to reduce the risk of further deterioration in health for those who have been in hospital and support their recovery. Importantly, the scheme offers an alternative to being admitted to a care home.

From pilot to permanent scheme

Anchor's Rushey Fold scheme now has four out of 29 units designated for D2A, having been set up in 2023 with a trial of one unit. These include three two-person, one-bedroom flats (one with an external entrance) and a one-person, one-bedroom flat. Rushey Fold is designed for people over the age of 55, and the D2A scheme provides temporary accommodation for people discharged from hospital.

Referrals are managed through the local authority's hospital discharge team, who make sure residents meet eligibility criteria. The local authority then leases the units on a permanent basis, covering the costs during each person's six-week assessment period. During their stay, residents receive reablement support and their housing and care needs are evaluated, smoothing the transition to longer-term living arrangements.

Working in partnership

The scheme runs as a three-way arrangement between the landlord, council and care provider. Bolton Cares are contracted and paid by the council to deliver care on behalf of the council in all ten extra care schemes in Bolton. They are a separate entity to the council but are wholly owned by it.

The scheme is funded through the Hospital Discharge Fund from the Ministry of Housing, Communities & Local Government, with the goal of reducing hospital discharge delays.

The scheme's success relies on a strong partnership between Anchor, Bolton Cares, Bolton Council and NHS colleagues. Weekly allocation meetings ensure collaborative decision-making, while care services and additional on-site support hours are commissioned by the local authority.

Anchor's engagement with local authorities across England shows the potential of this model to work in different locations, with similar schemes operating in Manchester and other councils. The pilot showed the importance of feedback mechanisms and open communication to continual learning and improvement, with a shared commitment driving innovation.

Impact

The D2A scheme has significantly improved residents' lives and recovery by providing a secure, supportive environment tailored to their individual needs. Residents have said they feel "peace of mind" because of dedicated on-site care and the opportunity to regain their independence with the right support in place:

> **"The best things about Rushey Fold are the people and the atmosphere: I feel safe. I'm living on my own in my own flat, but I know I'm not alone because there are people around me and staff will pop in throughout the day to visit and support me. [...] However, I'm still independent because I can go out as and when, knowing I have a secure place to return to."** Len, Rushey Fold resident.

The scheme shows the importance of building community connections to combat social isolation, with residents saying they feel secure because of a positive community atmosphere. Feedback consistently shows the scheme's transformative role in improving wellbeing and independence, reducing hospital re-admissions, and encouraging stability.

One participant shared how their stay restored their confidence after leaving hospital, improving their quality of life:

> **"My time at Rushey Court turned my life around. [...] Because I am unable to read, and I now need help with my shopping, laundry and self-care the support at Rushey Fold, and knowing there is someone there, means I feel safe - and I don't feel alone. My family also have the peace of mind that I'm being looked after".** John, Rushey Fold resident.

The scheme's success is evident: some residents who initially came to Rushey Fold through D2A have chosen to stay due to the supportive community. To date, seven of 12 people who have been through the pilot moved to permanent extra care housing tenancies, with five choosing Anchor homes, while others moved back into their previous homes.

Challenges

Changes in hospital discharge dates can present logistical challenges, but close communication between partners has made processes smoother. Weekly meetings and contingency planning has been key to making sure residents have the best experience possible after leaving hospital. The partnership has learnt that clearly defined roles help mitigate risks, and adaptability enables the team to address any issues while maintaining focus on resident care and recovery.

Reflections on supporting older people's housing needs

Anchor is England's largest not-for-profit provider of housing and care for people in later life. It provides housing to rent and buy alongside residential care homes, including specialist dementia care. In total, Anchor serves more than 65,000 residents in almost 55,000 homes across almost 1,700 locations. Anchor operates in more than 85% of local councils in England.

This means Anchor are in a position to pilot and reflect on the benefits of D2A initiatives in extra care schemes. The approach shows a strategic opportunity to bridge the gap between post-hospital care and housing. Nationwide implementation, supported by stable funding and standardised procedures, including allocation panels, would improve efficiency and effectiveness, as well as relieve pressure on the NHS.

Findings from across the case studies

While the case studies present a range of different housing and support models for people with varied needs, when speaking to the health and housing partners involved, we heard similarities in how they are delivered, the challenges they've faced and the impact they have had on people's lives.

Why do we need new approaches to hospital discharge?

The initiatives in this report were all developed to reduce housing-related delays to discharge and prevent readmissions. By working together, they show there is an alternative, where no one is discharged to settings that do not meet their needs, such as temporary accommodation or even the streets.

