

Evaluation of the *Bay6* service for homeless patients in three Devon hospitals

Final Report

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1 Report Summary

Bay6 is a service run by Community Housing Aid (CHA), a voluntary organisation based in Exeter for homeless people. The primary role of the Bay6 service is to secure accommodation for homeless or vulnerably housed people who are patients at one of three foundation trust hospitals in Devon.

Its aim in finding accommodation for these patients is to reduce delayed discharges, improve patient health and well-being, and thereby to also reduce future acute admissions and presentations to A&E services. More fundamentally, when homeless or vulnerably housed people are admitted to hospital it is a key opportunity to identify their housing as well as their health needs, and arranging safe and stable accommodation can enable a wide range of other statutory and voluntary services to help vulnerable people.

The University of Exeter Medical School and Devon County Council's Public Health Directorate were commissioned by CHA to carry out an initial evaluation of the Bay6 service. This report presents the findings from this evaluation. The evaluation aimed to answer the following four questions:

1. How is the service provided and used by Bay6 and hospital staff? Is it provided and used differently in the three hospitals where it currently operates?
2. What are the perceptions of hospital and Bay6 staff of the impact of the service on health and other outcomes for homeless patients?
3. What are the perceptions of hospital and Bay6 staff of the impact of the service on the use of NHS resources?
4. Are there any potential savings to CCGs and NHS Trusts arising from the implementation of Bay6, in terms of reduced readmissions, reduced delayed discharge and reduced emergency admissions? If so, what are they?

The evaluation used a combination of qualitative research methods (analysis of nine interviews with Bay6 staff (3) and NHS staff (6)) to answer questions 1, 2 and 3; and quantitative methods (analysis of routine hospital use data of 104 Bay6 service users, to answer Question 4).

1.1 How is the Bay6 service provided and used?

Until March 2015 four specialist housing workers were employed to find accommodation for patients who were homeless or became homeless while a patient in one of three Devon hospitals. While inpatients identified as homeless by hospital staff were the main group referred to the service, some referrals were of patients attending the A&E department. The Bay6 housing workers are specialists in arranging local accommodation to meet the varied individual accommodation needs of homeless people.

The physical and mental health care needs of homeless patients referred to Bay6 by the hospitals were generally typical for this population. Many patients had a history of drug and alcohol misuse, they had a range of mental health difficulties and they were often admitted or presented to A&E for reasons related to these problems. This combination of problems helps explain their high use of hospital services compared with non-homeless people.

Though the Bay6 housing workers spent some days on site at the hospital, more often visits were made following referrals received by telephone. Hospital staff made referrals to Community Housing Aid's co-ordinator and cases were allocated to the appropriate Bay6 worker for that hospital.

The type of staff referring patients to the Bay6 service varied between the hospitals. In the three hospitals where Bay6 was provided during the study period, referrals were made by discharge coordinators (one hospital), psychiatric liaison team nurses (one hospital), or in the third hospital by any staff on any ward.

The effectiveness of the service was inevitably dependent on the ability of hospital staff to identify that patients are homeless or at risk of homelessness. Sometimes this happened relatively late during a hospital admission.

The housing worker would then make a formal assessment of the patient's housing situation, and begin the process of identifying appropriate safe accommodation to which they can be discharged. Even if patients are discharged before safe accommodation can be organised, the Bay6 worker can often continue to work with the discharged patient to help support both their accommodation and access to other health and social services.

1.2 What are the perceptions of hospital and Bay6 staff of the impact of the service?

Hospital workers were in no doubt about the beneficial impact of the Bay6 service.

The hospital staff interviewed said that the Bay6 service had a beneficial impact on the post-discharge health and well-being of homeless patients. They believed the provision of accommodation avoided patients being discharged to the streets and thereby reduced the risk of their health deteriorating. They also believed the provision of accommodation enabled the provision of post-discharge health care services which improved patients' mental and physical health.

Hospital staff also claimed that improving a patient's health through the provision of accommodation reduced readmissions to acute wards and presentation to A&E. They also reported that length of stay had been reduced because Bay6's intervention expedited the discharge of patients. These perceptions are consistent with the quantitative analysis which, overall, found a lower use of hospital services by homeless patients in the period after Bay6's intervention.

Importantly, from both an economic and patient safety perspective, hospital clinical staff said that Bay6 had saved large amounts of their own time; time that would otherwise have been spent finding accommodation for homeless patients. As a result they had more time to care for other patients on their ward. This is consistent with Bay6 workers' accounts of the time-consuming and challenging task of finding accommodation for homeless patients.

1.3 Are there any potential savings to CCGs and NHS Trusts arising from the service?

We conducted an analysis of hospital use data before and after their referral to the Bay6 service, for a sample of 104 homeless hospital patients. The usage figures exclude the episode of care where the Bay6 referral was received. The analysis showed that:

- Homeless patients that use the service were very high users of hospital care – our analysis estimated that across these three Devon hospitals they had, on average, 3 hospital admissions per year, 7.1 A&E attendances (of which 4.5 involved arrival by ambulance) and 3.7 outpatient appointments. The potential cost savings from improving the health of this group are therefore similarly high.

- In the 6 months before use of the Bay 6 service, the 104 homeless patients with relevant data cost the NHS about £398,000 in hospital care. In the 6 months after using Bay6 the same patients cost the NHS £310,000 – that is £88,000 or 22% less.
- Most of this observed change in hospital costs incurred was due to less expensive inpatient admissions (£202,000 vs £271,000) rather than fewer inpatient admissions (157 vs 155). However, in the six months after using Bay6 there were fewer A&E attendances (367 vs 273) and fewer A&E attendances by ambulance (187 vs 233) than in the 6 months before. These observed reductions in A&E attendances would be associated with reductions in A&E costs of 24% and 19% respectively – or saving an estimated £44,000 per year.
- The Bay6 service seems to have more mixed impact on inpatient admission length of stay. While in one of the hospitals, the length of stay was lower after use of Bay6 than before (3.6 vs 4.8 days), across all three hospitals there were slightly longer hospital stays after use of Bay6 than before.
- The table below shows the actual before and after data, for the 104 patients whose data we analysed, and associated with £88,000 of estimated savings during the 6 months after using the service. If these before versus after differences in hospital costs reflect longer term changes in use of hospital care due to the service, then this would mean that a Bay6 service which deals with 200 referrals in one year, would lead to an estimated £340,000 of savings to the NHS during the following year.
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Cost	6 months before using Bay6	6 months after using Bay6
Cost of inpatient admissions	£271,773	£202,695
Cost of Outpatient	£22,108	£25,139
Cost of A&E	£35,074	£26,639
Total Cost in Hospital Setting	£328,955	£254,473
Cost of Ambulance	£68,735	£55,165
Total Cost	£397,690	£309,638

Source: Public Health Devon, derived from NHS Secondary Uses Service data, 2015.

2 Introduction

Bay6 is a service run by Community Housing Aid (CHA), a voluntary organisation based in Exeter for homeless people. Bay6's primary role is to secure accommodation for homeless or vulnerably housed people who are patients at one of three foundation trust hospitals in Devon. Its aim in finding accommodation for these patients is to reduce delayed discharges, improve patient health and well-being and thereby reduce acute admissions and presentations to A&E services. Its operation at two of the hospitals has ceased or is uncertain due to funding cuts.

The University of Exeter Medical School and Devon County Council's Public Health Directorate were commissioned by CHA to carry out an evaluation of the Bay6 service. This report presents the findings from this evaluation. In this introduction, we describe the literature on homeless patients and health care, Bay6's operational history and activity and the evaluation aims and methods.

2.1 Homeless patients, health and health care

The Department of Health conservatively estimates that the cost to hospitals of homeless patients is £85 million, 90% of which is accounted for by in-patient care (Department of Health Office of the Chief Analyst 2010). This is proportionally eight times higher than the cost of providing in-patient care for the comparator population of people of working age. Homeless people's average length of hospital stay is also three times that of other members of the population (Department of Health Office of the Chief Analyst 2010). The health care needs of homeless patients are atypical and 'tri-morbidity' characterises the long-term homeless; that is they often experience mental illness, physical illness and drug and alcohol misuse (Hewett 2012). The longer lengths of hospital stay of homeless patients are therefore attributed to their more complex health care needs. (Department of Health Office of the Chief Analyst 2010).

Department of Health guidance on the admission and discharge of homeless patients advises that:

"All acute hospitals should have formal admission and discharge policies which will ensure that homeless people are identified on admission and their pending discharge notified to relevant primary health care services and to homeless services providers."

(Department of Health 2003).

Subsequent guidance specified that protocols should be implemented to ensure that patients are not discharged to the streets or into inappropriate accommodation, and that these protocols should be jointly produced by hospitals, health service commissioners, local authorities and the voluntary sector (Department of Health and Department of Communities and Local Government 2006). A model protocol has been produced by Homeless Link and St Mungo's (Homeless Link and St Mungo's 2011). A 2011 survey found that only 39%¹ of local authorities have in place protocols for the admission and discharge of homeless patients (Homeless Link and St Mungo's 2011).

2.2 Bay6's operational history and activity

Until March 2015 four specialist housing workers were employed to find accommodation for patients who were homeless or became homeless while a patient in one of three Devon hospitals. These will be referred to in this report as the Shire, County and City Hospitals. Two part-time workers were attached to the City Hospital and between them they were available between Monday

¹ The response rate was 33% so it is not clear whether this is an over or under estimate.

and Friday each week; one part-time worker was attached to County Hospital whose hours were spread between Mondays and Fridays; and one part-time worker was attached to the Shire Hospital who was available on two days of the working week. The Bay6 worker attached to the City Hospital was employed by CHA and the other Bay6 workers were employed by two other local homeless voluntary organisations. Hospital staff made referrals to Community Housing Aid's co-ordinator and cases were allocated to the appropriate Bay6 worker.

The first period of Bay6's operation from October 2013 to May 2014 was funded by a Department of Health homeless programme to support homeless patients after they leave hospital. CHA's management informed us that the terms of this funding largely limited Bay6 workers to expediting patient discharge from hospital and provided little capacity to enable them to work with patients post-discharge. There was a second period of interim funding provided by the County and City hospitals and the voluntary organisation that employed the Bay6 worker at the Shire Hospital. This funding enabled Bay6 to continue operating until September 2014 once the first funding grant had been expended. The third period of operation was from September 2014 to March 2015 funded by the NHS England Regional Innovation Fund (RIF). CHA management report that the RIF funding gave Bay6 workers more flexibility and time to work with patients post discharge. This meant that if a patient was discharged to the street or was provided with temporary accommodation, there was still scope for workers to find more secure accommodation for them. This broader scope was also intended to improve the likelihood that Bay6 could prevent re-admissions to acute wards and presentations to A&E. The operational guidelines for the RIF funding are in Appendix A. The RIF funding came to an end on 31 March 2015. Subsequent funding has been provided from local integrated care budgets to enable Bay6 to continue operating at the City Hospital for 12 months and at the County Hospital for one month. The Bay6 service at the Shire Hospital has not received any additional funding and it has ceased operations there.

Data provided by CHA shows that between the start of Bay6 operations in October 2013 and February 2015, it received 187 referrals of which 109 patients (58%) were found temporary or permanent accommodation. As Table 1 shows, the Bay6 service attached to the Shire Hospital found accommodation for proportionally more patients than the service attached to the other two hospitals.

Table 1. Numbers of patients referred and proportions housed by Bay6 (2015)

	Number of patients referred	Proportion of patients housed
Shire Hospital	36	69%
County Hospital	49	57%
City Hospital	102	55%

A reliable comparison cannot be made between the three funding periods in each of the sites because of the relatively small number of referrals in each site in the third period.²

² There were 151 referrals in the first and second funding periods and 36 referrals up to the end of February in the third period.

