Discharge Grants 2024-2025

Review Template

Scheme Name	Housing Enablement Team
Discharge Grant funding allocation for 2024-25	**£165,760**
Service area (e.g., Community services etc.)	Hospital Discharge
Service Lead & Contact Details	Shanice Senghor – shanice.senghor@blaby.gov.uk - **07825256481**
ICB Service Lead & Contact Details	
Geographical Place coverage (e.g. City, County, Rutland or LLR)	Leicester, Leicestershire and Rutland
Service Provider/s (e.g. In-house or sub-contracted) If sub-contracted please provide a copy of the sub-contract this funding contributes to.	Blaby District Council act as host for the Housing Enablement Service

Scheme Description **Including:** • What is the key purpose of the scheme? • What additionality has this funding enabled beyond standard service delivery?	**Background:** The Housing Enablement Service began as a pilot in 2014 in the Bradgate Mental Health Unit. The success of the initial pilot led to a sister pilot in the UHL hospital covering the LRI, Glenfield and General Hospital. In 2016 the two pilots were merged into a single service with a single management structure. Increased success has since led to further pilot expansions of the service into the MH Rehab sites at Stewart House and the Willows, the MHSOP wards in the Bennion Centre and Evington Centre and into all the Community Hospitals in Leicester and Leicestershire. The key focus in 2014 was to radically redesign housing support and create an integrated housing offer for clinical care settings. The service is focused on delivering health and wellbeing outcomes for patients and to alleviate housing related barriers to discharge. HET has also pick up additional work regarding complex cases that no other service is designed to take. For example, there have been several cases whereby patients with No Recourse to Public Funds have been in hospital with Tuberculosis and HET have created and supported a discharge pathway. Since 2015, the Housing Enablement service has benefited from a dedicated partnership team who have worked intensively with stakeholders to break down barriers to change, co-produce solutions, and challenge the system, across a very complex (national and local) policy landscape for health and care. **The Key Purpose of the HET Service is to:** • Ensure patients are discharged from hospital in a timely manner to a safe place or their usual place of residence • Help prevent delayed transfers of care **The service aims to do this by providing:** • An access point into a range of practical housing support solutions within hospitals - Continually improving the customer journey; making services easier to access and navigate and ensuring the right discharge solution is available at the right time with the right outcome. • A common, holistic housing needs assessment process - Provide efficient, cost-effective service delivery through service redesign; capitalising on opportunities to create more effective

	working practices, and improved processes to create more timely and appropriate solutions to aid hospital discharges. • A broader, targeted offer of practical housing support - Providing a pragmatic response to a wide range of complex issues that contribute to an extended length of stay and/or a delayed discharge in various care settings. • Sole responsibility for fulfilling the DTR legal obligation placed on public bodies. In January 2023, The Housing Enablement Service brought forward a business case to request funding from 1st April 2023 to 31st March 2026 from the Integrated Care Boards (ICBs) in Leicester City and Leicestershire County and the Leicestershire Partnership Trust (LPT). **The additional discharge funding allowed the service to:** • Recruit an additional support officer post in UHL needed to support increased demand. • Increase funding for interventions to allow HET to cope with the increased demand across all sites, provide quicker interventions and enable more discharge solutions. • Cover BDC overhead costs not factored into the previous contract and allow BDC to continue hosting the service. • The addition of a new service manager post to strategically support the service and the wider LLR system in relation to housing discharge support and involvement in complex discharge cases. • Fully operate without a waiting list - UHL Hospitals (LRI, Glenfield and Leicester General) All Community Hospitals in Leicester and Leicestershire Bradgate Mental Health Unit MH Rehab Sites (Stewart House and The Willows), Bennion Centre and Evington Centre (MHSOP), George Elliot Hospital (Leicestershire Patients only) • Recruitment of a triage officer role to support the volume of referrals and provide real time updates to clinical staff. The funding has enabled the service to continue to keep up with demand and patients are continuing to benefit from prompt query resolutions which wouldn't be offered without extra staffing

	resources. Partners across the health and care system, (who have already seen the dramatic impact of the housing discharge enabler service), can have confidence that measurable system wide benefits are generated when housing support is fully embedded in health and care pathways. The funding has also allowed the service is committed to continuous improvement and redesign to fit with changing NHS priorities and service delivery.