We heard concerns **about the negative impact that unnecessary discharge delays and readmissions have on the people experiencing them.** In particular, we heard about the profound impact that being detained under the MHA has on people which "can obviously stay with them for the rest of their life" (SWYPFT Hospital Discharge Service, NHS commissioner). Long periods of hospitalisation over months or years, can institutionalise people, meaning that they require a lot of support to live independently outside of hospital. It is crucial that they are discharged as soon as they are clinically ready to a "less restrictive and more humane environment" (Gloria House, NHS Commissioner) in the community, with the right support and supervision while they continue to recover, reintegrate into their community and break the cycle of hospital admissions.

But we also heard about the huge impact of delayed discharges and avoidable readmissions on the health system in terms of cost and resource pressures. NHS commissioners told us they **needed to reduce spending on hospital placements for people who no longer needed any clinical treatment.** For example, we were told that the cost of an excess general ward bed day is £587, while a stay on a mental health ward can cost somewhere between £500 and £700 per day. Money that, as one commissioner stated, is better spent in the community.

We also heard about how important it was for commissioners **to reduce the impact that these delays were having on bed spaces.** One mental health ICB commissioner stressed that "there is a queue the other side for people wanting beds" (Fieldhead, NHS commissioner), while another told us about the knock-on effects that delays on their mental health wards can have on A&E, increasing the number of people waiting more than 12 hours in A&E before being admitted.

Where there isn't sufficient space on mental health wards, hospital trusts have to commission placements for people in private hospitals, sometimes far away from their home and families. One trust spoke about the "eye watering amounts of money" they were spending on private sector mental health beds (Ibis House, NHS commissioner). For example, in one month in 2024, they spent £570k.

Unnecessary costs associated with readmissions could be avoided. If people have a safe place to live when they leave hospital that meets their needs, they might not need to return. Both schemes in general hospitals were set up to prevent people being discharged to the streets, the place that most likely made them ill in the first place. Unsurprisingly, those people were often readmitted not long after. One of the services described this as "a revolving door" for this group of people (Gloria House, housing provider).

We heard similar issues from those working in mental health hospitals. People in their care were often discharged to settings that did not meet their needs and would go through a cycle of: admission, discharge and readmission. Sometimes this included temporary accommodation, including hotels. Without the support they needed, this often resulted in crisis, and they would end up back in hospital.

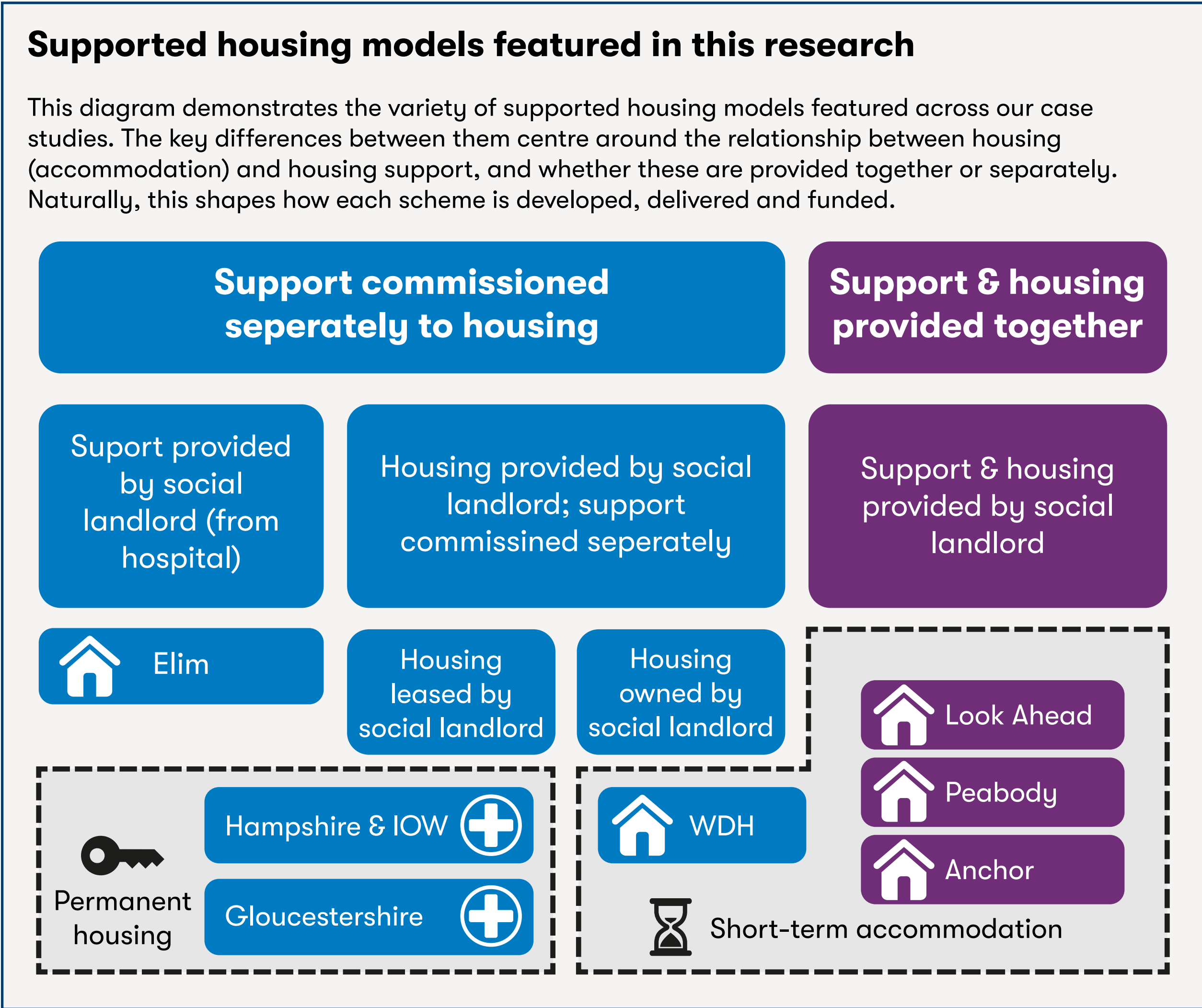
Learning Disability and Autism Commissioners in two ICBs told us how it is common for people with a learning disability and autistic people to be discharged to a residential care home or to a supported living home where care and housing is provided by the care provider. With both these elements led by the care provider, if the care element breaks down, then the person loses their home too. Finding another home at short notice to meet the needs of someone with complex learning disabilities is near-impossible. This means they are more likely to end up back in hospital. They were taking innovative approaches to ensure that the housing and registered care were commissioned separately for this group of people to prevent this from happening.