2.3 Evaluation aims and methods

The RIF funding covered an independent evaluation of Bay6 which has been carried out by the University of Exeter Medical School in collaboration with the Public Health Directorate of Devon County Council. This is the first evaluation of Bay6's work and was conducted to answer four research questions:

1. How is the service provided and used by Bay6 and hospital staff? Is it provided and used differently in the three hospitals where it currently operates?
2. What are the perceptions of hospital and Bay6 staff of the impact of the service on health and other outcomes for homeless patients?
3. What are the perceptions of hospital and Bay6 staff of the impact of the service on the use of NHS resources?
4. Are there any potential savings to CCGs and NHS Trusts arising from the implementation of Bay6, in terms of reduced readmissions, reduced delayed discharge and reduced emergency admissions? If so, what are they?

It was a mixed methods evaluation using qualitative and quantitative methods.

2.3.1 Qualitative methods

The qualitative part of the study addressed the first three research questions. To select hospital staff to be interviewed, we opted for a maximum variation qualitative sample to capture a breadth of hospital staff roles and the medical needs of patients for whom they cared. Funding constraints meant that only 9 interviews could be carried out. Those interviewed were:

- One Bay6 worker attached to each of the hospitals.
- The Trust's nursing lead for patient flow and a matron at the City Hospital.
- Two discharge co-ordinators at the County Hospital.
- The nurse psychiatric liaison team lead and the accommodation officer at the Shire Hospital.

The nursing lead for patient flow at the City Hospital managed patient admissions and discharge for the hospital. The matron oversaw nursing care on a gastroenterology ward. The discharge co-ordinators at the County Hospital were part of a team of ten who managed the discharge process for individual patients. Each discharge co-ordinator had responsibility for discharges from specific wards. Those in our study were responsible for the trauma and orthopaedics wards or A&E and the Emergency Assessment Unit. The nurse in the psychiatric liaison service at the County Hospital was responsible for carrying out biopsychosocial assessments of patients referred by A&E and the in-patient wards who had been identified as having a potential mental health problem. The accommodation officer at this hospital was employed by Devon Partnership Trust. She was responsible for post-discharge accommodation for psychiatric in-patients at the hospital as well as the accommodation needs for clients of other NHS mental health services elsewhere in the county.

The interviews explored the process of referring patients to Bay6; the process of finding accommodation for patients; hospital and Bay6 staff perceptions of the impact of Bay6 on the post-discharge health and health care of patients and the impact of Bay6 on the use of hospital resources. Respondents were interviewed using the topic guides in Appendix B.

The interviews were transcribed verbatim. They were analysed by the first author using Framework Analysis. The transcripts were first analysed to identify provisional codes for segments of data. These segments were then truncated into short sentences that summarised the verbatim data. The coding of the truncated segments was refined to develop a consistent set of codes. The codes were then used to identify themes and the headings for each theme were used to create a chart. The truncated data was entered into each chart where each respondent was allocated a row and the columns contained the truncated data for each respondent corresponding to specific themes and codes. A separate set of charts was produced for the Bay6 workers and for the hospital staff. To ensure that coding and charting was reliably carried out, these stages were crossed checked by a second member of the research team. Some charts for both sets of respondents had identical themes while others were unique to one or other sets. The charts were analysed to identify patterns in respondents' perceptions of Bay6 operation and impact.

2.3.2 Quantitative methods

The quantitative part of the study was designed to address research question 4 by analysing NHS Secondary Uses Service data (SUS) to estimate whether the use of Bay6 is associated with earlier discharge of homeless patients and with lower re-admissions; and to estimate the potential costs and savings to the NHS arising from the operation of Bay6.

Hospital service use data

Hospital Episode Statistics (HES) data are extracts taken from the Secondary Uses Service (SUS) data warehouse, at pre-arranged dates, and which is then validated and cleaned. While data relating to episodes and spells for a particular year can be amended and updated in SUS long after the year has passed, no further SUS updates are applied to HES which is fixed after final year data publication. This is why there can be differences between SUS and HES even when looking at the same time period.

SUS was used for this research both because it is constantly updated when new information regarding the spell is available and it is timelier (the HES data for 2014/15 was not going to be available until late in 2015) and because the data relating to homeless clients (who may be missing identifying features for the case such as postcode) are more likely to get cleaned out of HES data.

Identifying Bay6 clients in hospital data

As the clients had signed a consent form to share information with partner agencies, Devon County Council and New Devon CCG were able to view client level data from Bay6 monitoring information derived from client case notes. This data included the client's full name, date of birth (DOB), gender and the dates they had entered and left hospital along with the dates of the initial referral to Bay6 and the date the Bay6 assessment took place. The data also included a brief summary of client circumstances and the intervention provided.

Bay6 had seen 189 clients when the data was passed across in December 2014. Repeat clients were removed from the records with only the clients first intervention with Bay6 retained. Several clients had been supported by Bay6 more than once. Clients who on assessment were found not to be homeless, and also clients who were found to be homeless but refused Bay6 support were excluded from the sample at this stage.

Data from Bay6 was matched manually with the NHS records to locate the common pseudonym used on SUS data provided to the local authority. The match was undertaken using a combination of

the client's name, DOB, hospital attended and admission date. Using this method 189 unique clients who had been seen by Bay6 were identified. This was a much higher success rate than expected considering this client group include those who are street homeless, very mobile and are typically recorded under a variety of names/ name spellings across record systems.

For the purpose of the evaluation a 'before and after' picture of care needed to be established. For this reason only clients where the intervention took place more than 6 months before the time of the last SUS extract were included (end of November 2014). This reduced the case study sample size to 112 clients who received an assessment from Bay6 between November 2013 and May 2014.

2.3.3 Data fields extracted

The following data fields were extracted into an Excel spreadsheet for analysis:

Bay6 client ID

NHS number

Client name

Date of birth

Age on referral

Gender

Month and year

Number of inpatient admissions (6 months before, and 6 months after using Bay6)

Length of stay of each inpatient admission

Primary reason for each inpatient admission

Number of A&E visits (6 months before, and 6 months after using Bay6)

Number of A&E attendances by ambulance (6 months before, and 6 months after using Bay6)

Number of outpatient appointments (6 months before, and 6 months after using Bay6)

2.3.4 Data checking and cleaning

Several queries were run in the SUS database locally and the records of all secondary care usage for these clients within 6 months of their Bay6 intervention were extracted.

Identified clients were checked to ensure that they had a hospital spell at the correct site to ensure the validity of the match. Two clients were removed at this stage as they had the same name and DOB but had attended a different hospital and therefore had an incorrect NHS number.

Six clients were found to have incomplete hospital spell records, either because they had been admitted to hospital in November and had not left hospital before the production of the SUS extract; or because an administrative error had caused a client to leave hospital but the details of the record were not included in the SUS extract. These clients were excluded from the sample because the nature of these admissions and their cost could not be derived.

A final cohort of 104 clients was identified who had received a Bay6 intervention and who could be reliably identified in SUS records.

2.3.5 Calculating the cost of hospital service use

Payment by Results (PbR) amounts are included in the SUS records for all hospital episodes which are not part of a block contract. Where the episode of care for a case study client had a PbR figure, it was used as the cost of the episode. Where the PbR figure was missing or null (for example where the activity was part of block contract activity) proxy costs were used. The proxy costs used in this evaluation were taken from the NHS Reference Costs (for 2013-14) which give average costs per bed day for inpatient admissions, for outpatient appointments and A&E visits. Average costs for an ambulance call out were derived from the NHS Reference Costs. These are nationally recognised costs and are a conservative figure given the complex health needs of the clients. Ambulance costs are likely to be higher locally than the national figure to reflect the distances travelled in such a large rural county and the proportionately higher number of ambulances needed to ensure response times are within acceptable limits. However, the national figures have been used throughout to allow comparability of this evaluation with other areas in the UK.

- For A&E data only one record had a PbR cost amount missing, that attendance was estimated at £124.
- 318 inpatient records had a PbR cost and 83 did not so an estimated cost was generated. £255,697 of inpatient admissions are based on this evaluation's estimates and £527,889 on Payment by Results (including the Bay6 index case).
- 174 outpatient records had a PbR cost and 241 did not, so an estimated cost was generated. £26,751 of outpatient attendances are based on this evaluation's estimates and £20,496 on PbR.
- All ambulance attendance costs are based on the average cost of an ambulance attendance.

Characteristics of the sample

Of the 104 clients 82 were male and 22 female. They were a wide range of ages, with some in their 80s and others in their teens.

Table 2. Age profile of study sample

Age group	Number of clients
Age 16-24	14
Age 25-34	20
Age 35-44	21
Age 45-54	19
Age 55-64	13
Age 65+	17

3 Findings: the referral of patients to Bay6

In this section we report on the process by which hospitals referred patients to Bay6. It describes this in terms of patients' health care needs, who has responsibility for referring patients to Bay6 and the barriers and facilitators to making these referrals. These barriers and facilitators cover how hospital staff or systems identify homeless patients, the timing of referrals and hospital staff awareness of Bay6. This section informs the first research question.

3.1 Patient health care needs

The physical and mental health care needs of homeless patients referred to Bay6 by the hospitals were generally typical for this population. That is, we were told that many patients had a history of drug and alcohol misuse, they had a range of mental health difficulties and they were often admitted or presented to A&E for reasons related to these problems. For example, patients seen by the psychiatric liaison team at the Shire Hospital and by A&E at the City Hospital included those who had self-harmed or had taken drug overdoses; one of the City Hospital wards treated those with alcohol related problems such as liver disease and alcohol dementia and some patients were admitted for alcohol detoxification. Patients were also admitted to the trauma and surgical wards although it was always not clear whether or how these admissions were related to alcohol, drug or mental health problems. Not all homeless patients, though, had these difficulties. For example, Bay6 had taken referrals of older people who had been living abroad, who had returned to England for medical treatment but whose families were unwilling or unable to accommodate them.

3.2 Referral responsibility

The responsibility for referring patients to Bay6 varied between the hospitals. At the County Hospital discharge coordinators were responsible for managing patient discharge. We were told that they made most of the hospital's referrals to Bay6 although some nurses had also made them. The City Hospital did not have a discharge team and so any member of the ward staff (such as doctors, nurses, sisters, physiotherapists and OTs) made referrals.³ At the Shire hospital, nurses in the psychiatric liaison team referred patients to Bay6. Psychiatric in-patients at the Shire Hospital were referred by nurses or the accommodation officer or referrals were made by discharge coordinators for patients treated elsewhere in the hospital.⁴

Therefore the referral of patients was largely centralised into the hands of ten discharge coordinators at the County Hospital. At the City Hospital referral responsibility was dispersed amongst a large number of clinical staff. A hybrid of centralised and dispersed responsibility for referral operated at the Shire Hospital.

3.3 Referral barriers and facilitators

The barriers and facilitators for hospitals referring patients to Bay6 were whether and how hospitals identified homelessness, the timing of referrals to Bay6 and hospital staff awareness of Bay6.

³ We were told that the nearest equivalent role to discharge coordinator at the City Hospital is the onward care team which arranges packages of care for patients with complex needs. However, we were also told that housing is seen by them as a local authority responsibility and so they will not deal with homeless patients.

⁴ We did not interview Shire Hospital discharge coordinators.

3.3.1 Identifying homeless patients

Frequency of identifying homeless patients

The senior nurses at the City Hospital and the discharge co-ordinator attached to the acute wards at the County Hospital told us that the housing circumstances of in-patients were routinely identified as part of the process of admitting in-patients. However, there was some discrepancy between hospital staff and Bay6 workers accounts of whether homeless patients were routinely identified to the extent that Bay6 workers did not think that hospitals routinely did this. One Bay6 worker said that her hospital's efficiency in identifying homelessness varied between wards, although the Bay6 worker at the County Hospital reported that her hospital's identification of homeless patients was improving. One Bay6 worker estimated that about a half of homeless patients were not identified. The Bay6 worker at the City Hospital described hospitals identifying homeless patients as:

"...our constant battle. The sooner someone calls us on ward about this person being homeless, the better. (Bay6 worker, City Hospital)

Means of identifying homeless patients

It was reported that the means by which homeless patients were identified depended on the types of service that was provided to a patient. The psychiatric liaison service at the Shire Hospital took referrals from other parts of the hospital if a patient had been identified as having a potential mental health problem. These were either patients who had presented to A&E or who had been admitted as in-patients on the acute wards. In either case, the patient was ready for discharge and the role of psychiatric liaison was to assess the patients mental health prior to discharge to determine the patient's mental health needs and how they could be met. They did so by carrying out a biopsychosocial assessment of the patient. These were comprehensive assessments which included a patient's social networks, the support they received in the community, their income, their drug and alcohol use and their physical and mental health needs. In rare cases, these patients were admitted as psychiatric in-patients. For most patients, this assessment helped identify the community services that a patient would need and as part of this assessment they routinely identified whether a patient was homeless.