Quantitative and Qualitative Evidence of Impact and Benefits, Outcomes and Outputs for

- Service Users and
- The System

The HET service is skilled in working with often the most vulnerable and complex patients including those with mental health conditions, multiple long-term conditions, the homeless, victims of domestic abuse and those with no recourse to public funds. A key to its success is the pragmatic response required to help patients, families and carers navigate complex pathways. The service not only provides housing solutions but also benefits advice, residency documentation and access to foodbanks. In addition to this staff work in the community with patients once they are discharged to support them particularly when accessing longer-term housing solutions for example in the private rented sector.

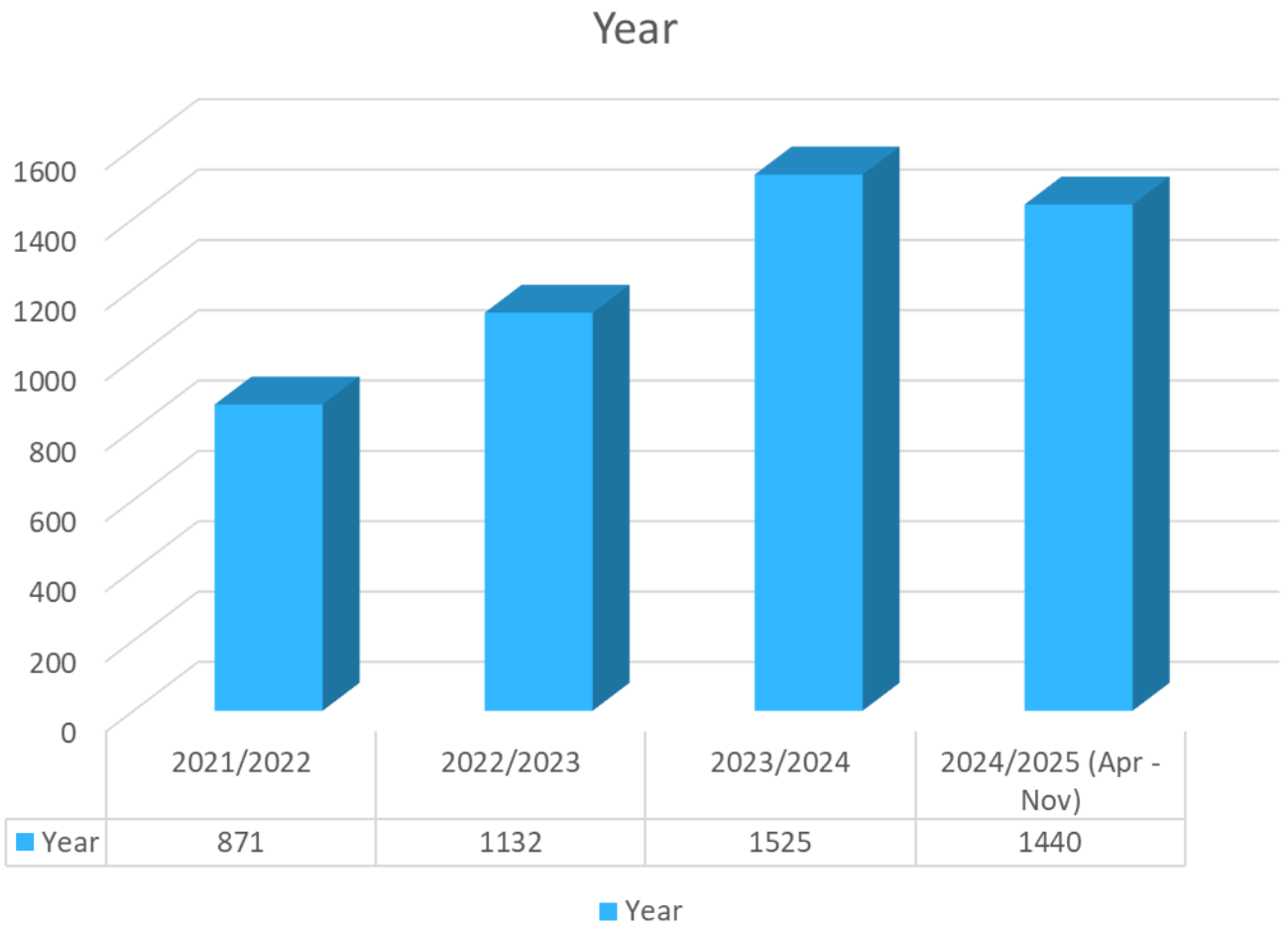
The evidence that good-quality housing is critical to health is well established (Public Health England 2017). A well-housed population helps to reduce and delay demand for NHS services and allow patients to go home when they are clinically fit to do so. It is estimated that the cost of poor housing to the NHS is £1.4 billion per year (BRE 2015)1 . So, it is clearly in the interests of the NHS and local authorities, to work more closely with housing partners as STPs develop to reduce demand on acute services and local authority services.