> **"They [the care provider] sign an SLA [service level agreement] with the landlord. We like that model because it separates the care and the housing. So, if for any reason the care breaks down, somebody doesn't lose their home. Because if they lose their home, they're so much more likely with all their needs to end up back in hospital. So it gives that security."** (Hampshire and Isle of Wight ICB, NHS commissioner)

Anchor's housing scheme in Bolton operates a Discharge to Assess (D2A) model which was introduced nationally by the NHS in 2020 and has been described as "a cornerstone of modern care for older, vulnerable people".[51] Although the model has multiple pathways within it, it broadly serves the aim of supporting people to leave hospital as soon as possible, with their longer-term needs assessed in an appropriate setting outside of hospital. Anchor believe that expanding programs like D2A nationwide could bridge gaps in care and housing, ensuring a smoother transition for older people leaving hospital or unsuitable environments. In creating a pathway to independent living for older people, these schemes also have a positive impact in both the short and long term

How it works – development, delivery & funding

This research features case studies from supported and older people's housing providers. Some schemes support individuals with a wide range of needs, while others provide services designed for specific groups of people and/or specific support needs. This also reflects the type of hospital discharge pathways that each scheme facilitates—whether this is from a mental health or acute trust. The schemes and partnerships all differ in the way they are developed, delivered and funded, but have usually been piloted and adapted before finding an optimum way of working.



Development

Approaches to identifying the properties for the scheme tended to be either **repurposing existing properties already owned by housing associations or, less commonly, NHS sites, or purchasing properties off the open market. Both approaches require adaptations to make them fit for their new purpose.**

For example, in two of the case studies, the housing association identified one of their properties that had previously been used for supported housing, requiring lower adaptation requirements. This meant it took less time to prepare the scheme and at a lower cost. However, one disadvantage was that the building had not been tailored to specific support needs, and meant the providers were more limited in how they could design and optimise the space.

In the case of Anchor's D2A scheme in Bolton, the scheme operates within an already-existing extra-care scheme, Rushey Fold. All Anchor's housing with extra care locations are fully wheelchair accessible, including walk-in showers and lifts to upper floors, and each home is also fitted with a 24-hour emergency call system. This means that Anchor are ideally placed to support the transition from hospital to a supported living environment and respond flexibly and swiftly to referrals from Adult Social Care.