Homeless patients admitted as in-patients to the psychiatric wards at the same hospital were identified by the patient informing ward clinicians that they were homeless. It is not clear whether there was a routine process of enabling patients to do this. In any event, we were told that the severity of a patient's mental illness determined how quickly homelessness was identified. Homeless patients who were relatively well were identified within a few days of admission. But if they were very unwell, for example if they had had a psychotic episode, their mental health might be such that it was not feasible or even appropriate to identify their housing needs. For these patients the priority was addressing their mental health difficulties and their housing circumstances were peripheral concerns in the early part of treatment. For these patients, their housing circumstances might not be identified for many weeks.

In the case of elective patients at the County Hospital, we were told that the pre-admission assessment should have identified whether a patients housing circumstances were suitable for their post-discharge needs. But it was also acknowledged by hospital staff that some wards might not have identified homeless patients until very close to when patients were about to be discharged.

Barriers to identifying homeless patients

Bay6 workers felt that hospital staff sometimes overlooked asking patients about their housing circumstances because staff were too busy providing routine patient care. Patients might have become homeless while in hospital and this either meant that they were not identified or that it delayed the identification of their housing needs. For example, landlords have evicted patients post-admission because of their drug or alcohol use or failure to pay rent or maintain the property. For the same or similar reasons, the partners of some patients might have decided that they did not want them to return the family home.

Bay6 workers acknowledged that even if hospitals routinely checked patient's housing circumstances, some patients did not always disclose that they were homeless. This problem might be compounded because hospitals did not necessarily verify the address given by patients. As one Bay6 worker remarked:

"What happens is when someone goes into hospital, no-one checks whether they're homeless, if someone gives an address, they don't check that address is true or false..."
(Bay6 worker, City Hospital)

Even if homeless patients are identified, Bay6 workers said that if patients changed wards information about their homelessness was not passed on. One Bay6 worker gave an example a patient who had been admitted for six weeks, who had been evicted from her accommodation while in hospital, who had been moved between wards but where information about the eviction was not passed between the wards. The problem of information not being passed on was corroborated by a discharge co-ordinator at the County Hospital who said that:

"it [homelessness] could be that it's been missed down in A&E, it might have been highlighted but then it's not been dealt with because they've gone directly to a ward and then it's kind of at the last minute they've gone "oh gosh, this person's homeless".
(Discharge Co-ordinator, County Hospital)

A referral to Bay6 might also have been delayed if discharge co-ordinators worked across more than one ward. This meant that they might not have picked up the case until a day or more after a homeless patient had been identified. Hospital staff also reported that homelessness might not have been immediately identified where a patient was admitted for a short period, such as for one or two days, or where patients presented to A&E.

3.3.2 Referral timing

Variations in hospital speed of identifying housing status led to variations in how much time Bay6 workers were given to find accommodation prior to discharge. If homelessness was not identified until close to discharge, Bay6 workers reported that this gave them very little time to find accommodation for a patient. The Bay6 worker at the Shire Hospital reported that the time between referral and discharge varied between 30 minutes and three weeks. It is possible that this depended on whether referrals were made by psychiatric liaison, the in-patient psychiatric ward or another part of the hospital but we were unable to explore this. At the County Hospital, we were told that referrals to Bay6 were typically 24-48 hours prior to discharge although this was most likely because the patient had been admitted for no more than two days. Patients admitted for longer were more likely to be referred earlier which increased the chances of finding suitable accommodation. For example, a patient was admitted for one week for alcohol detoxification at the

City Hospital. They contacted Bay6 at the start of his stay and by the time of discharge he had been accommodated by a service providing residential rehabilitation. However, it is not clear the extent to which longer admissions increased the likelihood of finding accommodation for patients at each of the hospitals.

The Bay6 worker at the City Hospital felt that nearly all patients were referred to her very close to discharge because of the late identification of homelessness-She said that the wards:

"Don't necessarily pick up on the housing problems ...until it comes to discharge". (Bay6 worker, City Hospital)

She gave an example of a patient who had been admitted for a week but who was not referred to Bay6 until one hour before discharge. The Bay6 worker at the Shire Hospital also gave an example of a patient referred one hour before discharge. Although, he was discharged to the street, accommodation was eventually found for him by Bay6. Details of this referral are given in Patient Story 1.

Patient story 1

A man in his 70s who was a wheel-chair user had been sleeping in public toilets for nine months. He was often drunk, he had very poor personal hygiene and had a reputation for being cantankerous. His GP refused to treat him unless he was sober and had showered. Consequently, he had many presentations to A&E to have his leg ulcers treated, including the removal of maggots. On one occasion, he was admitted to a ward and was referred to Bay6 one hour prior to discharge. The patient refused any offer of help from Bay6 and he was discharged to the street. The Bay6 worker and a rough sleeper worker searched for the patient the next morning and he accepted that he needed accommodation for the winter. The Bay6 worker referred him to the local authority social services department who accepted that they had a duty of care to him. The Bay6 and rough sleeper workers searched the streets for the patient and when they found him they explained their plan to move him into a nursing home. Once this accommodation had been secured, they spent a week trying to locate the patient which included successful encounters only for the patient to disappear again. On the final day that they found him they remained with the patient until a minibus could collect him to take him to a nursing home. Because he was resident in a nursing home, a district nurse visited him to change his leg dressings. It appears unlikely that he would have represented to A&E.

3.3.3 Hospital staff awareness of Bay6

The close relationship between Bay6 and the Shire Hospital's psychiatric liaison team was such that the team's awareness of Bay6 was high. But because of a break in the provision of the Bay6 service at the Shire Hospital caused by a disruption to its funding and the large number of ward staff, the accommodation officer felt that the awareness of nurses on the psychiatric wards had diminished and consequently referrals from them had declined. The Bay6 worker also said that this disruption to funding had undermined other wards knowledge of the service. Her capacity to promote Bay6 had also been restricted by being contracted to work only 5 hours a week to deliver the service. Her weekly hours had recently been increased to 14 hours which she said had given her more scope to build relationships with staff to promote the service.

On the City Hospital's gastroenterology ward, all new nurses were given an induction which included informing them about Bay6's work and their publicity material was displayed on the ward's alcohol teaching board. Their profile was also maintained by the Bay6 worker making casual visits to the ward to remind staff of the service. Bay6 publicity material was also displayed in other wards and

the hospital had heavily promoted Bay6 to the hospital's Occupational Therapists (OTs). The Bay6 worker echoed this in her description of a close working relationship with OTs which had helped overcome the barriers to referrals such as limited staff awareness of Bay6 and the timing of referrals.

"If the OTs are on board and aware of what we do, we work as a team and that works so well... We're going further and further into gelling that together. We've had OTs come here so they can see what we do, we've gone over there...so we can work closer as a team and that works much better". (Bay6 worker, City Hospital)

She also felt that awareness was high on the gastroenterology ward which made most referrals. But she was less certain about staff awareness elsewhere in the hospital having met many staff who were not aware of the service. Because nursing teams change two or three times each day, she was unable to meet all nurses to promote the service.

One of the discharge coordinators at the County Hospital felt that the visibility of Bay6 was not especially high, although she said that this had been improving. The Bay6 worker at the same hospital, though, described a welcoming, close and trusting working relationship with hospital staff. This had helped spread awareness of Bay6 by word of mouth through her informal discussions with staff about the service and displaying publicity material on most wards. She attributed an increase in the number of wards and coordinators referring patients to this increased awareness.

4 Findings: The process of finding accommodation

This section examines the process of finding accommodation for patients and most of this section draws on the experience of Bay6 workers of this process. We describe their reporting of the types of accommodation and support services that Bay6 seeks for patients and the barriers and facilitators to finding this accommodation. These barriers and facilitators cover the speed of Bay6's response to referrals, hospital discharge practice, the housing application process and criteria, the availability of housing, patient motivation and cooperation, Bay6 professional networks and Bay6's working methods. As with Section 2, this section also informs the first research question.

4.1 Accommodation and support service options

The Bay6 workers identified a potential choice of five main types of accommodation that they tried to find for patients. These were: temporary accommodation, specialist housing, permanent social housing, private rented accommodation and living with friends or family.

Data provided by CHA indicates that between November 2013 and February 2015 about 38% of those found accommodation were placed in temporary accommodation, 23% were placed in supported accommodation, a hostel or a nursing home and 49% were found longer term accommodation.⁵

4.1.1 Temporary and permanent accommodation

Temporary accommodation was usually bed and breakfast (B&B) accommodation funded by the local authority. But this also included (for City Hospital patients at least) a night chair provided by a

⁵ Longer term accommodation includes those who returned to their previous accommodation.

voluntary organisation.⁶ The extent to which this is adequate provision for a patient discharged from hospital merits further enquiry. If a patient met a local authorities eligibility criteria and the authority accepted that they had a duty to accommodate them, the initial offer of accommodation was likely to be B&B. They would then reassess whether the patient was eligible for permanent accommodation provided by housing associations. In the part of Devon in which one Bay6 worker was located, she estimated that most patients placed in temporary accommodation would eventually be offered permanent housing. However, the wait for permanent accommodation might be many months and possibly longer. It was probably a rare case but a psychiatric inpatient was offered immediate permanent accommodation when Bay6 told the local authority that their initial decision not to offer this meant that the patient was 'bed blocking'.

4.1.2 Specialist accommodation

Specialist accommodation included residential drug and alcohol rehabilitation, nursing home care and supported accommodation. (The latter prepares people for independent living by providing them with the requisite skills such as managing tenancies and budgeting). If the patient had applied for specialist accommodation and the local authority had approved a placement, the provider then also carried out their own assessment to determine whether the patient met their eligibility criteria and whether they had available space. All applications for admission to residential drug and alcohol services were administered by RISE, the organisation which provides substance abuse services in Devon. But access to these services was dependent on available space and whether the placement could be funded. If there was likely to be a gap between hospital discharge and being placed in specialist accommodation, Bay6 workers have asked families to accommodate the patient pending the placement.

4.1.3 Private rented accommodation

If patients did not already have private rented accommodation, Bay6 workers also attempted to find it. Available accommodation was identified through advertised vacancies, the Bay6 workers personal contacts or through a voluntary organisation that rents property from private landlords. This organisation sub-lets to homeless people for short-term periods until more permanent accommodation can be found. There was the potential for deposits and rent in advance to be paid by local authorities, although since July 2014 this funding had been restricted.⁷ Bay6 workers also helped patients apply for this funding and assisted patients in making housing benefit claims.

4.1.4 Returning to previous accommodation

Some patients might have been living in private rented accommodation or social housing prior to admission but their tenancies were threatened because of their non-payment of rent or their anti-social behaviour. These patients faced the prospect of eviction while in hospital and where possible Bay6 workers worked with landlords or local authorities to save the tenancy. Patients might also have been living with partners or family members prior to admission but while in hospital found that they were not welcome to return. Bay6 workers worked with families to persuade them to allow the patient to return. For example, the wife of a patient addicted to alcohol was reluctant to allow him to return to their home but Bay6 persuaded her to accommodate him in a caravan located on their property. In some cases, the patient might have been reluctant to return to their family too. If they

⁶ This is a chair in which a homeless person could rest for the night.