The HET service has a direct benefit for the LLR System as outlined below:

With HET's Business Critical Service	Without HET Disparate Service Offer
Improved DTOC rates – Increases potential to meet national DTOC targets	**Housing related enquiries have to be completed by clinical /social care staff –** detracting from patient care including duty to refer for homeless patients.
Reduce re-admissions – Due to instigating longer term housing solutions (e.g. warm homes, clean and clear, access to the private rented sector)	**Increasing residential care placements –** Where patients unable to live independently at home

Reduces Health Inequalities – Improving outcomes for vulnerable and marginalised patients	**Uncoordinated non-clinical discharge activity –** Potentially resulting in DTOC and increased length of stay
System Integrators – The bridge between clinical care and community services.	**DTOC delays –** Increase due to a lack of coordination around housing and other non-clinical/social related issues
Outcomes – 22 different outcomes linked to a network of partners offering a pragmatic response across numerous agencies including district councils, Home Office, voluntary sector	**Increased readmissions –** Due to no / poor housing provision
System Connectivity – Linked to a network of other partners – action homeless, foodbanks, furniture packs, clean and clear & voluntary sector	I**ncreased length of stay –** whilst housing issues are resolved
Demand Management – Demand has continuously increased in BMHU and UHL, with data showing that for UHL in particular, total annual referrals for 2022/2023 were surpassed in just 6 months in 2023/2024.	**Housing service becomes a lottery depending on your care setting**
Continuity of Service – Irrespective of care setting	**No system or recognised process for the most vulnerable –** (e.g. homeless, dependent)
Early Identification of Housing and community service Needs – Optimises flow through hospital	**Hospital Flow –** Bottlenecks of patients with complex discharge needs decreasing hospital flow

	HET also provides return on investment by reducing healthcare costs associated with delayed discharge, emergency readmissions and reduced A&E attendances. Since the last business case in 2018 HET's intervention has seen: • A fall in housing related emergency admissions up to 70% • Housing related A&E attendances a reduction of 56% • There is a 50% rise in 'no activity' (no further services required across health, social care and community) from 40 service users prior to Housing Enabler intervention to 80 service users post intervention. (Across 30 days) The NHS constitution 'Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. HET's integrated approach to housing support directly aligns with this vision and will support the model of future service delivery; helping to ensure people can get the right level and type of support at the right time to help prevent, delay or reduce the need for ongoing support and maximise their independence. This funding has allowed HET to be able to accept more referrals and there has been a significant increase in demand this has been created by HET integrating further into the system. **Volume of Service Users Benefiting from the service:**



As the HET service has grown, demand on the service has also grown. From the point at which the last contractual agreement was signed, there have been three principal areas where demand on the HET service has significantly increased:

	Expansion in further sites therefore needed for staff resource Increase in referral numbers Increase in clean and clear cases to support discharge home As well as an increase in the sites covered and an increase in referrals, HET as also picked up additional duties that were not factored into the initial funding contract. For example, in recent years there have been several patients with TB that needed long-term treatment in the community, unable to be discharged from hospital because they had no address to go to and could not access statutory homelessness services because of their status in the UK. In order to prevent these patients becoming lengthy delays in vital IDU beds, HET agreed to secure accommodation for these patients and manage them in the community so that they could receive continual treatment outside of hospital. There is no additional funding provided for the demand on staff member's time for the management of these cases, which has put significant strain on HET as ordinarily, HET is an inpatient only service. HET also pick up Duty to Refer (DTR) cases. DTRs is a specific legal duty placed on Hospital Trusts, requiring them to refer patients that are either homeless or threatened with homelessness to Local Housing Authorities. HET satisfies this duty on behalf of UHL and LPT in all cases that are referred to HET. The HET Team Leader is also assisting in working with UHL and LPT to review and rewrite their discharge policies in relation to this duty. Without HET, this duty would fall on clinical staff to do, taking away vital time they could be spending with patients. HET staff are also experts in homelessness, so are able to ensure that DTRs are handled efficiently within the letter of the law. The vital service that HET provides was not factored into the last funding agreement and needs to be considered now so that HET can ensure we have the correct number of appropriately trained staff to manage this additional workload. Service user satisfaction is exceptionally high, with 97% of feedback being positive. Patients have expressed significant appreciation for the team's effective communication, with many stating they were kept well-informed throughout the process and felt reassured by the team's responsiveness. Service Users expressed feedback during a recent survey: *Service User 1*

