Hammersmith and Fulham:

Service Review of Stepdown Bed Provision

April 2023

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BREAKING BARRIERS INNOVATIONS

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Authors

Sherife Hasan

Jacqui Gibson

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1. Introduction

1.1 Policy context

Within the health and social care sectors, mental health care is a prominent issue. Over the past few decades there has been a positive shift towards treating and supporting people with severe mental illness in the community, rather than in hospital. This is reflected in the reduction of mental health inpatient beds in England, which has decreased by 73% since 1987/88 from around 67,100 to 18,400.[1]

Despite this occupancy rates in mental health inpatient wards can exceed 90%, with some areas regularly seeing occupancy rates of 95% (an occupancy level of 85% is recommended).[2] While the evidence suggests that a large percentage of people in mental health wards are well enough to be discharged, the 2019 review of the Mental Health Act found that around 50% of delayed discharges in mental health wards were due to housing issues.[3]

Government policy for integrated care systems (ICSs) and primary care networks (PCNs) is moving towards a more integrated health and care system and pathways, including the provision of care that is joined up and out of hospital. This is vital to support residents with complex mental, physical and social needs to live in the community. If residents are not given the support they need, they are more likely to reach a crisis point and require inpatient care. Therefore, each part of the pathway must link together and be flexible enough to allow residents to move between different services as needs change.

It is vital to integrate supported housing into the pathway as evidence indicates it can reduce out-of-area placements and improve the experience and outcomes for residents. The NHS and social care sector do not have access to the estates, the capital or specialist knowledge to provide supported housing alone, so it must be done in partnership with appropriate voluntary sector and housing providers.[4]

1.2 Background and methodology

Hammersmith and Fulham Council with support from West London NHS Trust established a number of stepdown beds for mental health. Breaking Barriers Innovations (BBI) were commissioned to conduct an independent review of this stepdown provision.

BBI carried out a rapid review from January 2023 to April 2023. Due to the short timescale, it was decided to use a mixed-method approach using both qualitative

[1] The Strategy Unit (2019), Exploring Mental Health Inpatient Capacity (https://www.strategyunitwm.nhs.uk/sites/default/files/2019-11/Exploring%20Mental%20Health%20Inpatient%20Capacity%20accross%20Sustainability%20and%20Transformation%20Partnerships%20in%20England%20-%20191030_1.pdf)
[2] The Strategy Unit (2019), Exploring Mental Health Inpatient Capacity (As Above)
[3] Independent Review of the Mental Health Act (2018), Modernising the Mental Health Act
[4] https://www.nhsconfed.org/system/files/media/MHN_Supported%20housing_4.pdf

and quantitative methods. This offered the best approach as it would enable the authors to provide a better picture of the project. This approach included:

- **Interviews with professionals** - BBI carried out interviews with 16 professionals - commissioners, providers and frontline workers. Each interview respondent was informed that their views would be anonymised. Any views expressed in this report are solely the views of the interview respondents who took part in this review. The interview questions for professionals can be found in Appendix A. The authors also attended the weekly Stepdown Meeting on 9th March 2023 as observers. This meeting provides frontline workers the opportunity to discuss and provide updates on their cases.

- **Interviews with residents** - On behalf of BBI, providers spoke to residents to see if any would be willing to be interviewed. Only two residents agreed to be interviewed. These are vulnerable residents grappling with a range of issues, including mental health and substance misuse, so it is not surprising that most refused to take part. However, the authors were given access to case notes and have put together case studies, which outline the complexities that residents and frontline workers face.

- **Data gathering** – There is no specific individual or agency tasked with the overall responsibility of gathering and collating all the data from the various providers. Therefore, the authors were given data from a variety of sources. This data has been reviewed and attempts were made to assess relevant outcomes and outputs, and to carry out comparisons between each provider. However, the data provided was unsuitable to assessing and comparing outputs and outcomes because it differed in terms of content and format, so limited data could be included in this report. This issue is discussed in section 4 of this report.

In spite of that, this report has made the best use of the available information and interview responses to consider the key issues and to provide recommendations.

2. Overview of stepdown provision

2.1 Introduction

The stepdown provision is a short term, community-based accommodation service for people who have a recognised need for a level of supported accommodation on leaving hospital. The stepdown provision aims to help residents to reintegrate back into the community in a safe and supported way into supported accommodation or into independent living.