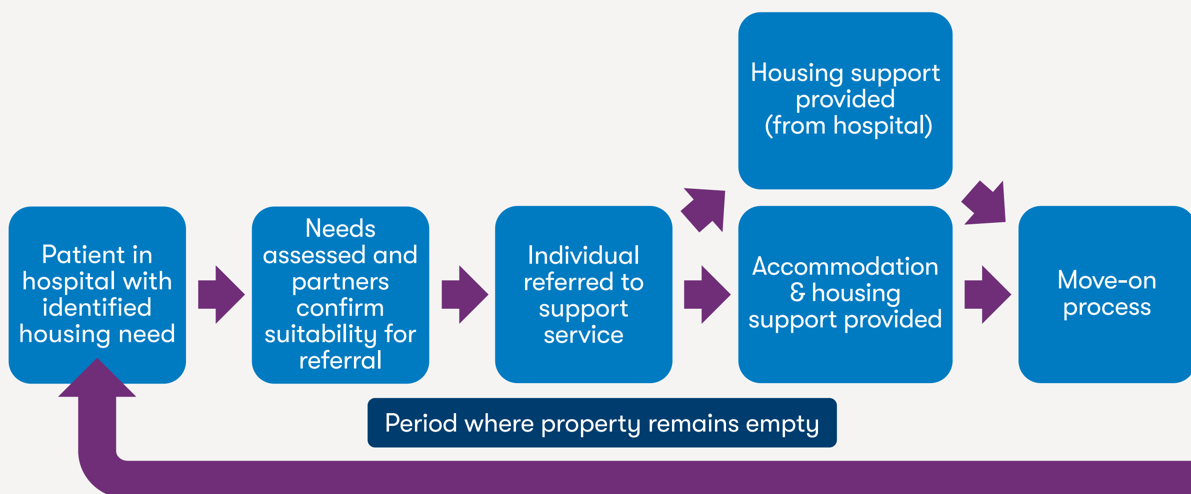
One commissioner for people with a learning disability and autistic people worked with a specialist housing developer to identify suitable properties available on the open market. They have also explored repurposing previously used NHS buildings, including buildings that were purchased alongside the closures of hospitals brought about by the Transforming Care plan. The ICB acknowledged that purchasing individual properties may not be sufficient to meet demand, and they have worked to create their own profile of future demand over the next five years to ensure they are ready to respond strategically.

Gloucestershire ICB have started to work with registered housing providers to develop supported housing schemes in the area for people who are ready to be discharged. While there were very few examples of building new homes across the case studies, the learning disability and autism commissioner in Gloucestershire ICB told us that developing new homes is their preference as it is cheaper and can be more tailored to the individual compared to purchasing and adapting existing homes, but it takes longer and is not always possible without a housing strategy and forward planning.

Delivery

Illustration of a typical hospital discharge journey

This diagram shows a typical journey of a patient across our case studies who is supported with their housing needs as they are discharged from hospital.



A housing need may be identified before or after the patient is deemed 'medically fit for discharge'. **Several schemes aim to begin housing planning as early as possible in advance to reduce the possibility this would cause a delay.**

NHS and housing colleagues discuss an individual's needs and whether they are appropriate for the support service. These discussions may take place with supported housing providers, or specialist housing coordinators working within the hospital. We heard about **the importance of joint working to ensure housing expertise is involved early on in these discussions.**

In some instances, such as Anchor's D2A model, there may be a distinction between a rapid assessment to prepare a person for hospital discharge, and an assessment looking at their longer-term recovery and/or housing needs once in a more suitable environment. This is in accordance with statutory guidance from NHS England and the Department of Health and Social Care.[52] In the diagram above, this longer-term assessment is broadly covered under "housing support".

Individuals are referred once they are confirmed as being suitable for the scheme. Several housing providers have no fixed criteria, while others provide a more specialist service to certain patient groups, or referrals are managed by the local authority's adult social care team. In some cases, suitability is based on accessibility requirements.

The schemes for people with a learning disability and autistic people are intended to be a long-term, permanent home for the person, if that is what they want. They commission the care and housing separately, with care provided by a registered care provider and housing provided by a registered housing provider.

Although Anchor's D2A scheme in Bolton operates on a short-term basis of six weeks, its placement within a wider extra care housing scheme means that some individuals have become permanent residents in Rushey Fold following their initial stay. This shows an advantage of purpose-built properties that are suitable in both the short and the long-term and the ability of Anchor as a specialist, large landlord to respond to multiple types of demand.

Most of the hospital discharge services featured in this research were shorter term. Individuals receive support to prepare them to move on to longer term accommodation. For these schemes, support tended to be provided by the housing provider, apart from the SWYPFT hospital discharge scheme, where the housing is provided by WDH but Inspire North are commissioned to provide the support, including housing-related support.