⁷ CHA speculate that this was because of central government cuts to local authority income.

chose not to return - even if their partner had asked them to leave - local authorities deemed this as having abandoned a tenancy. This would have made them ineligible for local authority funded accommodation. To avoid this, Bay6 workers attempted to persuade the patient of the necessity to return to their home.

4.1.5 Support services

In seeking accommodation, Bay6 workers worked with other agencies that support homeless people. These include RISE, rough sleeper workers and other voluntary and public sector outreach services; voluntary organisations that provided meals, clothing, sleeping bags and shower facilities for homeless people; and care and befriending services for older people. Working with these agencies might have been especially important if Bay6 were unable to find accommodation for patients and they were discharged to the street.

4.1.6 Barriers and facilitators to finding accommodation

The Bay6 workers and hospital staff identified the barriers and facilitators to finding accommodation for patients. These were Bay6's speed of response to referrals, hospital discharge practice, the housing application process, the availability of housing, patient motivation, Bay6 networks and their working methods.

4.1.7 Bay6 speed of response to referrals

Hospital staff reported that Bay6 workers were very quick to respond to referrals, usually on the same day and sometimes within a few hours. For example, the Bay6 worker took a referral from the City Hospital on New Year's eve, they spent several hours on the phone negotiating with providers to find a place for the patient and, as an interim measure, she was given a night chair in a hostel. She was subsequently offered a bed in the same hostel. A quick response was particularly necessary for patients assessed by psychiatric liaison at the Shire Hospital given that once a patient was assessed they were required to be discharged on the same day.⁸ Because of their usually longer lengths of stay, there was less need for a rapid response to referrals of psychiatric in-patients although we were told that the Bay6 worker still responded within two days. The hospital workers contrasted Bay6's speed of response with that of local authority staff who we were told took many days to respond to referrals and thereby risked patients being discharged to the street.

The quick response to City Hospital referrals was made possible because two part-time Bay6 workers were able to provide a service there on each day of the week. The hours of the Bay6 worker at the County Hospital, while part-time, were spread through the week and this was likely to have made a same or next day response feasible. The Shire Hospital Bay6 worker was only available on two days of the week which most likely would have delayed her ability to respond quickly. However, because the CHA co-ordinator took all initial referrals from the hospitals, Bay6 were in effect able to respond immediately and to allocate the case to the Bay6 worker at the Shire Hospital on her working days.

4.1.8 Hospital discharge practice

The amount of time for Bay6 workers to find accommodation for a homeless patient while in hospital was shaped by whether hospitals were willing to discharge patients onto the streets. With the exception of psychiatric inpatients at the Shire Hospital, if a patient did not have a medical need

⁸This was because they took referrals from in-patient wards or A&E from which the patient was ready for discharge. Further details about the role of the psychiatric liaison service is given in section 2.3.1

which required suitable accommodation to meet it and they were medically fit, all three hospitals discharged homeless patients to the streets.

For patients who were medically fit, it was unlikely that discharge would be delayed to enable accommodation to be found, although occasionally an exception had been made. For example, if there were no bed pressures in the Emergency Assessment Unit at the County Hospital and Bay6 were able to visit a patient the next day, the discharge coordinator had made arrangements for homeless patients to be admitted for an overnight stay. The Bay6 workers at each of the hospitals also reported that some wards have kept a patient for longer to enable accommodation to be found. However, they reported that general practice was to discharge medically fit patients. One of the discharge coordinators had used Bay6 to ask their advice about whether patients were likely to have met the local authorities housing eligibility criteria and, where they did not, this gave the hospital more confidence in discharging them to the street. These were usually patients who had originally come from other parts of the UK, such as the North West and Scotland.

There were two exceptions to the practice of discharging homeless patients to the streets. First, if patients required post-discharge medical or social care for which suitable accommodation was needed, a patients hospital stay could be extended. These included patients who had undergone alcohol detoxification where discharge to the street would have increased their risk of relapsing to abusing alcohol. A clinician at the City Hospital explained that the rationale for this was that:

"...if you're detoxing a patient and you've come so far, you wouldn't want to send them out to the street because they will fail. So you're going to be keeping them until you find a different way of finding them accommodation which can be ... incredibly time consuming".
(Patient flow manager, City Hospital)

Patients who required district nurses to change wound dressings or needed post-discharge social care were also be kept in hospital to enable accommodation to be found. For example, Bay6 managed the case of a patient whose need for an oxygen tank and social care required good quality accommodation. To enable this to be arranged with the local authority, the patient was transferred from the County Hospital to a community hospital where he remained for a week prior to moving into permanent accommodation. Patient Story 2 is also an example of a patient remaining in hospital to enable accommodation to be found.

Patient story 2

A male patient had been admitted to hospital with a severe leg infection caused by intravenous drug use. He was under the care of drug and alcohol services and had been maintaining his use of methadone when in hospital. The likelihood was that he would require an amputation and so would need the use of a wheel-chair, extensive physiotherapy and after-care to change his dressings. The hospital was not going to discharge him because of these needs but the patient was very anxious that he would not be found accommodation, would not be able to cope and would resume his drug use. The Bay6 worker made a housing application to the local authority using evidence about his post-discharge medical care needs and a report from the drug and alcohol service that he needed accommodation to maintain his drug treatment. The local authority accepted him as a priority case and he was offered B&B accommodation.

The second exception was psychiatric in-patients at the Shire Hospital. We were told that the consultants would not discharge patients unless they can be discharged to suitable accommodation as to do otherwise increased the risks of readmission. The accommodation officer said that:

*"Consultants are very good at saying, "No, I'm not discharging until they've got somewhere properly to go" because they'd just be back here and that's pointless".
(Accommodation Officer, Shire Hospital)*

This gave Bay6 or the accommodation officer more time and opportunity to find accommodation for these patients. For example, an inpatient who had been victimised by neighbours because of his mental health difficulties had been kept in hospital until suitable accommodation could be found.

4.1.9 Housing application processes and criteria

To qualify for B&B, specialist accommodation or social housing, patients were first assessed by a local authority housing department to determine whether they met their eligibility criteria and whether they had a priority need. In assessing need, local authorities took into account issues such as whether applicants were vulnerable, their medical needs and their tenancy history. The Bay6 worker attached to the Shire Hospital felt that local authorities took seriously referrals from Bay6 because of the higher likelihood that the applicant would have health problems in addition to being homeless. As she put it:

"If I was to phone up [the local authority] and say "I've got a Bay 6 referral"...they take it a little bit more seriously because they know that there's probably additional issues there." (Bay6 worker, Shire Hospital)

So long as evidence was provided by the hospital, the medical needs taken into account by local authorities included the patient's need for post-operative care or the nature of their medical condition. But we were told that some conditions, such as depression, that once would have qualified applicants as eligible, were no longer sufficient unless the patient was under the care of a community mental health team. And even those with apparently obvious needs might still have required Bay6 to persuade local authorities to accept an application. For example, one of the Bay6 workers dealt with an amputee whose rent arrears meant that a local authority was initially reluctant to house the patient. They subsequently offered her temporary accommodation because of her disability.

A patient's engagement with other services was also taken into account. For example, a potentially eligible patient is one with mental health difficulties, a history of substance misuse, who was maintaining the use of a methadone prescription and who was working with drug and alcohol services. It was unlikely that those without these support needs and who were 'just' homeless would have been deemed a priority by the local authority. As one Bay6 worker remarked:

"The more vulnerable and the more medical needs you have and the more engagement with services that are already there, sometimes the better chance you have of help and support to get somewhere...[but] not necessarily all the time" (Bay6 worker, City Hospital)

The patient's reputation with the local authority - such as whether they had a criminal record - might also have been an impediment to qualifying for housing. A patient's tenancy history was also taken into account. For example, a local authority might decline an application if patients were deemed to

have voluntarily left their previous accommodation or had rent arrears. Where possible, the Bay6 workers would advocate strongly on the patient's behalf to argue that their vulnerability qualified them for housing.

Bay6 workers assisted patients in making an application to a local authority including making representations to them on the patient's behalf. One Bay6 worker said that her experience enabled her to judge whether a patient was likely to be deemed a priority. However we were also told that eligibility criteria was not clear, that they were being interpreted more tightly and that individual housing officers varied in how they interpreted them; the impact being that some local authorities were more likely than others to offer temporary accommodation.

If patients were too ill to travel to appointments with housing officers, the officers had been known to visit the patient in hospital. But we were also told that this had become less likely for patients referred from the County Hospital because of substantial cuts in the number of local authority housing officers who dealt with homeless people. We were also told that the local authority housing advice staff who dealt with the Shire Hospital patients never visited patients. We were also told that staffing cuts also meant that housing officers took two to three weeks to return telephone calls where once they would have been returned within two days. In spite of these barriers, one of the Bay6 workers said that housing officers worked very hard and "*do a fantastic job*" (Bay6 worker, City Hospital). Patient Story 1 provides an example of how a patient's need for extensive post-operative care qualified him for local authority funded accommodation.

4.1.10 The availability of housing

We were told by the Bay6 workers that a significant impediment to finding accommodation for patients was its lack of availability caused largely by public spending cuts. Consequently, spaces in specialist providers were fewer, they were often full and so had long waiting lists. In some cases, services had been entirely cut such as a woman's refuge and a homeless hostel for ex-offenders. Because of limited availability, the application process to specialist providers was slow. Local authorities also differed in the amount of temporary accommodation that they were willing to fund. One of the homeless floating support services (which helps find private rented accommodation) had had its funding cut and we were told that it was becoming harder to find private landlords willing to take tenants on housing benefit. In spite of such problems, Bay6 workers had a stoical attitude:

"nothing is ever completely shut, it's just how long it takes to get them in there and if there's space" (Bay6 worker, City Hospital).

4.1.11 Patient motivation and cooperation

Even if Bay6 workers offered their services to patients and could potentially find accommodation for them, patients also needed to be willing and motivated to accept support. But Bay6 workers found some patients were resistant because of their chaotic lifestyles and their reluctance to change this. This included patients who had been living on the street for a very long time and who made a conscious decision to return there. One of the Bay6 workers said that:

"There are some clients that are happy rough sleeping and they're entrenched and they've been out for years and they don't want to come back in and you've got to respect that and as hard as it is to say to someone "Off you go, go and live in that toilet", that's their life choice and that's what they want to make". (Bay6 worker, Shire Hospital)

In spite of patients' resistance, Bay6 efforts to find accommodation could have been successful. A very good example of this was shown in Patient Story 1. The patient was an especially challenging case yet the Bay6 and rough sleeper workers worked very closely and went to great lengths to locate an older, street homeless patient and to move him into nursing accommodation.

At other times, the efforts of Bay6 were less successful. For example, Bay6 persuaded a housing department to offer B&B accommodation to a woman who had undergone alcohol detoxification and which could have resulted in her and her partner being re-housed. However, she was unwilling not to return to living with her partner in a building with a notorious reputation for substance misuse. She returned to live there, she resumed her drinking and the local authority no longer considered that they had a duty of care to her. In another case, a patient with liver and kidney failure and a history of multiple A&E admissions had been admitted for alcohol detoxification. He was in the process of being evicted while in hospital but he was allowed to stay until alternative accommodation could be found. But he declined this and was discharged to the streets.

