# Appendices

## Table 1

The demographics of professionals participating in the research, by occupation and location

| | | Health Board Area | | | | | | | | Totals |
|---|---|---|---|---|---|---|---|---|---|---|
| **Base** | **Occupation** | **AB** | **Betsi Cad** | **C&V** | **CTM** | **Hywel Dda** | **Powys** | **Swansea Bay** | **Wales** | |
| **Hospital based** | Discharge Liaison Nurse Manager | 1 | | | 2 | | | 2 | | 5 |
| | (* pre Covid) | | | | | | | 1 | | 1 |
| | Occupational Therapist* | | | 1 | | | | | | 1 |
| | Housing/Development Manager for Learning Disabilities and Mental Health (NHS) | 1 | 1 | | | | | | | 2 |
| | Patient Flow Coordinator | 1 | | | | | | | | 1 |
| | Hospital Discharge Senior Practitioner/ Manager (Social Services) | | | | 2 | | | 1 | | 3 |
| | Care Management Officer (Social Services) | | | | | | | 1 | | 1 |
| **Community based** | Adult Services Team Leader/Manager (inc. CMHTs) | 3 | 1 | 1 | | | | | | 5 |
| | LA Housing Senior/Team Leader/Manager | 4 | 5 | 2 | 2 | 1 | | 2 | | 16 |
| | LA Housing Practitioner/ Prevention Officer | | | 1 | | | | | | 1 |
| | LA/NHS Commissioner (HSG) | 1 | | | | | | | 1 | 2 |
| | RSL Manager/ Housing Officer /Service Coordinator | 2 | 1 | 2 | 1 | 1 | | | | 7 |
| | Third Sector Manager | | 1 | | | 2 | | 1 | 3 | 7 |
| | Third Sector Support Worker/Officer | | | 1 | | | | | | 1 |
| | | **13** | **9** | **8** | **7** | **4** | **-** | **8** | **4** | **53** |

## Table 2

The number of respondents indicating in interviews 'what works well' in discharge planning

| What works well | Community based | Housing & Social Care* |
|---|---|---|
| Dedicated/specialist mental health Housing Linkworker posts | 7 | 2 |
| Access to well linked up services and resources | 5 | 5 |
| Housing related health/joint funded posts | 1 | 1 |
| Joined up working/good relationships between Health and Housing | 1 | 3 |
| An MDT approach | - | 9 |
| Community services being involvement in MDT/discharge planning | 4 | 1 |
| Having experienced and established Social Workers/Teams | 2 | 3 |
| Multi-agency working | 4 | 4 |
| Non-health posts/teams being ward/hospital based | 1 | 3 |
| Discharge planning involving good communication/information sharing | 6 | 10 |
| Involving and fully understanding the patient's needs | 7 | 7 |
| Discharge where planning and preparation started early | 7 | 5 |
| Access to each other's notes/IT systems | - | 3 |
| Face to face assessment and advice | 1 | - |
| OT assessments | 2 | - |
| Priority banding within the housing allocation system | 1 | - |
| Step down accommodation | 1 | - |
| Intermediate Care Fund (for adaptations) | 1 | - |
| Patient Flow Coordinators | - | 2 |
| Provision of estimated discharge dates by consultants | - | 1 |
| Having a clear single point of contact | 1 | - |
| The 'What matters assessment' | - | 1 |

*this includes a joint or health funded housing specialist role

## Table 3

The number of respondents indicating what could work better/make the process easier in discharge planning

| What could work better/make the process easier | Community based | Housing & Social Care* |
|---|---|---|
| More accommodation options | 8 | 3 |
| Mutual understanding of each other's Policies & Procedures and Rules & Regulations | 16 | 6 |
| Identification of housing needs | 1 | 1 |
| Early/automated notification of need for housing intervention/advice | 15 | 5 |
| Communication/information sharing | 9 | 8 |
| Joined up working between Health and Housing | 3 | 2 |
| Having a clear single point of contact within health | 5 | 2 |
| Equal duty of care to ensure the outcome of discharge is positive | 1 | - |
| Having dedicated/specialist Housing Linkworker posts | 5 | - |
| Having involvement in MDT/discharge planning | 7 | 2 |
| Fully understanding the patient's needs | 6 | 2 |
| Shared and reciprocal training between Health and Housing | - | 3 |
| Adherence to a recognised pathway/protocol | 8 | 1 |
| A central information point re; services and resources | - | 3 |
| More funding (or longer-term funding) / staff | 6 | 10 |
| Provision of/more provision of step-down accommodation | 1 | 3 |
| Managing adaptations and grants | 1 | - |
| Addressing the social issues that affect general wellbeing | 1 | - |
| Better integration (e.g. IT systems) | 4 | 2 |
| Working to the same frameworks, policies and guidance | - | 1 |
| More care package options | - | 1 |
| Learning from unsafe/poor discharges | 1 | - |
| Reduced pressure to free up hospital beds | - | 1 |
| More community MH resources that prevent unnecessary admission | - | 1 |

*this includes a joint or health funded housing specialist role

# Case studies

## Case Study A

I am Ward Manager, on a functional mental health ward for the over 65's. We treat and ensure that all patients leaving the ward have appropriate housing support. We run regular MDT meetings to discuss needs that are anticipated. I support staff to consider those who require ongoing support, working to ensure that commences on patient admission.

Discharge is very fluid at this point as often patient presentation and subsequent needs can change the referral pathway. We refer onto ongoing support services to provide follow up if required and we also provide a pack of paperwork to other agencies, to support their work. This contains a 'this is me' profile, information on the patient's likes and dislikes and what their needs are.