Many of these short-term supported housing schemes were impacted by housing shortages, which made it difficult to find suitable long-term housing for people to move on to. This was sometimes due to the need for accessible housing to meet physical need but also needs arising from mental health challenges. We heard how it can be particularly difficult to find housing for people with mental health challenges who have a history of property damage. One of the step-down services for people being discharged from a mental health hospital were having to restrict who they could support through the scheme to people who they have at least an idea about where they will move on to.

Local housing shortages also impacted Elim's H.O.M.E Service, which consists of housing support officers working within the hospitals to identify housing for people to be discharged to. This tended to be temporary accommodation, including B&Bs, particularly for people in the general hospitals. In the past they worked with private landlords to provide permanent housing for people to move into, however they were finding that fewer landlords are willing to do this and Local Housing Allowance rates have not kept up with rising private rents.

Funding

To develop the supported housing schemes, varying amounts of capital funding were required to purchase, adapt and/or build the homes. Sources of capital funding included grants from NHS England, but also private investors, sometimes from ethical investment funds, when grants were not available.

NHS commissioners and housing providers raised the importance of capital grant funding, for both those providing short-term accommodation and those identifying long-term supported housing for people with a learning disability and autistic people. Access to capital funding was a key barrier for two of the case studies.

Learning disability and autism commissioners in one ICB told us how they needed capital grant funding to continue to be able to secure supported housing for the people in their care. While there are grants available through NHS England, these are limited. Therefore, the ICB currently relies on private funding, which results in higher rents and greater risk for the ICB who cover the rent when the property is vacant. They thought that "a relatively small amount of public funds would really move this market and change the picture" (Hampshire and Isle of Wight, NHS commissioner). In another ICB the commissioner felt that using 100% capital grant funding was key to bringing housing associations on board (Gloucestershire ICB). With grants limited, this restricted the number of people they could support through this approach.

In terms of revenue funding, support for individuals could be covered by the NHS Hospital Discharge Fund, NHS Continuing Care (including joint funding with Local Authority Adult Social Care). And, while rents could often be recouped through Housing Benefit (either fully or partially subsidised by DWP), in some schemes housing costs were initially covered by the ICB.

Funding agreements needed to be carefully designed to cover risks to all providers. These included damage to the property and periods of the property being vacant (voids). Although on rare occasions, the ICBs covers the cost of void properties, the risk of this happening frequently and for long periods could be mitigated for by having a clear monitor for demand for the service and a smooth referral process. Another ICB highlighted that empty periods could also allow for refurbishment or adaptations to the property, and that these gaps were not very common.

Health and housing providers involved in the step-down services told us that **short-term funding restricted their ability to build trusting relationships with partners across organisational boundaries as well as with the staff** delivering the service. Similarly, there was a concern that the requirements of the procurement processes, particularly when setting up a contract for services following a pilot, also make it challenging to maintain relationships which are so key to delivering these kinds of services.

Partnership working

Across our case studies, each scheme is the result of a carefully developed partnership that spans across service delivery, funding, planning and strategy. Housing Associations and NHS ICBs were at the heart of these partnerships, with local authorities also playing an important role. Although partnership working had its challenges, partners we interviewed felt that it resulted in a higher quality service and better outcomes for individuals.

Generally, supported housing providers and health professionals acknowledged that there had been **little previous experience of partnership working between their sectors in the recent past.** In some instances, there had been previous attempts to establish a health and housing partnership for hospital discharge, which had either not happened at all, or were not feasible to continue. Without this shared history to draw from, they found themselves working in an unfamiliar territory.

Although local authorities, the NHS and supported housing providers all had different perspectives on the problems with housing and hospital discharge, they all understood how acute these problems were, and felt they could make a unique contribution to addressing them. Hampshire and Isle of Wight ICB recognised that their involvement as health professionals was critical for addressing the unmet need of housing provision for individuals with a learning disability and/ or autism—as housing providers would not be able to address this on their own.

> **“There is a need. There’s a massive area that nobody’s doing anything with, and this is where the NHS needs to jump in”** (Hampshire and Isle of Wight ICB, NHS commissioner).

Almost every partnership featured in our case studies had its origin in a conversation and a willingness to be proactive. Establishing a relationship from scratch was difficult for some partners, and NHS colleagues acknowledged that their sector needed a greater adjustment to working in partnership with others, particularly housing professionals. One NHS representative explained that it took time to convince colleagues about the need to be involved in housing – an area traditionally seen as outside of their remit. Another said that the NHS sometimes preferred to work independently to reduce the risk involved when working with others.