The overarching principles[5] for the Hammersmith and Fulham stepdown provision is as follows:

- Patients should be discharged from hospital when they no longer require the level of care provided by an acute mental health ward (clinically fit for discharge) and their needs can safely be met in the community.

- Longer-term care and support needs should be assessed in the most appropriate setting and at the right time for the person. This is not just about increasing service capacity, but also identifying where care can be continued in a non-acute setting with extra benefits from doing this in a more community recovery focused step-down placement.

- Discharge packages should be instigated as soon as someone is ready to leave hospital, doing what is right by patients, and crucially removing delays and disputes over funding and responsibilities (and if needed resolving these after the discharge support has started).

2.2 Aim of stepdown provision

Interview respondents were asked for their views on the aims of the stepdown provision and there was agreement that the key aims were to:

- Support people to reintegrate back into community in a safe and supported way, into supported accommodation or independent living.
- Reduce the length of hospital stays and improve flow within pathway.
- Make the best use of the current spaces within the supported living system and to develop more space so people do not have to be placed outside the borough in the future.
- Reduce risk factors e.g., substance misuse and offending behaviours.

[5] Protocol for Step Down Bed (LBHF) Draft as of 8th September 2022

2.3 Support provided in stepdown provision

Interview respondents outlined the range of support available within services providing stepdown beds, including:

- Encouraging participation in group activities
- Support with criminal justice court proceedings
- Supporting residents to maintain personal hygiene
- Supporting resident to maintain their living quarters
- Maintaining links with clinical teams and care co-ordinators
- Supporting residents to adhere to treatment plans e.g., prompting residents to self-administer medication
- Support with PIP applications and benefits
- Vocational/employment support
- Applying for grants
- Befriending
- Referrals for foodbanks
- Supporting residents to access community facilities e.g., shopping
- Supporting residents to reconnect with family members
- Supporting residents to apply for a Freedom Pass
- Psychosocial interventions for the management of financial exploitation and violence/aggression
- Supporting residents to register with a GP, dentist, optician
- Encouraging residents to work with substance misuse services
- Providing residents with emotional support and to gain confidence

2.4 Profile of residents

There is limited data available on residents, but data has been provided from June 2022 to March 2023 on gender and age. During this period, 24 residents had accessed the stepdown beds and the data showed:

- Gender - only 2 residents were female.
- Age – 45% of residents were over 40 years of age. The full breakdown is in the table below:

Age Range	Number	Percentage
20-29	5	21%
30-39	5	21%
40-49	7	29%
50-59	4	17%
Not Known	3	12%
Total	24	100%

2.5 Overview of workforce for stepdown provision

The workforce was seconded/recruited from a variety of organisations to take on a range of roles – see table below:

Employer	Duration	Role
SHP	1 year STC	1 x Private Rented Sector Worker - finished
SHP	1 year STC	2 x Stepdown staff matrix managed WLT Manager – 1 finishes June 2023, the other finishes September 2023 1 x Stepdown staff managed by SHP - finished
LBHF	Agency	1 x Social Worker – finishes September 2023 1 x Senior Social Worker – finishes April 2023
LBHF	1 year STC	1 x Programme Lead, commissioning – finishes June 2023
LBHF	2 year STC	1 x Mental Health Housing Officer – finishes January 2025
Hestia	1 year STC	1 x MH specialist floating support worker - finished
Turning Point	2 year funding	Get connected programme - 1 x paid staff, 2 x volunteers with lived experience. Substance misuse support/activities – finishes April 2024

Interview respondents stated that the Mental Health Housing Officer role had proved to be the most difficult to recruit but was considered to be a key role. The Step Down worker was also thought to play a vital role and was reported to be effective.

Overall, most interview respondents acknowledged that the funds for the stepdown bed had to be used quickly so some of these roles and responsibilities were not as well thought out as they could have been. Going forward, more thought needs to be given as to how workforce resources are best utilised.