"The Housing Enablement Team really helped me get discharged from the hospital quickly. They communicated directly with my landlord to extend my notice period, which gave me more time to sort things out and prepare for the move. I felt supported every step of the way, and it made a big difference in ensuring I didn't have to stay longer in the hospital. I really appreciate their help in making the whole process smoother."

Service User 2
"The team saved my life. I was so relieved when Claire said my home could be cleared so I could return after my hospital stay. I was overwhelmed and depressed. The Housing Enablement Team were told by the ambulance team that my home was a mess, they arranged everything I needed so I wouldn't have to deal with the stress of cleaning and sorting things out myself. They made sure my home was ready for me, and that allowed me to focus on my recovery instead of worrying about anything else. It was a huge weight off my shoulders. I am forever grateful"

Summary –

The Housing Enablement Team has proven to be a transformative service, significantly reducing delayed transfers of care (DTOC), decreasing costs, and improving patient outcomes. By addressing housing-related barriers, the HET has saved the NHS approximately **over £1.1 million** through reduced out-of-area bed costs and prevented readmissions for chronic homeless patients. The service also ensures smoother transitions for patients, reducing bed stays by up to an average of **7 days per patient**. while delivering essential long-term housing solutions for over **62% of homeless patients**. Losing funding for the HET would reverse these achievements, leading to prolonged hospital stays, higher healthcare costs, and diminished quality of life for vulnerable patients. Without the HET, the system would face increased pressures, risking a return to inefficient pathways and substantial financial and human costs.

Key Facts

	✓ Provides patients with longer term sustainable housing solutions to reduce the burden on acute care ✓ Reduces housing related discharge delays and length of stay in care settings ✓ Reduces the burden on health and social care staff in dealing with complex service user needs, freeing up capacity within the system for other aspects of patient care ✓ Provides return on investment by reducing healthcare costs associated with DTOC's, emergency readmissions and reduced A&E attendances ✓ Reduces residential care placements by supporting patients to live independently at home. ✓ Provides a proactive, integrated and pragmatic response with immediate availability to small amounts of funding to cover costs associated with speeding up discharge

Any other data collected and reported and how often Please attach data and case studies to support this review.	**<u>UHL Long-Term Tuberculosis Treatment Case</u>** Mr C was a 21-year-old gentleman originally from Vietnam. He was believed to possibly be the victim of trafficking as he reported being taken first to China at age 5 and then the UK at age 15. He has never had any documentation and has never been known to Children's services. At age 18 he was left alone and then spent the next few years living with various acquaintances and working cash-in-hand jobs. He came to the attention of the HET service when he was admitted into the LRI with Tuberculosis (TB). Due to his diagnosis, he could not return to his previous acquaintance's property as they did not want him back whilst having TB, leaving Mr C homeless on the ward with no rights in the UK. It seemed that Mr C would become a long delay in the ward as he needed consistent TB treatment for a minimum of 12 months. However, with the support of the CCG, HET was able to source accommodation for Mr C to be discharged to, where he would be safe and could receive continual TB treatment in the community. The HET Support Officer has provided ongoing practical support to Mr C for the length of his stay in the accommodation, such as supporting him with shopping and other tasks. HET also referred Mr C to the British Red Cross for support with an Asylum claim. This allowed Mr C to be supported to leave hospital safely, ensuring there is some long-term plan for Mr C's housing and welfare and reducing the need for a lengthy hospital admission, saving public money and reducing the demand on important hospital beds. **<u>Community Hospitals Case</u>** Mr D was a 55-year-old gentleman admitted into one of the Community Hospitals in LLR. On admission, he was living in a social housing property. Mr D was known to mental health services and physical health services due to ongoing issues with recurrent depressive disorder and OCD, as well as ongoing investigations regarding bowl irregularities. Concerns were expressed by ward staff and the medical team that the patient would be unable to be discharged home because his flat was very unkempt and cluttered, leaving no room for him to mobilise. There were also signs of mouse excrement. HET received consent from Mr D to visit the property along with his sister and social worker. The HET Support Officer assessed the property and took photos of the flat, which confirmed the condition of the property and the work/support needed to make discharge safe. The HET Support Officer then had the property quoted and facilitated the work to be carried, cleaning and clearing the property so it was safe for Mr D to be discharged. This action allowed for a prompt discharge from hospital for Mr D and meant that he could receive ongoing care in his own home.