Some patients might have been reluctant to engage with Bay6 because of their previous experience of dealing with local authority housing departments. Their experience of being interviewed and assessed only to be told that they did not qualify for accommodation acted as a disincentive to repeat the exercise. Bay6 workers were sympathetic to this. One Bay6 worker described how some homeless patients might see the housing application as a pointless exercise:

"...some people just can't deal with the excess, the interviews that they have to go through and the numerous questions. I have to do an interview, then the homeless team have to do an interview, they may refer them to Path who have to do an interview. It's all the same questions...They've been through the system...especially the drug and alcohol side of it. ...They know they won't be priority ... they think "Why should I sit through three interviews when they're all the same questions and I'm just going to be told I'll have to carry on ...". (Bay6 worker, County Hospital)

4.1.12 Bay6 professional networks

To carry out their work, the Bay6 workers reported that they worked closely with local authority housing officers, housing providers and other services. Some of these relationships had been established through their previous employment with these or similar organisations and enabled the Bay6 workers to readily identify the most appropriate staff to contact. Relationships had also been built through networks of housing organisations. For example, one of the Homeless Hub's in Devon acted as a regular meeting of provider organisations and local authorities to discuss those living on the streets and available accommodation. This forum was used to raise the profile of Bay6 and it had been used to find accommodation for patients. They also had close working relationships with the providers which helped to keep Bay6 informed about the availability of spaces and to share the job of finding accommodation. As one Bay6 worker remarked:

"We're all up against the same thing, we all work together". (Bay6 worker, City Hospital)

4.1.13 Bay6 workers working methods

In some cases, Bay6 workers and hospital staff worked very closely with each other in finding accommodation or in arranging the provision of specialist support. Patient Story 3 illustrates the

close co-operation between a discharge co-ordinator, the Bay6 worker and the patient's family which prevented a delayed discharge and enabled the provision of accommodation that met the patients post-discharge care needs.

Patient Story 3

A male patient was in private rented accommodation, had a history of substance misuse but was known to the local drug and alcohol team. He was admitted to hospital for major surgery which meant he would become disabled and would require a wheelchair and aids and adaptations in his home. The discharge co-ordinator spoke to the patient about the quality of his housing and both agreed it was not suitable for his post-operative recovery and that he should be referred to Bay6. The Bay6 worker helped the patient make an application for housing to the local authority. Initially he was offered bed and breakfast accommodation. The discharge co-ordinator organised OT and physiotherapy assessments of the B&B accommodation to judge whether it met his mobility and support needs. The patient's family also became involved and offered to help him find alternative private rented accommodation. While the Bay6 worker was on leave, the discharge co-ordinator discussed with the local authority whether bed and breakfast or alternative private rented accommodation would be most suitable. The Bay6 worker then submitted the OT and physiotherapy assessments and letters from doctors to the local authority. The outcome was that the patient moved into B&B accommodation for ten days and then moved into a privately rented ground floor flat. The family and the local authority shared the cost of the rent deposit and rent in advance. The discharge co-ordinator arranged a package of care with the local authority social services department. The discharge co-ordinator said that the Bay6 worker was instrumental in ensuring that the housing application process was expedited. This was because she was able to 'drive' the patient's case quickly in the face of the pressures that the housing department was under and their slower processes of dealing with applications for housing. By doing so the Bay6 worker prevented the delayed discharge of the patient and enabled suitable accommodation to be found.

These working relationships sometimes continued after the patient has been discharged. For example, the psychiatric liaison service at the Shire Hospital and the Bay6 worker collaborated in finding a post-discharge placement for a rough sleeper in a drug and alcohol rehabilitation home. In other cases, hospital staff had no dealings with patients or Bay6 once a referral had been made.

Homeless patients were described by hospital staff as distrustful of authority and without anyone to care about them but that Bay6 helped overcome both problems. For example, Bay6 workers were willing to accompany patients to psychiatric assessments and to appointments with housing services. Hospital staff praised Bay6 workers skills in working with homeless patients to gain their trust, of being non-judgemental and for having the time to establish a relationship with them. This, they felt, helped engage patients with the services to which Bay6 could arrange access. As one senior nurse put it:

"...that's all they need, a buddy to go with them, just so that they've got somebody they can lean on." (Patient flow manager, City Hospital)

Hospital staff also compared favourably Bay6's approach with that of local authorities. We were told that Bay6 were much more responsive to referrals and, unlike local authorities, they would see the patient very quickly at each of the hospitals. In the days before Bay6 was operating, hospital workers said they were frustrated by the negative attitude of local authorities towards homeless people. Hospital staff said that Bay6's sense of a duty of care and their high level of commitment and

determination was such that they went to enormous efforts to find accommodation for patients. When asked whether the Bay6 service could be improved, hospital staff could not fault them.

5 Findings: the perceived impact of Bay6 on patient health and the use of NHS resources

Bay6 and hospital workers reported various perceived impacts of Bay6 on: patient health outcomes, patient length of stay, the provision of post-discharge care, readmissions and A&E attendance and the use of hospital staff time.

5.1 Patient health outcomes

Where patients were medically fit to be discharged, we were told that it was likely that without Bay6's intervention patients would have been discharged to the street. Hospital staff described these as 'failed discharges' because there was a higher likelihood that these patients would resume their alcohol or drug misuse and so were likely to be readmitted. They also said that discharge to the street increased the patient's risk of self-harming and deterioration in their mental and physical health. One of the hospital staff had observed many rough sleepers who have been:

"Attacked, violated, assaulted, had possessions robbed from them, been urinated [on]." (Psychiatric liaison nurse, Shire Hospital)

She added that for these patients the benefits of:

"A roof over their head ... when they've become that disturbed and distressed is massive ... they feel safe, then they don't need to come back to the emergency department because their levels of distress go down". (Psychiatric liaison nurse, Shire Hospital)

Staff at the City Hospital reported that Bay6's intervention had helped break the cycle of the resumption of alcohol and substance misuse, deteriorating physical and mental health and repeated admissions. They attributed this to accommodation enabling patients to be registered with a GP which increased the likelihood a patient's physical and mental health care needs would be met.

We were also told that the service provided by Bay6 helped hospital staff manage borderline cases where the patient was medically fit to be discharged yet they were still vulnerable. Patient Story 4 illustrates Bay6's management of such a patient.

Patient story 4

A young woman had been attacked on the street, she had had brain surgery and the hospital considered her to be vulnerable. She was initially unable to return to supported housing because there was no further funding for the placement. The likelihood was that she would either be kept in hospital for longer than was necessary or that she would be discharged to the street. If she was discharged to the street, the hospital felt it was highly likely that she would be readmitted. The Bay6 worker advised the hospital who to contact in the housing department and they also made phone calls on behalf of the hospital to resolve the patient's housing difficulties. The outcome was that the young woman was able to return to the supported accommodation where she had previously been living. The hospital matron said that Bay6 intervention saved staff time in finding accommodation and also meant that a delayed discharge, and discharge to the street and re-admission were avoided.

It was suggested that in some cases, Bay6's intervention had helped save lives. For example, the psychiatric liaison team had very strong concerns about a young man who had been sexually abused when younger, he had been in care and who they believed was at high risk of further abuse from living on the street. His vulnerability was such that they thought he was at risk of dying by suicide if he was returned to the streets. Bay6 arranged immediate temporary accommodation for the patient which the psychiatric liaison nurse believed saved his life.

Even if patients were not homeless, they might have been vulnerably housed if, for example, they were living with abusive partners or partners who abused drugs and alcohol. We were told that some of these patients self-harmed as a means of coping with these stresses and would present to A&E or, in some cases, be admitted to a psychiatric ward. It was reported that by finding suitable accommodation and by arranging access to support services, these patients were removed from a stressful home environment and could be helped to manage their lives better.

One clinician at the City Hospital felt that if Bay6 no longer delivered their service, hospitals would revert to their usual practice of discharging most homeless patients to the street, giving them little more than details of soup kitchens and that this would result in their health deteriorating and being readmitted. When asked for her views on what would happen if the Bay6 service was withdrawn she remarked:

"What a backward step that is, it's going back into the Dark Ages isn't it? It's crazy."(Patient flow manager, City Hospital)

5.2 Provision of post-discharge care

The Bay6 worker at the Shire Hospital said that relatively few patients required post-discharge care but those that needed it were more likely to engage with drug and alcohol and mental health services if they had safe accommodation. The discharge co-ordinator at the County Hospital also felt that patients who were found accommodation were also more likely to have complied with their treatment plan. An address also enabled the patient to be registered with a GP who could then coordinate the provision of mental and physical health care services. Patients discharged from the City Hospital could be registered with a GP practice which specialised in working with homeless patients. The psychiatric liaison nurse at the Shire Hospital told us that street homeless patients might have required treating for dermatological conditions and blood born viruses. They might also have had other needs such as treatment for leg ulcers, services to address their self-harming or medication to help manage their mental health. She said that having an address enabled these needs to be provided by district nurses, CPNs and social workers. The psychiatric liaison nurse said that Bay6's service went beyond finding accommodation. She described Bay6 as coordinators of social care and other non-medical services such as CAB and welfare benefits advice. She said this was:

"A bit like a spider diagram, they sit alongside the patient in the middle and they coordinate all those links out to the other services and without them being there coordinating that, none of those links happen and the patient sits in isolation".
(Psychiatric liaison nurse, Shire Hospital)

Not all Bay6 workers or hospital staff followed-up patients post-discharge and so this made it difficult for them to judge the extent to which finding accommodation for patients enabled the provision of post-discharge medical care.

5.3 Length of hospital stay

In most cases we were told that psychiatric liaison and A&E services discharged patients once they had been assessed irrespective of their housing needs. Relatively few of their patients required an in-patient admission. Therefore, it was unlikely that Bay6 reduced the length of stay of patients dealt with by these services. It was less clear whether the length of stay of psychiatric in-patients at the Shire Hospital was affected by the intervention of Bay6 given that the ward had an accommodation officer who was able to organise post-discharge housing. Nevertheless, the accommodation officer felt that the extra help provided by Bay6 sped up discharge.

Before the introduction of the Bay6 service, nursing staff at the City Hospital told us that homeless patients remained on the wards for longer. This was because the time taken up by nurses arranging accommodation for homeless patients was spread over a number of days. Their lack of housing knowledge also increased the time that it took them to find accommodation for patients. We were also told that they would put off dealing with the housing needs of homeless patients so they could focus on their priority of caring for in-patients. The matron at the City Hospital told us that:

"[Bay6] helps us to get people out quicker because they know the discharge process, they know what's out there, what's available and they can do a lot of the ground work for us." (Matron, City Hospital)

The potential for Bay6 to delay discharge might have been a disincentive for hospital staff to refer patients. We were told by a discharge coordinator that it was highly likely that A&E staff at the County Hospital had not referred patients to Bay6 because they feared that doing so would have delayed their discharge to the next day. In the same hospital, we were also told by a discharge coordinator that a colleague on an acute ward had not made referrals for the same reason.⁹

5.4 Re-admissions and A&E attendance

Hospital staff reported that a consequence of patients being discharged to the street was a deterioration in their health and therefore an increased likelihood in re-attendance or even re-admission to A&E. Hospital staff claim to have observed fewer A&E attendances by homeless people as a result of Bay6's intervention. The patient flow manager at the City Hospital gave examples of homeless patients who had frequently presented to A&E, who had subsequently been housed by Bay6 and whose A&E attendance had ceased or decreased. One of these was the patient referred to earlier who had presented at A&E on New Year's Eve. The patient flow manager estimated that she had been admitted to the City Hospital on 120 occasions mainly because of multiple overdoses or alcohol abuse. Bay6 secured accommodation in a hostel for the patient and, her attendances had been far fewer. At the Shire Hospital, it was reported that no patients referred to Bay6 had been readmitted within 28 days. For example, a patient with poor mental health and a history of alcohol abuse had been admitted to hospital on numerous occasions because of repeated injuries sustained by accidents when drunk. Bay6 found him supported accommodation and he had established a more stable life through regular church attendance and joining a bridge club. He had also been abstinent for 35 days and consequently had had no more accidents requiring hospital admissions.