The willingness to take risks and try something different was a requirement from all partners we spoke with. At a basic level, this risk centred around the possibility that the time and resources required would not guarantee success.

> **“...there’s a financial risk [...] There’s a clinical risk which I guess is how people feel placing individuals that would otherwise be on wards in the community. There’s a bit of a risk for us as an organisation, that we are willing to take people who would otherwise be on wards, and what happens when it goes wrong”** (Ibis House, housing provider).

For local authorities and NHS commissioners, they took a financial risk with the initial investment required to develop, purchase or adapt supported housing, and an ongoing commitment to the scheme. One NHS trust and a housing provider mitigated this risk with a shared voids agreement (establishing how costs and commitments to lenders will be paid if or when the property is empty) to share the financial liability more equally. The Trust’s relationship with the local authority also meant that individuals could be nominated for the scheme who received joint funding from the NHS and Adult Social Care. In another partnership, the local authority and the ICB paid for housing costs upfront, with the housing provider then collecting and refunding income received through Housing Benefit. An additional advantage of this meant that they could allocate one bedspace to individuals with No Recourse to Public Funds, who face extra challenges with finding suitable accommodation.

Effective partnership working and communication were key to addressing risks—whether this was identifying operational risks in advance or addressing issues that emerged during the partnership. This improved trust in their partners' expertise and capabilities to deliver on their areas of responsibility. One supported housing scheme offered little clinical infrastructure out of choice, instead preferring to use the expertise of NHS colleagues and ensure they were helping their residents connect with ongoing clinical support in the community. In the same way, the NHS partner recognised that their staff didn't have the skills or knowledge to support patients with housing issues, and doing so would not be an effective use of time or resources. Within the context of hospital discharge, supported housing has a role to play as an individual begins to need more practical and holistic support to support their recovery and independence, rather than clinical support:

> **"[...] particularly with mental health, the clinical input is important, but probably only ever 20% of the solution, 80% of it is what I might describe as social. And unfortunately, within the NHS, we're very focused on clinical outputs and clinical solutions, almost to the exclusion of everything else. But it's everything else that really makes the difference".**
> (SWYPFT, NHS commissioner).

Another factor was having a local strategy that all partners are involved in delivering. Some housing and health providers felt this was missing and would be beneficial to the delivery of their services. This would also bring with it some assurances around long-term commitments for housing partners. Through collaboration between the NHS trust, housing provider and local authority, one of these schemes enabled the development of a local strategy around supported housing, generating a shared vision, which the NHS commissioner felt was enabling a more "sustainable long-term development of the system" (Ibis House, NHS commissioner).

The NHS, local authority and housing professionals we spoke with felt that the benefits of partnership working extended beyond the effectiveness of the scheme. One NHS ICB explained that they had become more skilled at building relationships with other stakeholders since the partnership, and that their approach had shifted away from working in isolation. A second NHS representative explained that working collaboratively meant they could think more strategically in the future about planning their services.

In some cases, the partnerships were so successful that they expanded to create new schemes or to work together at a higher level. One NHS Trust had begun employing a homelessness officer specialising in mental health to work at the local council, and another ICB created a job role who had responsibility for developing these relationships. One housing provider recently created a housing coordinator role for people with a learning disability and autistic people which is funded by their ICB on an ongoing basis. Despite challenges to the sector, several organisations had further ambitions or plans to expand their current partnerships or seek new ones after experiencing the benefits of working in collaboration.

Positive impacts

There were significant impacts across all case studies, including cost savings for the NHS and local systems, reduced pressure on the NHS and improved health and wellbeing and new opportunities for the people supported to leave hospital.

By discharging people to more cost-effective accommodation in the community once they no longer needed any hospital treatment, **huge cost savings have been generated across the local systems.** This was a consistent theme across the case studies, despite people's different support needs and models of schemes and services used.

Gloria House, a six-bed hospital discharge scheme in Hackney has generated savings of over £1.8 million to North East London ICB since 2018 by speeding up hospital discharge for people experiencing homelessness.

South West Yorkshire Partnership Foundation Trust estimate that, by supporting 8 to 10 people to reduce their length of stay by 2-3 months, their hospital discharge service could save between £113,520 and £344,100 per year.

For people with a learning disability and autistic people, even discharging a small number of individuals has generated staggering cost savings. 21 supported housing units that provide permanent homes for individuals in their care have saved Hampshire and Isle of Wight ICB £1m a year, while commissioning supported homes for two individuals in another ICB has generated total savings of £386k per year across local authority and Gloucestershire ICB budgets.