## Case Study B

My previous role was managing discharge liaison nurses across the Health Board and I would work differently in different settings, even though discharge planning should be consistent. We should plan discharge from admission and plan for a return home at that point, not wait until the person is medically fit to be discharged. The situation is improving and thought is going into discharge earlier but often not at admission when the best information about a home situation is available.

Effective discharge planning may depend on who is responsible for ongoing care and support at the time of discharge. For example, there are some patients who require no further care and support from health services, but may have the continued involvement of a Social Worker if they need care at home. Equally, for some of those who require housing support they may not need ongoing support post discharge.

## Case Study C

As a Housing Department, we work in partnership with the Health Board, having a Homelessness Prevention Officer embedded in the hospital setting, to identify patients that may be discharged to no fixed abode, or whose accommodation is no longer suitable. The Officer works with the patient and Occupational Therapy, Social Services and Mental Health professionals to assist in a planned move.

This can be either to more suitable accommodation, or for their current home to be made suitable, or to assist them in presenting as a homeless person to be considered for emergency accommodation and prevent hospital bed blocking.

## Case Study D

The following case study offers an illustrative example of the impact of poor communications in discharge planning arrangements.

"Communication with the Local Authority accommodation assessor was not good. This was done only using text messages or 'phone calls. This does not demonstrate good governance at all as there is no clear audit trail (of what arrangements were proposed, discussed, or agreed).

The assessor was keen to get (my mother) discharged telling us that her bed was needed at the hospital, where we knew there were already empty beds (there). I was asked to pick my mother up from one location, and to take her to another temporary location, with only 30 minutes notice given. When I said that I could not do that as I was working, I was asked if my mother had money with her so that she could pay for a taxi between the two locations, a distance of approximately 40 miles and after her being in hospital with pneumonia for 10 weeks!

When I said that she did not have her purse I was then asked to meet the assessor at my mother's house, with her purse, clothing and food that my mother might need, again with a disregard for the fact that I was working and that my mother had been in hospital for 10 weeks".

# Service delivery case studies

The following service model case studies were identified as good practice examples of organisations worked together to improve how housing advice and housing related interventions took place. They also illustrate how community-based housing bodies link into the hospital discharge planning process in a timely manner.

## Case study A

**Aneurin Bevan UHB area**

Housing Link Workers, Patient Flow Coordinator and a Social Services Housing Support Officer

Some of the Local Authorities across the 5 counties of Gwent commissioned Housing Link Workers (named differently in various locations) through the Housing Support Grant and delivered by a third sector partner.

The posts are based (pre-Covid) in the mental health units and provide a link between the wards and the Local Authority Housing Departments, providing housing advice, assisting with assessments, and supporting a warm handover when discharge takes place.

In recognition that some Local Authorities had not commissioned the above posts, ABUHB funded a Patient Flow Coordinator to ensure full coverage across Gwent for all mental health patients. The post focuses on all aspects of housing in the discharge planning process and supports the more complex of cases.

A Housing Association provides a housing related floating support service across Newport, with one of the team moved into the Social Services Hospital Discharge Team to provide specialist advice and support for all housing related issues involved in discharge planning.

## Case study B

**Cardiff**

A Prevention Housing Officer and the First Point of Contact Team.

Funded by the Health Board but employed by the Local Authority, the Prevention Housing Officer provides a dedicated housing link between mental health units and the Local Authority's Housing Department. The post provides a similar service to the Housing Link Workers mentioned above.

The Local Authority funded and employed the First Point of Contact Team that sits within the People and Communities Directorate (Housing and Communities) and is a part of the Independent Living Services. Being hospital-based and working as part of the Integrated Discharge Team, they link up whichever services are required within the community to the hospital discharge planning process. They liaise with a range of services including housing options, landlords, reablement, floating support providers, and environmental health (as examples).

## CASE STUDY C

**Vale of Glamorgan**

Housing Link Workers, Senior Occupational Therapist and Discharge Coordinators

A third sector organisation provides the same Housing Link Worker as described above, bridging the health and housing interface between the mental health wards and Vale of Glamorgan Housing Options.

A Housing employed Senior Occupational Therapist line manages two Discharge Coordinators for the general needs wards for Vale residents. The Team provide housing related advice and the crucial link between the wards and Housing Options, with the majority of cases being dealt with by the Discharge Coordinators, leaving the senior OT to provide more specialist support for complex cases.

## CASE STUDY D

**Betsi Cadwaladr University Health Board**

A Development Manager

The post is Health Board funded and provides a specialist housing related function to the mental health wards across the Betsi Cadwaladr health board area. Working closely with the wards through an MDT approach (working with approximately 17 cases a week), the post holder applies an extensive range of prior knowledge and experience, giving consideration to community resources and housing provision to help facilitate effective hospital discharge.

The role also includes an element of training with a view to upskilling both hospital and housing staff. The postholder explained the importance of 'wearing two hats, health and housing'.

# Additional comments on developing the housing advice defintion

Although definition we used in our research was almost unanimously accepted by interviewees and survey respondents, we also recovered the following helpful comments at how the definition may be improved.

*'…to emphasise the need for flexibility and personalisation of the advice to meet each person's needs'*

*'…support for landlords especially throughout the Covid pandemic'*

*'I'd change the term home to accommodation. Not everyone has a home as such'*

*'…and include safeguarding, safe accommodation'*

*'…emphasis on expert advice and ensuring the information provides a realistic picture of housing options'*

*'…agree with definition, but here it certainly isn't integrated, but agree it should be'*

Other interviewees felt that advice should also contain guidance about housing suitability and availability, should highlight the costs of maintaining a tenancy, or a home and also provide information about grants and support services that may be available.