One of the Bay6 workers attributed reduced admissions to the change in the funding arrangements for Bay6 referred to earlier in the report. This funding enabled Bay6 workers to support patients for

⁹ The discharge coordinator's colleague was not interviewed for the present study so we can not verify this account.

a longer period post-discharge as means of preventing 28 day re-admissions. Patient Story 1 is a probable example of such an outcome. As one Bay6 worker put it:

"I felt last time it was slightly like you're in a battlefield, putting a plaster over the wound whereas now you can do something a bit more beefy and worthwhile"(Bay6 worker, Shire Hospital)

Access to accommodation and patient engagement were also identified by the Bay6 workers as two of the most important factors in preventing readmissions:

"Patient motivation and finding something suitable. If you've got those two things... 90% [of] them [stay] out of hospital"(Bay6 worker, City Hospital)

5.5 Impact on hospital staff time

The hospital staff valued Bay6 workers' knowledge and expertise which they said they did not have and were unable to acquire. They said that their job, after all, was not to find accommodation but to care for patients. Before the Bay6 service was introduced, hospital staff struggled in dealing with local authority housing departments on behalf of homeless patients, finding it hard to get hold of staff and being 'fobbed off' by officials. They also said that they would spend a large amount of time trying to contact housing officials, marshalling information about patients and making application to housing departments. This work was spread out over many days as responsibility for finding accommodation was passed from one nursing team to the next or would take up many days of a discharge coordinator's time. In spite of these efforts, hospital staff said they might still have been unsuccessful in finding accommodation.

The work of the psychiatric liaison team at the Shire Hospital was especially disrupted by the time that it took to manage homeless patients. They had a small staff team of five and were handling up to nine referrals a day from other parts of the hospital which require two team members to carry out lengthy biopsychosocial assessments. Time spent searching for accommodation for a patient reduced their capacity to carry out these assessments. For example, we were told that one of the psychiatric liaison team had once spent eight hours unsuccessfully finding accommodation for a patient, which resulted in the patient being discharged to the street.

One clinician felt that one of Bay6's strengths was that it had more 'clout' than hospital staff with local authorities. Although the accommodation officer based at the Shire Hospital had housing knowledge that clinical staff did not have, she felt that Bay6 had a broader knowledge than she of the available options. Hospital staff also valued their working relationships with Bay6 workers, the quality of Bay6 workers' relationship with patients and for their motivation and commitment in finding accommodation for patients. As the patient flow manager at the City Hospital put it:

"If they can possibly fix it, they will, they don't give up until they've exhausted every eventuality. And some of our clients are really complicated! They're really tricky and trying to find them accommodation with all their history and all their problems is really difficult... It leaves them [nurses] free to do what they should be doing...Caring for the patients, saving lives." (Patient flow manager, City Hospital)

Hospital workers reported that the introduction of the Bay6 service had saved them large amounts of time when dealing with patients who needed suitable accommodation for their post-discharge care or for patients who were especially vulnerable. We were told that such complex discharges took

up a great deal of nursing time and that there were insufficient nurses on the wards to deal with them. Hospital staff reported that Bay6 workers had significantly helped relieve the pressure on nurses to manage complex discharges. This had enabled hospital staff to focus on their priority of dealing with other patient's medical needs or arranging packages of care for non-homeless patients. A clinician at the City Hospital remarked that Bay6 were:

"Experts in their own field. You can't do without them. I don't know where we'd be actually because we've got so used to them now...there's a lot of nurses that he started since Bay 6 has been here and they'd be completely lost." (Patient flow manager, City Hospital)

Because Bay6's service freed up staff time and expedited the discharge of patients, another clinician remarked that:

"They're my saviours. I know that sounds a bit cheesy but they are my saviours because before this, it was a struggle. It's a struggle at ward level." (Matron, City Hospital)

Patient Story 4 also illustrates how Bay6's intervention in finding accommodation for a patient saved staff time.

6 Findings: NHS resources and potential savings

Homeless patients that use the service are very high users of hospital care – our analysis of the records of 104 patients estimated that they had, on average, 3 hospital admissions per year, 7.1 A&E attendances (of which 4.5 involved arrival by ambulance) and 3.7 outpatient appointments. The potential savings for improving the health of this group are therefore similarly high.

Compared with the six months before using the Bay6 service, in the six months after the number of A&E attendances by these patients was much lower (367 vs 273), as was the number of A&E attendances by ambulance (187 vs 233; see Table 3). However, the number of inpatient admissions was about the same, and the number of outpatient appointments increased slightly.

Table 3. Hospital use before and after use of Bay6

	6 months Pre Intervention (excluding index case*)	6 months Pre Intervention (including index case*)	6 months Post Intervention (excluding index case*)
Number of inpatient admissions	155	244	157
Number of bed days (excluding day cases)	774	2,190	923
Number of outpatient appointments	191	191	224
Number of A&E Attendances	367	367	273
Number attending A&E via ambulance	233	233	187

*The index case is the hospital admission at which the patient was first referred to the Bay6 service. NB. The difference in the number of inpatient admissions with and without the index case (244 – 155 = 89) is less than the 104 in our dataset because some were referred to Bay6 direct from A&E.

In the 6 months before use of the Bay6 service, the 104 homeless patients with relevant data cost the NHS about £398,000 in hospital care (see Table 4). But in the 6 months after using Bay6 the same patients cost the NHS £310,000 – or 22% less. Most of this observed change in hospital costs incurred was due to less expensive inpatient admissions (£202,000 vs £271,000) rather than fewer inpatient admissions (157 vs 155). The observed reductions in A&E attendances would be associated with reductions in A&E costs of 24% and 19% respectively – or saving an estimated £44,000 per year.

Table 4. Hospital service costs before and after using Bay6

Cost	Pre Intervention (excluding index case*)	Pre Intervention (including index case*)	Post Intervention (excluding index case*)
Cost of inpatient admissions	£271,773	£580,890	£202,695
Cost of Outpatient	£22,108	£22,108	£25,139
Cost of A&E	£35,074	£35,074	£26,639
Total Cost in Hospital Setting	£328,955	£638,072	£254,473
Cost of Ambulance	£68,735	£68,735	£55,165
Total Cost	£397,690	£706,807	£309,638

* The index case is the hospital admission at which the patient was first referred to the Bay6 service.

If the before versus after differences in hospital costs we have observed (using six month data, in three hospitals, from about 100 patients) reflect longer term changes in use of hospital care due to the service, then we estimate that a Bay6-type service which deals with 200 referrals in one year would lead to an estimated £340,000 of savings to the NHS during the following year.

The Bay6 service seems to have more mixed impact on inpatient admission length of stay (Table 5). While in one hospital, the length of stay was lower after use of Bay6 than before (3.6 vs 4.8 days), across all three hospitals there were slightly longer hospital stays after use of Bay6 than before. This may in part be due to the fact that not all patients who received the Bay6 service ultimately had accommodation found for them, and also that for some accommodation was found after discharge from hospital.

Table 5. Length of inpatient admissions (excluding day cases)

Average length of inpatient stay (days)	'County' hospital	All 3 hospitals
Bay6 intervention stay	10.4	17.5
Stays before Bay6	4.8	6.9
Stays after Bay6	3.6	8.5
All Stays	6.2	10.4

7 Discussion

The aim of the qualitative part of the evaluation was to answer research questions 1, 2 and 3:

1. How is the service provided and used by Bay6 and hospital staff? Is it provided and used differently in the three hospitals where it currently operates?
2. What are the perceptions of hospital and Bay6 staff of the impact of the service on health and other outcomes for homeless patients?
3. What are the perceptions of hospital and Bay6 staff of the impact of the service on the use of NHS resources?

To address these questions, we carried out qualitative interviews with 3 Bay6 workers and 6 hospital staff to explore their perceptions of the process of referring homeless patients to Bay6, the process of finding accommodation for them and the impact of finding accommodation on patient's post-discharge health and their use of NHS resources.

The data that we gathered was especially rich in enabling us to explore the first research question. In doing so, we identified the barriers and facilitators in the referral and accommodation finding process. These are summarised in Table 6. Our data was insufficiently rich to enable a full exploration of the second and third research questions, although the data provided useful insights. In exploring each research question we suggest avenues for future research and identify the limitations with the study.

7.1 The process of referral of patients to Bay6

7.1.1 Patient health care needs

The health care needs of patients referred to Bay6 were generally typical for those of the homeless population. That is, they often had both physical and mental health care problems, and a history of substance misuse.

7.1.2 Referral responsibility

The staff responsible for referring patients to Bay6 varies between the hospitals. At the County Hospital referrals was largely centralised in the hands of ten discharge coordinators. At the City Hospital referral responsibility is dispersed amongst all clinicians on each of the wards, mainly nurses, OTs and physiotherapists. A hybrid arrangement operates at the Shire Hospital where referrals are made by discharge coordinators, ward nurses, psychiatric liaison staff and the psychiatric inpatient's accommodation officer.

7.1.3 Referral barriers and facilitators

Identifying homeless patients

We were told by hospital staff that a patient's housing circumstances are routinely identified as part of the admissions process or when patients present to A&E or the psychiatric liaison service. However, there was some discrepancy with Bay6 workers perceptions of whether hospitals do this in all cases. Bay6 workers' experience was that homelessness was not identified when hospital staff were too busy to do this or if information about patients was not passed between staff when patients change wards. Even if homelessness was identified by hospital staff, doing so might have been very close to when the patient was discharged by the hospital. This was on the same day for patients who presented to A&E or psychiatric liaison. For patients admitted to hospital for only one or two days, homelessness was inevitably identified close to discharge. The timely identification of homelessness was frustrated if patients did not disclose their housing circumstances to staff or because they became homeless after admission. The timing of identifying homelessness would have affected the timing of the hospitals referral of a patient to Bay6.

Referral timing

The Bay6 workers reported very wide variations in the time between patients discharge and a referral being made. These estimates ranged from effectively no time at all to several weeks. This might have been because patients had been admitted for a short period. The factors that affected hospitals identifying homelessness were also likely to have affected the timing of referrals. But we do not know how these and other factors, such as hospital staff awareness of Bay6, interacted to determine the timing of referrals.

Staff awareness of the Bay6 service

Bay6 workers felt that hospital staff awareness of the service varied within each hospital, especially amongst clinical staff. We do not know whether this awareness was dependent on whether referrals were centralised or dispersed or whether these arrangements affected whether homeless patients were routinely identified and referred.

7.2 The process of finding accommodation

7.2.1 Accommodation and support service options

The main types of accommodation options for patients were temporary accommodation, specialist housing, permanent social housing, private rented accommodation and living with family members. As well as identifying accommodation, Bay6 could also arrange access to support services for homeless people, especially services that supported the street homeless, and to non-residential drug and alcohol services. Bay6 workers applied their knowledge of housing options, its availability and eligibility criteria and their patient knowledge to judge which types of accommodation to find for patients.

7.2.2 Barriers and facilitators to finding accommodation

Bay6 speed of response to referrals

All hospital staff reported that Bay6 workers were very quick to respond to referrals, usually on the same or the following day, and that they were considerably quicker in responding to referrals than local authorities. The extent to which the working hours of Bay6 workers affected their speed of

response to referrals and their management of the subsequent stages of the housing process requires further research.

It was not possible to assess the extent to which the likelihood of finding accommodation depends upon the speed of response to referrals. If patients were discharged to the streets, Bay6 workers might still have attempted to find accommodation for them. The current RIF funding of Bay6 enabled the service to work with patients after they had been discharged from hospital. This should have given Bay6 workers a longer period in which to find accommodation for patients even if they were referred to Bay6 close to discharge or had been discharged to the street, but our data was not able to confirm this.

Hospital discharge practice

Bay6 workers reported that it was common practice for medically fit patients to be discharged to the street. This was corroborated by some hospital staff. It was inevitable that if these patients were referred to Bay6 close to discharge, Bay6 had limited time to arrange accommodation for them prior to discharge. Patients who required suitable accommodation to provide post-discharge medical care appeared unlikely to have been discharged to the street and might have been kept in hospital for longer pending accommodation being found. There was a *de facto* policy at the Shire Hospital of not discharging psychiatric in-patients until suitable accommodation was found for them but we do not know whether this was the practice at the other hospitals. There was some evidence that the fear that a referral to Bay6 would have delayed discharge also discouraged hospital staff from making a referral, although we do not know whether this practice was widespread.