Further savings can be made through reductions in use of more expensive out of area and independent hospital beds, as well as readmissions. Through the introduction of a step-down service, East London Foundation Trust was able to completely stop the use of private sector mental health beds by August 2024 when, at one time, they had 20-30 people in a private sector bed, each costing around £1000 a day. In the first 6 months of 2024, this was costing a total of £376,471 per month.

Additionally, the H.O.M.E hospital discharge service in Gloucestershire had a huge impact on the number of readmissions of people who were homeless. The general hospital where it's based had 41 readmissions of people who were homeless in 2019. By 2023, after the service had been introduced, the number had reduced to a fifth, only 8 people.

We also heard how, with the right support and environment, people's support needs, and costs associated with that support, could start to reduce. For example, a commissioner for people with a learning disability and autistic people told us that hospital placements were costing around £10k per week for some people in their care. The homes they commission outside of hospital cost around £5k per week, including rent and Adult Social Care support, but this could go down to about £3k as their health and wellbeing improved and they had developed skills needed to live independently (Hampshire and Isle of Wight ICB).

This example shows **the incredible difference that a home with the right support in the community can have for people who have spent far too long in an overly restrictive hospital environment.** NHS and housing providers shared many examples of the positive impact all these initiatives have on the people they support. A commissioner for people with a learning disability and autistic people told us that, for the people they had supported to leave hospital into their own home, the difference is "indescribable". Discussing one person in their care, they said: "You can just see the sheer joy and peace within which he lives" (Gloucestershire ICB, NHS commissioner).

A significant benefit of supported housing is the physical safety it provides to residents. Across the case studies we have seen how specialist housing that is adapted to residents' needs, alongside carefully considered care and/or support, can prevent further hospital admissions. For two residents in Anchor's extra care scheme, their previous housing situation had partly led to their being admitted to hospital in the first place. One resident was living in a home that was prone to damp, and was admitted to hospital with hypothermia, while a second experienced a fire that meant their home was uninhabitable.

Importantly, this additional support and security does not undermine residents' autonomy. Two Rushey Fold residents described how having support with domestic tasks and the reassurance from living in a community with staff and other residents meant they felt comfortable to come and go as they pleased, knowing that had their own front door and a safe place to call home. This shows it is possible to provide care tailored to an individual while also delivering value at a wider system level, because supporting older individuals with their recovery and towards greater independence also has benefits for local resources and the community.

An overarching theme across all the case studies, was the way in **which these initiatives opened opportunities for people that previously wouldn't have been possible.** One commissioner described the homes as "a launchpad for their lives" which reflects many of the individuals' stories we heard (Hampshire and Isle of Wight ICB, NHS commissioner). These opportunities included being able to take part in group activities, accessing other support services, engaging with their local college, getting into exercise or finding employment. We were told about a person with a learning disability who previously was not allowed to go into a kitchen due to risks around fire. But after moving into his own home, with a high-level of support, they had started to go into the kitchen to help with washing up the dishes. This was something hospital clinicians had never thought possible.

Conclusion and recommendations

The case studies featured in this research demonstrate the important role that supported housing can play in minimising delays to people being discharged from hospital. They show how supported housing services to meet the needs of those experiencing homelessness, people who have mental health challenges, people with learning disabilities and autistic people and older people outside of hospital, in less restrictive settings. Most importantly, for many they can act as a "launchpad for their lives", building the skills to live independently and opening opportunities to engage in new activities, education and work.

The case studies indicate the significant impacts that collaboration between supported housing and health can have on local systems, including demonstrable cost savings for the NHS and the public purse more widely through reducing unnecessary bed days, as well as reducing readmissions and use of more expensive out of area and private sector mental health beds.

The research highlights the opportunity for supported housing to alleviate the huge pressures that our health system is currently facing. With a lack of NHS strategic focus on housing, these types of initiatives are developed in an ad hoc way, often driven by passionate individuals determined to address the issues they are facing. This requires NHS organisations and housing providers to step into an unfamiliar sector, relying on pre-existing relationships and a strong culture within the area of joined up working across housing and health in the area.

We heard about shared challenges in delivering these schemes, including securing capital funding for the properties. For commissioners looking for long-term supported housing for people with a learning disability and autistic people, a lack of capital grant funding limited the number of homes they could secure for people in their care. For those drawing on private finance, it also resulted in higher rents and therefore higher Housing Benefit costs.

We've heard a strong call for longer-term revenue funding. Most of the services started out as pilots and moved on to business-as-usual delivery. However, this still involved relatively short-term contracts, restricting their ability to build trusting and effective working relationships with partners and retaining skilled and experienced staff to deliver the service.