2.6 Positives elements of stepdown provision

Respondents outlined a number of benefits, as the comments below demonstrate:

> *"Prior to stepdown beds most of these clients would either return to their own accommodation and might not receive the supported they needed in the community or might be placed in temporary accommodation like a B&B and those with complex needs didn't tend to do very well. So stepdown may be flawed but on the whole it's been very useful and helpful, and it's prevented the cycle of people going back to their accommodation and then getting into crisis and ending up back in hospital and back in the system."*

> *"It is a useful service to have, it gives people coming out of hospital a transition period and we're able to work with clinical teams to put together a robust support plan for the client."*

The positive elements of the stepdown provision are outlined in the table below:

Positive elements of stepdown provision	
Issues	**Benefits**
Good engagement with voluntary sector providers	• The workforce was seconded from a variety of organisations and these partner organisations have worked well together for the benefit of some of the most vulnerable residents who have the most complex needs. • It was reported that providers have been responsive in addressing needs of these residents. Examples of good practice were highlighted such as the Single Homeless Project, which was described as having 'exceled' in terms of the support they provided to residents. It was reported that *"their work is consistent and every client that has gone there has come out better".* • Good substance misuse support has been provided by Turning Point and there is an improved joined up approach between voluntary sector colleagues to attract more people with varying levels of need into substance misuse treatment. • Collaboration and communication have improved, and trust has been built between the different providers, including the establishment of data sharing agreements. • Some respondents would now like to see voluntary sector take on a wider role, including in the strategic planning of services. As one respondent commented: *"We feel part of the West London pathway, which is fantastic, as it's not something we've had with other contracts in the past."*
Support for vulnerable residents	• Better outcomes for residents. • Enabled residents to be discharged from inpatient services earlier. • Monitored how they are coping on discharge from hospital. • Supported them with practical tasks and treatment plans. • Relationships between housing support workers and residents has been vital in helping them to maintain their tenancies and prevent individuals from falling into crisis. • Able to provide continued support for some residents when they move into independent accommodation. As one respondent commented: *"We're getting more outcomes for our residents and we're changing the way we are working in terms of incentivising our residents and making them feel valued and giving them a sense of achievement for the small steps that they take."*

2.7 Learning from stepdown provision

Interview respondents highlighted a number of areas of learning, which are outlined in the table below:

Learning from stepdown provision	
Issue	**Learning**
Oversight and coordination	There are a range of organisations involved with the stepdown provision but there is no single person or organisation with overall oversight and coordination. Respondents reported that there is a lack of clarity as to who is responsible for overseeing: • the overall stepdown provision • performance and contract monitoring, and ensuring targets are met • a quality of care and standards are in place within each service As one respondent commented: *Some excellent work has come out of it, but I think it could have gone better with a bit more thinking and managing it more effectively."*
Clarity around workers' roles and responsibilities	• Funds had to be used quickly so workers were seconded from range of organisations. • As a result, some roles and responsibilities were not as well-thought out as they could be. • There are issues around how workforce resources are currently being utilised. • Respondents reported that some of the roles will be reviewed and may not continue or will be adapted. • There needs to be a clear policy to clarify and outline the roles and responsibilities of the workers.
Early discharges and inappropriate placements	• Some respondents expressed concerns that residents may be discharged early and inappropriately placed in stepdown beds, e.g., residents who do not need an inpatient bed and are physically fit. • But there was concern that assessments did not always consider the impact of wider factors such as substance misuse issues.
Variable quality of voluntary sector provision	• There were concerns that while voluntary sectors agencies are delivering the service as required, the quality of care can be varied. • Respondents reported that not all providers are able to provide the same standards of care or support to residents. For example, some properties are old and not purpose built, which can create restrictions on the care and support providers are able to provide.
Spot purchasing of stepdown beds	• Respondents were concern about the use of spot purchasing for stepdown beds as this only offered a short-term solution for residents so was not considered to be the best use of funds. • Respondents suggested these funds could be redirected to support housing services and the pathway to develop longer term solutions.
Voluntary sector providers not always included reviews	• Respondents stated that voluntary sector providers were not regularly included in all relevant reviews and care planning meetings.