Housing application process and criteria

Bay6 workers applied their knowledge of local authority and provider eligibility criteria and processes to determine the most realistic options to pursue and they used this knowledge in an attempt to obtain accommodation. This was knowledge that most hospital workers said that they did not have and could not acquire and which meant that, before Bay6, they had struggled with finding accommodation for homeless patients. For them, their priority was caring for patients and finding accommodation for homeless patients would have been a secondary priority.

For temporary, specialist and permanent accommodation, local authorities applied eligibility criteria. Bay6 workers reported that these criteria were unclear, might not have been interpreted consistently by housing officers but that it was interpreted very tightly. In making assessments to determine whether patients were a priority for housing, local authorities took into account a patient's medical and social needs, the patient's reputation and their engagement with other services. This required Bay6 workers to marshal evidence, including that provided by the hospital, in order to make a strong case to the local authority. It was reported that the speed at which local authorities responded to applications and carried out assessments was undermined by staffing cuts. If the local authority accepted that they had a duty to house, a patient would be placed in temporary accommodation, a specialist placement or permanent accommodation. The latter was more likely to be offered once a patient had already spent time in temporary or specialist accommodation. If a place in specialist accommodation was approved by the local authority, the patient still needed to satisfy the provider's admission criteria and its provision was also dependent on space being available.

In some cases, Bay6 worked to save a social housing or private rented tenancy if this was in jeopardy if, for example, patients had been evicted or were at risk of being evicted for rent arrears or anti-social behaviour. In other cases, Bay6 attempted to persuade patients to return to the family home. This might have been especially necessary where their refusal to do so would have been deemed by the local authority as abandoning a tenancy and therefore made them ineligible for local authority funded accommodation. Another option was private rented accommodation or being housed by a family member. Bay6 workers would assist in applying to local authorities for discretionary payments for rent deposits or rent in advance. Bay6 workers might also work with the patient's family to persuade them to accommodate them.

Availability of housing

We were told that the likelihood of a homeless patient being found accommodation was constrained by the lack of availability of specialist accommodation, the lack of temporary accommodation which local authorities were willing to fund, a scarcity of private landlords willing to let to those on housing benefit and the rationing of local authority discretionary payments. We were told that most of these impediments have been created by public spending cuts.

Patient motivation and commitment

Even if there is potential to find accommodation for patients, obtaining it was dependent on the patients' willingness and motivation to change their chaotic lifestyle and to engage with Bay6 or support services. In some cases, patients chose to return to the street. To overcome these barriers, Bay6 workers attempted to gain patient's trust and cooperation, even if they had been discharged to the street. In some cases, they went to considerable lengths to do this. Sometimes they were successful, at other times not. Patients' reluctance to engage might have been because of their previous experience of being assessed by housing departments which had resulted in not being offered accommodation.

Bay6 professional networks

In navigating the housing landscape, Bay6 workers drew on their network of relationships and contacts with local authorities and housing providers in the public, voluntary and private sectors.

Bay6 working methods

In some cases, Bay6 worked in collaboration with other housing workers and with hospital staff to find accommodation even if a patient had been discharged to the street. Working with patients discharged to the street was facilitated by changes to the terms of Bay6's funding. However, not all hospital staff maintained a relationship with Bay6 after they had made a referral. Hospital staff praised Bay6 for their knowledge, expertise and commitment and the quality of their relationships with patients. They contrasted this to the negative and unhelpful attitudes of local authority staff. Bay6 workers, though, had a more positive view of housing officials.

Table 6. Facilitators and barriers to finding accommodation for homeless patients

Stage of service	Facilitators	Barriers
1. Hospital staff identifying homeless patients	Routine identification of homelessness as part of the admissions process Homeless patients identified early in their hospital stay	Absence of routine identification of homelessness as part of the admissions process Delays in hospitals identifying homeless patients
2. Hospital staff referring patients to Bay6	High hospital staff awareness of Bay6 Discharge practice enabling patients to stay in hospital pending accommodation being found Sufficient time is given to Bay6 to seek accommodation prior to discharge	Low hospital staff awareness of Bay6 The practice of discharging patients to the street The close proximity of identifying homelessness, the timing of discharges and referrals to Bay6
3. Bay6 responding to referrals	Quick response to Bay6 referrals	
4. Bay6 identifying accommodation options for patients	Bay6 workers housing knowledge, experience and use of networks	
5. Bay6 applying for and finding accommodation for patients	Bay6 workers' housing knowledge, experience and networks Bay6 workers commitment and style of working with patients Patients who are willing to engage with Bay6, other services and to change their lifestyles Bay6 workers and hospital staff collaborating in finding accommodation Families and patients willing for accommodation to be in the family home	Patients who are unwilling to engage with Bay6, other services and to change their lifestyles Local authority and provider eligibility criteria and processes, including slow speed of response The limited and reduced availability and funding of temporary, specialist and permanent accommodation The limited availability of private rented accommodation, especially for those needing housing benefit The erosion of local authority discretionary payments for deposits and rent in advance Family or patient resistance to living in the family home

In describing the operation of the Bay6 service in the three hospitals, it is clear that hospital staff highly valued the service. Staff identified homeless patients as inpatients, or when they presented to A&E or to psychiatric liaison. Once these patients were identified they referred them to Bay6. However, Bay6 faced barriers in this process because patients who are homeless might not have

been identified or they were identified relatively late during their time in hospital. There were wide variations in the time between discharge and referrals being made and there were variations in hospital staff awareness of the service. Psychiatric inpatients and patients requiring post-discharge care were more likely to have been kept in hospital until accommodation was found, and this facilitated the process of finding accommodation. The practice of discharging medically fit patients to the street probably acted as a barrier to finding accommodation but Bay6 still looked for accommodation for these patients.

Bay6 workers had accumulated a great deal of knowledge and experience of working with homeless patients to find accommodation for them in their area. In doing so, they managed the barriers in the referral process and the barriers presented by the local housing application process. They had established relationships with local authority housing officers and a variety of housing providers and homeless organisations. They knew about the range of available accommodation, they were familiar with local authority and provider's eligibility criteria and application processes and they worked with private landlords and families to accommodate patients. They understood how the chaotic lifestyles of some homeless patients were an impediment to finding accommodation for them. This knowledge and experience of the housing landscape and of patient need equipped them to make judgements about the most realistic housing options for patients. We were told that they went to great lengths to work within a system of limited and highly regulated provision, and to work with patients to improve their chances of finding accommodation. This accumulation of skills and knowledge contributed to their success in finding accommodation for patients.

The barriers and the facilitators that we have identified can be used to inform subsequent improvements or evaluations of Bay6 or similar services that are provided in other hospitals. By using either qualitative or quantitative methods, these factors can be explored in more depth to evaluate their impact on finding accommodation for homeless patients, or modified to improve the service (e.g. by improving NHS staff awareness of the service).

Some of these facilitators and barriers are amenable to control by the NHS or Bay6, such as hospital staff awareness of the service, or whether homelessness is routinely identified as part of the admissions process. Other factors are less likely to be controllable by the NHS or Bay6, especially patient behaviour and motivation; or local authority funding of housing services. If the future funding of Bay6 could be secured, the efficiency of the service can be improved and differences between each of the hospitals can potentially be dealt with by addressing those facilitators and barriers over which Bay6 or the NHS has some control.

7.3 The impact of Bay6 on patient health and the use of NHS resources

7.3.1 Preventing discharge to the street and consequent health outcomes

By discharging patients to the street, it was reported that it increased the patients' risk of being a victim of crime, self-harming and resuming their drug and alcohol misuse. We were told that as a result their mental and physical health was likely to worsen and that there was also a greater risk of suicide. These include 'borderline cases' where patients are medically fit for discharge but who are vulnerable to resuming the cycle of alcohol and drug misuse a deterioration in their physical and mental health. If patients returned to abusive relationship or partners who are abusing drugs or alcohol, staff said that there was also a greater risk of their mental and physical health deteriorating. Hospital staff described these as failed discharges but that they can be prevented by providing safe

accommodation for patients, an outcome that hospital staff said that Bay6 are more likely to achieve than hospital staff. It was anticipated that more patients would be discharged to the streets if the Bay6 service was withdrawn.

7.3.2 Provision of post-discharge care

Hospital staff who have followed up patients observe that the provision of accommodation enables the provision of medical and social care such as district nursing and community mental health services. The provision of post-discharge care was likely to prevent a deterioration in patient's mental and physical health as it enabled patients to be registered with a GP who can then coordinate their physical and mental health care. Bay6 also had a role in coordinating patients social and other non-medical care where accommodation was found for them. Staff also reported that the provision of accommodation also makes it more likely that patients complied with treatment plans. This appears to be consistent with the quantitative findings which found an increased use of outpatients subsequent to the intervention of Bay6. However, the extent to which accommodation had improved the provision of post-discharge care was difficult to judge because staff often did not follow-up patients once they had been discharged.

7.3.3 Length of stay

Providing accommodation for patients had not had any perceived impact on length of stay for patients who present at A&E or to psychiatric liaison patients given that these patients had to be discharged the same day. The impact on the length of stay for psychiatric inpatients was uncertain given that these patients are not discharged until accommodation can be found. While the accommodation officer could find accommodation for them, the Bay6 worker was described as an extra pair of hands and that she had more housing knowledge. Staff at the City Hospital were more confident that Bay6 expedites the discharge of complex homeless patients from acute wards given that they found accommodation more quickly and successfully than hospital staff. There was some indication that A&E and other staff had not referred patients to Bay6 because of the fear that doing so would have delayed discharge.

7.3.4 Readmissions and A&E attendance

As a result of Bay6's intervention, some hospital staff observed fewer admissions and presentations to A&E, especially from those who had a history of frequent admissions and attendances. At the Shire Hospital, we were told that there had been no 28-day readmissions. These perceptions are consistent with the quantitative findings which showed a lower use of A&E subsequent to the intervention of Bay6. A perceived reduction in readmissions was attributed to Bay6 enabling patients not to be discharged to the streets and thereby reduced the risk that their mental and physical health deteriorated. The opportunity to prevent readmissions was also attributed by Bay6 workers to changes to their terms of funding which enabled them to work with patients after they had been discharged. Not all hospital staff observed these outcomes due to the volume of patients that they dealt with or because they did not follow-up patients once discharged.

7.3.5 Use of hospital staff time

Homeless patients who needed accommodation for post discharge care were described as complex discharges. When hospital staff were responsible for arranging accommodation for these patients, the time it would take would often be spread over several days as staff put it off and handed it over

to other nursing teams. A great deal of hospital staff time was also expended in organising accommodation and their efforts to do this could be fruitless.

We were told that the result was that patients' length of stay was longer. The hospitals reported that Bay6 workers' housing expertise and success in finding accommodation had relieved staff time spent on managing the discharge of homeless patients. They also reported that this has freed up their capacity to provide routine patient care and to arrange packages of care for non-homeless patients.

7.3.6 Qualitative study limitations and future research

Compared to the volume of data that we gathered to describe the operation of the Bay6 service, the data to deal with the perceived impacts of Bay6 was relatively modest. This was because Bay6 workers and hospital staff often did not necessarily follow-up patients once discharged, or the volume of patients dealt with by hospital staff deal made it hard for them to remember whether patients had had previous admissions. Although we cannot be certain, those outcomes that they recalled might have been for patients who made an unusually large use of hospital services or were cases that stood out in their minds because of their distressing or atypical characteristics. The relatively limited amount of data that we have about perceptions of health and health service impact mean that these findings are provisional.

We were also unable to interview staff with similar roles in each of the hospitals or from all parts of the hospitals who may have treated the full range of homeless patients' medical needs. Any comprehensive qualitative evaluation would require a larger purposive sample of hospital staff. Such a study would also ideally include the patient's perspective and that of local authorities, housing providers and other support services working with homeless people.

Nevertheless, the qualitative findings presented in this report indicate the range of factors which could be used to inform a retrospective or prospective quantitative study of health outcomes, use of community health and social care services, admissions rates and the use of hospital staff time in hospitals. Such a study could compare outcomes in hospitals in which Bay6 (or similar services) operated and those in which it did not.