	MHSOP Case Mr G is a 69-year-old gentleman and a UK citizen. Prior to his admission into hospital, he was living in an 11th floor flat in the city centre. He suffers from hoarding issues and also had an infestation of bed bugs. He was admitted into hospital suffering from poor mental health and suicidal tendencies. The OT determined that his home was affecting his mental health as he previously had a partner who had committed suicide and was found within Mr G's flat. The OT's asked for him to be placed in another form of accommodation and were not happy to discharge back to the previous flat. Mr G gave permission for HET to visit the property and carry out an assessment. Upon assessment it was determined his home was in disrepair, infested and hoarded. HET asked Mr G if he would be happy to move location if we could support this into sheltered accommodation , which he agreed to do. HET then sourced an immediately available property through our partnerships with local housing associations ; this was a ground floor self-contained one bedroom unit within a new area to give Mr G a fresh start. HET supported the application process, viewing and successful sign up. HET also supported the move of any items Mr G wanted to keep with two Housing Support Officers helping him with this process. This enabled Mr G to be discharged from hospital into a new environment which would prevent him from needing to be readmitted. **UHL Adults Case** Mr B was a 74-year-old gentleman and a UK citizen. On admission to hospital, he was living in a social housing property in Charnwood. Mr B was admitted with a hip fracture as the result of a fall in his property and also had COPD. His fall was caused by the poor condition of his property and Mr B suffers with hoarding issues. Mr B gave the HET permission to visit his property to take photos, which showed clear signs of hoarding and suggested that Mr B had been unable to care for the property for some time due to his other health issues. HET were able to arrange a clean and clearance of the property to make it safe for Mr B to be discharged to with a package of care. The Safe Spaces team were also able to offer on-going support for Mr B's hoarding issues to ensure that did not negatively impact on his health in the future. This intervention allowed Mr B to return home, rather than go into care, which he did not want to do and allowed a safe discharge back into the community that otherwise would have resulted in a lengthy hospital admission and costly residential care placement.

Could the scheme continue to operate with a lower level of annual funding than at present? What impact would a level of reduced ICB funding have for the System and Service users? Please describe any risks/issues you are aware of if we continue to fund the scheme and how these are being mitigated? **Quanative & Qualtative impact Speciaqlly**	If HET were to receive less funding, the impact would be felt deeply across both the healthcare system and the vulnerable individuals it supports. While the service might continue to operate, its ability to meet the growing demand for housing support and deliver timely solutions would be severely limited. With reduced funding, HET would be forced to handle fewer referrals and possibly need to create a waiting list and the team would have less capacity to address housing-related delays. This would mean more patients would experience **longer hospital stays**, particularly those with complex housing needs, such as people with mental health issues or chronic homelessness. Delays in discharge would increase, causing more **bed-blocking** in hospitals and longer waiting times for patients needing ongoing care. This would not only lead to a **strain on bed pressures** but also escalate the costs of care, as patients would be in hospital longer than necessary. The healthcare system would be under more pressure, and the reduction in timely housing support would likely result in **higher readmission rates**, as patients would face difficulties transitioning back to their homes or stable accommodation. For patients, losing funding would mean fewer options for securing the **housing support** they need to recover. People facing homelessness, in particular, would be at a higher risk of being discharged to unsafe or unsuitable accommodation, leaving the trust at risk. Without HET's help, patients may struggle to find permanent housing, face delays in obtaining **home clearance's or furniture**, and could be left in temporary, inadequate conditions that exacerbate their health issues. For those with mental health challenges, it would mean **more stress, instability, and uncertainty**, which could lead to a decline in their condition and a higher chance of **re-admission to hospital**. **Vulnerable patients** who are discharged into poor housing conditions would have limited access to follow-up support, resulting in longer-term negative effects on their mental and physical health. In short, a reduction in funding would make it much harder for HET to provide the support that many of the most vulnerable patients rely on. The **knock-on effects** would be felt not only in the form of increased hospital admissions and prolonged stays but also in the day-to-day lives of individuals who, without stable housing, would continue to struggle to recover and rebuild their lives.