This could also be affected by procurement requirements, for example when setting up a contract for services following a pilot, without sufficient flexibility to value existing partnerships and experience of delivering that service. Longer-term financial commitments and greater flexibility in procurement processes are important to making these partnerships viable for housing and support providers.

These challenges could be alleviated with a more strategic national direction on health and housing, including guidance and support for local areas to develop their own housing strategies for people with support needs. An effective strategy could provide assurances for housing providers to step into this space, with indications of longer-term commitments, and NHS organisations with a framework to work collaboratively with housing providers to meet the accommodation needs of the people they support.

Recommendations

We know there are strong links between housing and health. The evidence in this report highlights the impact this has when discharging people from hospital. Any hospital discharge should not only consider people's health and care needs, but also their need for a secure, safe and affordable home. To achieve this:

- Integrated Care Boards and housing providers should engage with each other to remove housing barriers where these are a key cause of delayed discharge or readmission.
- We need a national strategic direction on joint-working between health and housing providers to meet housing need for people leaving hospital. This should support Integrated Care Systems, local and combined authorities to improve their capacity for assessing local need and the strategic commissioning of specialist housing services.
- The government's upcoming National Housing Strategy and NHS 10 Year Plan should integrate health and housing. This way, policy can look beyond just the numbers of new homes and deliver the right homes in the right places that are affordable and meet people's needs.

There is a need for greater capital investment in supported housing as well as secure, long-term revenue funding for hospital discharge schemes. Decisions about funding should consider funding flows during and after discharge to deliver better value for money in the longer-term. This includes capital spending, revenue spend for the care and support service and personal or more usually benefit spending to cover the cost of the rent on the home.

- Capital grant should be sufficient to ensure that schemes, including Specialised Supported Housing, are financially viable, affordable for residents and deliver value for money for the benefits system.
- A lot of preparation work was done around the Housing Transformation Fund announced as part of the 2021 Health and Social Care White Paper. The £300 million DHSC funding was then removed. This should be reinstated and this work restarted.
- The opportunity of the planned longer term financial settlement for local authorities should be used to drive better strategic planning and long-term commitments on revenue funding for supported housing.

Appendix

Table 1: Number of patients with delayed discharge due to housing, Q3 2021- Q3 2024.

Year & Quarter	Weekly average number of patients
Q3 2021 (W/C 02/07- W/C 24/09)	49
Q3 2022 (W/C 04/07- W/C 26/09)	109
Q3 2022 (W/C 03/07- W/C 25/09)	159
Q3 2024 (W/C 01-07- W/C 23/09)	153*

**Reporting change in Q3 2024. Categories were previously amalgamated as Homeless/ no right of recourse to public funds/ no place to discharge to.*

Table 2: Number of delayed discharge days in mental health inpatient settings in September 2024, for the five most common known reasons for delay.[53]

Reason for discharge delay	Number of delayed days in September 2024
Housing - Awaiting supported accommodation	7,239
Awaiting availability of placement in care home with nursing	5,334
Awaiting availability of placement in care home without nursing	4,314
Awaiting commencement of care package in usual or temporary place of residence	2,668
Awaiting further community or mental health NHS Services not delivered in an acute setting including intermediate care, rehabilitation services, step-down service	2,218
Total (all reasons)	**41,386**

Table 3: Lower and higher estimates of cost savings from providing a supported home for patients waiting to be discharged from mental health inpatient settings to supported accommodation.

	Lower estimate (based on higher commissioned support costs)	**Higher estimate** (based on lower commissioned support costs)
Number of delayed discharge days due to waiting for supported accommodation[54]	109,029	109,029
Cost of mental health inpatient spell per night[55]	£651	£651
Average cost of supported housing per day*[56]	£169	£55
Difference in cost per day	£482	£596
Potential yearly cost savings	£52,583,129	£64,950,133

**This figure is derived from the average weekly eligible rent (including service charges) for Specified Accommodation Housing Benefit claims in November 2023, which was £266 per week for working age households within Specified Accommodation (Table 7:6). This is added on to the median amount of local authority funding per week per commissioned unit (Table 6:1). The lowest amount of average funding per client group was for clients with drug or alcohol problems at £120 per week, while average funding was highest for autistic clients and clients with a learning disability (£920 per week). These figures, added on to the eligible rent and service charges, provide the high and low cost estimates in the table above.*

Endnotes

1 NHS England (2024) Mental Health Services Monthly Statistics, Performance September 2024.

2 NHS England (2024) Discharge delays (Acute), Monthly timeseries from April 2021 onwards – pre May 2024 SitRep change and Acute discharge situation report, Monthly timeseries from April 2021 onwards – post May 2024 SitRep change.

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