7.3.7 Quantitative data analysis limitations and future research

The validity and reliability of analysis of centralised hospital use data for Bay6 service users depends on both the quality and completeness of the data collated by the hospitals, and the processes that we have used to identify those patients and calculate costs from the SUS data. We are aware of the following main limitations of our quantitative data analysis:

- The comparison of before versus after hospital use data is not a strong study design for being able to attribute any observed changes in service use to the use of the service.
- It was not possible to obtain the hospital service use records of all Bay6 service users at the time the analysis was conducted. Six were excluded because they had incomplete hospital spell records (perhaps because they were still in hospital at the time of the SUS data extract), two were believed to be duplicate records, and for the most recent users of the Bay6 service, 6 months had not elapsed since their first occasion of using Bay6. Nevertheless, our sample of 104 Bay6 service users represents a substantial proportion of all users of the service during the period.
- Some inpatient and other hospital episodes did not have locally available Payment by Results codes and costs that could be attached to them. Therefore, for some categories of

hospital service use national reference costs for more generic categories of admission or visit were used.

- The service is still relatively small scale and early in its implementation and evolution. Therefore, awareness and accessibility to the service for hospital staff may mean it is operating at lower than full capacity, which would misrepresent the cost-effectiveness of the service were it to expand and become better known and more used by staff in all wards in participating hospitals.
- The service use data relate to all homeless patients whether or not they were actually found accommodation by the Bay6 service. A subgroup analysis of those Bay6 service users who were found secure accommodation may have yielded different results.
- These estimates of potential cost savings do not include any estimate of the cost of clinical staff time saved by not having to try and find accommodation for homeless patients.

Overall, we believe the 104 patients for whom we had complete service use data for both 6 month periods were representative of the overall group of Bay6 service users. However, with a sample of this size we did not think it would be defensible to conduct and report separate analyses by hospital.

Future research on this and similar services should aim to obtain more complete data and collect it for a longer follow-up. In addition, it should aim to provide comparisons of outcomes with a control group of homeless patients (e.g. in other hospitals or other wards) who did not have access to or use the Bay6 service. If similar services are to be rolled out more widely, a cluster-randomised controlled trial, including an integrated process evaluation, should be carefully considered alongside such a roll out.

8 Conclusions

The processes of homeless patients being identified by hospitals, being referred to Bay6, and then finding accommodation for them are complex. The stages of these processes are inter-related and a broad range of factors shape their implementation. These factors depend on hospital practice, the specific ways in which Bay6 operates within a particular hospital, the ways in which local authority and housing providers work and the resulting level of engagement with homeless patients.

These observations can inform Bay6's work and the ways in which they work with hospitals and other services. Bay6 would be better informed in doing this if subsequent research was carried out to understand how these processes and factors interact and the impact that they have on housing outcomes; and how more secure housing then affects health and social outcomes.

We have been able to identify the perceived impact of Bay6's services within three of Devon's foundation trust hospitals, including on the provision of accommodation on patient health and the use of hospital and other health services. The perceptions of staff and the quantitative data on the use of hospital services of those patients who have been referred to the service are consistent in that, on average, the service was associated with lower demand for hospital care and lower NHS costs afterwards. To more firmly establish whether these changes and estimated savings are due to the service, how they are achieved, and whether they would continue after 6 months will require more data collection over a longer period of time, and comparison with health service use data from wards and hospitals where such a service does not exist. With larger samples, such research could also explore which subgroups of homeless patients it appears to have greater or more lasting

impacts on, including how much this depends on finding secure accommodation relative to other factors

The future of the Bay6 service is very uncertain. Our findings can inform the service's development and improvement. We also believe that this early evidence on its perceived and actual impact, both on vulnerable patients and on NHS resource use, provide a preliminary but reliable economic case for further NHS investment in the service.

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Appendix A – Bay6 operations guidelines

This document explains the aim of the project, who the service will work with, what work it will do and the criteria by which it will be judged.

BAY6 is funded by a NHS Regional Innovation Fund grant to work in the following hospitals: Royal Devon and Exeter NHS Foundation Trust; Northern Devon Healthcare NHS Trust (North Devon District Hospital) and South Devon Health Care NHS Foundation Trust (Torbay Hospital).

The following is taken from the May 2014 BAY6 Regional Innovation Fund bid.

The aim and purpose of the BAY6 project:

The aim of the project is to:

- Improve the health and wellbeing of patients who would otherwise be discharged as homeless
- Reduce the number of admissions, repeat admissions and delayed discharges of homeless people due to a lack of accommodation
- Reduce hospital bed nights
- Identify wards where homeless people are likely to be admitted
- Increase the monitoring on admission of a patient's housing status and to encourage the earlier identification of a patient's housing status by NHS staff to increase their chances of being discharged into appropriate accommodation.
- Reduce the number of readmissions within 28 days by homeless people. Early intervention to increase a patient's chances of being discharged into appropriate accommodation will increase their chances of engaging with primary, secondary and other services, and of successfully recovering from their treatment, illness or injury.

Who BAY6 will work with:

Patients referred to the service will include, but not be limited to, hospital in-patients who are:

- Street homeless
- Vulnerably housed where they cannot return due to the reluctance of friends or relatives
- In housing crisis where their ability to maintain their home is threatened
- Unable to return due to unsuitability or unavailability of accommodation (e.g. disaster, eviction, loss of property)
- Concerned that they will lose their accommodation while in hospital (e.g. due to financial issues)
- In any other situation leading to the threat of homelessness (e.g. because of domestic violence, relationship breakdown, release from HMP).

What BAY6 will do:

Homeless patients will always be supported in a sensitive manner and not stigmatised. BAY6 will improve engagement with hospital in-patients at risk of homelessness across Devon and Torbay and help to promote continuation of treatment post discharge by:

- Providing a single point of contact for NHS Trust staff to refer a patient at risk of homelessness and for self-referral by patients and relatives
- Providing dedicated staff who will work with, and advocate on behalf of, homeless patients, with the aim of identifying suitable accommodation before discharge, including identifying and salvaging existing accommodation where this is in danger of being lost or abandoned
- Working closely with NHS Trust nursing and medical staff to ensure the appropriateness of accommodation, and by working with discharge teams to ensure a well-meshed service for patients requiring funding for care and support
- Identifying and working intensively with homeless clients who access Emergency Department services a disproportionate amount of times
- Delivering effective in-house promotional campaigns, training and resources for NHS Trust staff to assist them to:
 - Identify housing issues at admission or soon after; understand the needs and fears of homeless people, their relatives and carers, and be aware of the support available through the BAY6 project
- Building effective working relationships with NHS Trust staff to ensure the success of the specialist housing service
- Working with stakeholders and NHS Trusts to identify and address inconsistencies, gaps in provision and delays resulting in patients being discharged as homeless.

The criteria by which BAY6 will be judged:

- The numbers of homeless patients seen on the day of referral by the specialist housing service (BAY6)
- Joint working between the specialist housing service, clinicians and multi-disciplinary teams
- Increased awareness by NHS staff on all wards and of all disciplines of the issues surrounding homelessness
- Reduction in the numbers of re-presentations at A&E within 28 days by homeless people
- Raising awareness amongst NHS Trust staff of specialist community support for homeless people to prevent admission
- Increase in numbers of homeless patients engaging, or re-engaging, with primary, secondary or community care
- Enhanced patient experience and improved health for homeless people.

Appendix B – Interview topic guides

Topic Guide - hospital staff

As you know, we are carrying out an evaluation of Bay 6 and I have some questions to ask you about your general experience of the Bay6 service, how it works in your location, and what you think of the service.

Check respondent has read the information sheet and ask to sign consent form.

Check respondent is happy for interview to be recorded.

Ask for name and role of respondent

1. Which staff at [name of hospital] tend to identify patients with housing problems?

Probe:

Specialist discharge staff

Clinicians

Admin staff

2. Which types of staff usually make referrals to Bay 6?

Probe:

Specialist discharge staff

Clinicians

Admin staff

3. How were the housing problems of those patients that you referred to Bay 6 identified?

Probe:

Do the patients tell you?

Do you identify the problem?

How do you become aware of the problem?

At what point in their hospital stay do you identify their housing need?

4. What have been your reasons for referring these patients to Bay 6?

5. Is it possible some staff might not have referred these patients to Bay 6?

Probe:

Reasons for this

Do you think that different types of staff are more/less likely to refer?

6. What has gone well in working with Bay 6?

Probe:

initial referral

response time
visibility of BAY6 staff on ward
how well BAY6 interacts with hospital staff/referrer.

7. What could have been better about working with Bay 6?

We would like to know whether Bay 6 has made a difference to the management of patients with housing problems.

8. Has Bay 6 made a difference to preventing delayed discharge?

9. Has Bay 6 made a difference to enabling a patient to be discharged to more appropriate accommodation?

10. *[Depending on answer to Q8 & Q9]* Why would their discharge have been more problematic before the Bay 6 service was introduced?

11. Does the provision of accommodation on discharge have an impact on the post discharge management of the patient's health care?

12. *[Depending on answer to Q11]* If so, how?

Probe:

Difference to:

medication use

wound dressings

out-patients appointments

communication with the GP

re-admission within 28 days

poorer recovery

other aspects of care

13. Has Bay 6 made any other differences?

Probe:

Care of the patient on the ward

The work of the staff on the ward

Any other care provided post-discharge

Anything else?

14. *[Depending on answer to Q13]* Why would these aspects of their care have been different before the Bay 6 service was introduced?

15. If the service provided by Bay 6 came to an end, what difference would this make?

Probe:

Delayed discharge

Post-discharge care
Re-admissions
Other types of care
The work of the staff on the ward

Topic Guide - Bay6 workers

As you know, we are carrying out an evaluation of Bay 6 and I have some questions to ask you about your experience of the Bay6 service. In answering these questions, please feel free to use examples of specific patients that have been referred to you.

Check respondent has read the information sheet and ask to sign consent form.

Check respondent is happy for interview to be recorded.

Ask for name and role of respondent

1. Who usually makes referrals to Bay 6?

Probe:

Specialist discharge staff

Clinicians

Admin staff

Is there anyone you have contact with more frequently with others? (If yes – Why do you think this is?)

2. Do you think that some hospital staff are more likely to refer patients to Bay 6?

Probe:

Which ones

Reasons for this

Who is least likely

3. If you think about specific patients, what has helped with their referral to Bay 6?

Probe:

Hospital policy/procedure for identifying patients with housing problems

timeliness of staff identifying a housing problem

proximity of referral to discharge date

quality of information provided by hospital staff

referrals made by discharge specialists vs generic hospital staff

4. What has hindered their referral of patients to Bay 6?

Probe:

Hospital policy/procedure for identifying patients with housing problems

timeliness of staff identifying a housing problem

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proximity of referral to discharge date
quality of information provided by hospital staff
referrals made by discharge specialists vs generic hospital staff

5. What has gone well in your work at [name of hospital]?
6. What could have been better about working with [name of hospital]?
7. What work do you do with other agencies?

Probe:

Drug/alcohol services
Housing
Social services
Welfare benefits
Others

8. What has gone well in your work with these agencies?
9. What could have been better about working with these agencies?

We would like to know whether Bay 6 has made a difference to patients with housing problems.

10. Thinking about specific patients, would you tell me if Bay 6 made a difference to preventing their delayed discharge?
11. If Yes, in what way?

Probe:

How do you know/why do you think that?

12. To what types of accommodation have these patients been discharged?
13. Do you think the provision of accommodation on discharge had an impact on the post discharge management of their health care?
14. [*Depending on answer to Q11*] If so, how?

Probe:

Difference to:
medication use
wound dressings
out-patients appointments
communication with the GP
re-admission within 28 days
poorer recovery

other aspects of care

13. Has the quality of the housing affected patients post-discharge care?

14. What impact do individual patients themselves have on how well Bay6 works?

15. Is there anything about the patients themselves that affects outcomes for them?

16. In your experience, what difference do patients think Bay 6 has made to them?