Risk/Issue	Description	Mitigation
Increasing Demand for Services	Growing demand for housing support services, potentially leading to an overstretched team and delayed housing solutions for patients.	Streamlining workflows, prioritizing urgent cases, exploring partnerships with local authorities and community organizations, and providing on-going staff training to manage higher volumes more efficiently.
Sustainability of Staffing	Insufficient staffing to meet the growing complexity of housing-related issues, and uncertainty due to reliance on external funding.	Seeking additional funding sources, integrating services with broader community programs, increasing team cross-functional expertise to handle a wider range of cases without additional personnel.
Continuity of Service in a Changing Landscape	Potential disruptions in housing availability due to changes in housing policy or priorities.	Strengthening relationships with local authorities and housing associations, engaging in housing policy discussions to ensure adaptability, and creating reliable, diverse housing pathways for patients.
Financial Constraints and Rising Costs	The risk of funding cuts or reduced scope of services due to financial pressure from local government or NHS budget cuts.	Demonstrating the value of HET through data collection, highlighting cost savings, and focusing on patient outcomes to secure long-term, sustainable funding from multiple sources.
Impact of Staff Burnout	Increased risk of staff burnout or stress, particularly with rising demand and tight funding, leading to turnover and reduced service quality.	Investing in staff well-being through regular debriefings, team support networks, mental health resources, and workforce planning to ensure adequate staffing while fostering a positive work environment to retain skilled professionals.

Outline risks and impact if Discharge Grant funding does not continue in 2025-26	If the Discharge Grant funding does not continue in 2025-26, the following risks and impacts could arise: • **Disruption to Service Continuity**: **Risk**: The cessation of funding could lead to a disruption of services currently provided and other discharge-related support functions. **Impact**: This may result in delays in patient discharge, affecting the hospital flow and potentially increasing the length of stay (LOS) for patients who would otherwise be discharged faster with housing-related support. • **Increase in Delayed Transfers of Care (DTOC)**: **Risk**: Without the grant funding, housing-related DTOCs could rise significantly, particularly for patients with complex housing needs, including the homeless or those requiring supported accommodation. **Impact**: Hospitals may see a rise in bed blockages, impacting hospital capacity and patient throughput. This could worsen already stretched NHS resources and prolong waiting times for other patients requiring acute care. • **Increased Pressure on Other Services**: **Risk**: The loss of the grant may place additional strain on other services, such as adult social care, local authorities, and homelessness services, who may not be equipped to take on the demand. **Impact**: The reliance on already overburdened services would likely lead to delays in resolving housing-related issues, resulting in a backlog of cases and potentially poorer outcomes for vulnerable patients. • **Negative Impact on Service Users**: **Risk**: Patients, particularly those with mental health issues, chronic homelessness, or housing instability, could face worsening living conditions or a return to homelessness. **Impact**: The lack of support would exacerbate physical and mental health conditions for patients who may be discharged without suitable housing, leading to a potential deterioration in their well-being. • **Deterioration of Patient Outcomes**:

	Risk: Without the discharge grant funding, the wraparound services that prevent homelessness and facilitate smooth transitions from hospital to community care could be severely reduced or stopped. **Impact**: This could lead to poorer long-term health outcomes for patients, including higher rates of mental health crises, relapse, and ultimately, the need for further healthcare interventions. • **Loss of Stakeholder Confidence**: **Risk**: The absence of funding might lead to dissatisfaction among patients, healthcare providers, local authorities, and other stakeholders involved in discharge planning. **Impact**: This could damage trust in the local health and social care system, potentially affecting partnerships and collaboration on future projects and initiatives. Without continued funding, the healthcare system could face operational challenges, including rising hospital costs, and service users could experience negative health outcomes due to inadequate housing support after discharge. It is essential to explore alternative funding solutions and strengthen cross-department collaboration to mitigate these risks.
Have alternative funding streams been scoped for this area of work.	Alternative funding streams for the service have been explored, but the Grants Officer at Blaby District Council has been unable to identify any viable sources to replace the Discharge Grant funding. Despite efforts to find alternative funding this has proven difficult. Housing and healthcare funding streams are often separate.

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