	• Examples were cited of services users being discharged from the clinical team to their GPs, but providers failed to be informed, so were unable to provide support around attending appointments. As one respondent commented: *"We only become part of the conversation when things go pear shaped and we're expected to step in."* • There were also issues raised around the lack of involvement in safeguarding and risk assessment reviews. For example, a female worker was unaware she was working with a resident who was a registered sex offender. By being involved in the relevant safeguarding meetings and being aware of risk issues the worker could take steps to mitigate any risks to herself and others.
Institutionalisation of residents and impact of the cost-of-living crisis	• Respondents reported that some residents have been 'sitting' in the pathway for many years and are reluctant to move due to their fear of losing their 'safety net'. • Some residents want to stay in the stepdown provision at the end of their 6 weeks and become unsettled when facing another move or the prospect of living independently. • The impact of the cost-of-living crisis has made residents more concerned about coping in private rented accommodation.
Engagement with housing services	• Respondents would like to have greater engagement with housing services to address accommodation needs. • This is vital if residents are to be rehoused within the 6 week period.
A more holistic wraparound approach is needed	• Respondents stated that a holistic wraparound approach is needed to address wider factors such as substance misuse and to support residents living independently. • Some providers may need more basic training around issues such as substance misuse to recognise need and ensure that residents are able to access the treatment provision they need. • Respondents would also like to see support provided to address the underlying trauma, issues and tiggers to prevent people becoming unwell again once they leave hospital.
Resident's empowerment	• It is important to acknowledge that stepdown provision means living in shared accommodation with strangers and with staff who have 'authority over them'. • It is important to strike a balance and to engage and empower residents, as far as possible, and to ask them what they want and need i.e., providing patient choice.

3. Overstayers in stepdown provision

Respondents stated that many of the residents in stepdown provision are from vulnerable groups, including people with:

- Anxieties and depression
- Long standing and complex difficulties e.g., schizophrenia, bipolar, personality disorders
- Social isolation issues - struggling to go out and engage with people and services
- People with substance misuse issues

Residents should only remain in stepdown beds for 6 weeks, however, respondents acknowledged that some services users, particularly those waiting for supported accommodation remain in stepdown beds beyond the 6 week period.

In terms of support accommodation, a referral should be made as early as possible with all the relevant documentation. An assessment can then be made on the appropriateness of the resident for supported accommodation, including discussion with social workers, probation officers, etc. This process may take 1 to 2 weeks. Once the resident has been accepted an appropriate vacancy is sought. If a vacancy is available, then an interview by the accommodation providers may take another week to arrange and to take place. If all goes well a placement should be offered within a week. So, the whole process should take about a 4 to 5 weeks if all goes smoothly.

However, respondents stated for the process to work effectively referrals, planning and assessments need to commence while the resident is still on the hospital ward and before being placed in a stepdown bed. As one respondent commented:

> *"Referrals can be made while people are still on wards, and we shouldn't wait till they are moved to a stepdown bed to start making assessments. The better prepared the situation is at the beginning the more control we have over other unexpected issued that come up and the quicker we can move referrals on. Everything is time sensitive, so the minute I get the referral I'm already matching them to possible vacancies, but those vacancies don't pop up on my time, they just appear when they do, and when they pop up they need to be filled quickly. There is a list of clients with a range of issues in the borough waiting for these vacancies, so we can't hold vacancies."*

Respondents stated that there is currently a waiting list for supported housing from one to three months, so it can take time to get people into supported housing and matched to appropriate accommodation.

Respondents reported that some residents have been moved to stepdown beds without a plan or an allocated worker to take responsibility and to coordinate their care. This has resulted in delays in trying to find out who is taking the lead on a case, completing referral forms, and gathering supporting documents such as IDs and financial information, which are required for a tenancy with a Housing

Association. The implications of these delays were clearly described by one respondent:

> *"There can be a lot of back and forth while this is all sorted out. At that stage it's a case of get the referral to me as soon as you can and I'll assess the client as soon as I can. But with all the delays it might be a month down the line and there have been missed opportunities in regard to vacancies that have come up and been offered to other people, who aren't necessarily in a stepdown bed, but they were ready to be referred. So, then we have to wait for the next group of vacancies to come up. All of which causes more delays."*

Respondents stated that delays may be caused by differences of opinion as to whether a resident requires supported accommodation. The resident will also have views as to whether they wish to move into supported accommodation and may disagree with a referral made on their behalf. In addition, a resident can turn down a placement or a supported housing provider can turn down the resident, which causes hold ups. A supported housing provider will need to provide a valid reason as to why they have rejected a referral as the Council can challenge the decision if they believe the reason is not valid.

As one respondent commented:

> *"We need to strike a balance to give the resident some autonomy and independence to make their own decisions about their accommodation and to come to the conclusion that in some cases it is in their best interest to give up a tenancy. But it can take longer than 6 weeks for them to come to this realisation and so we need time to work with residents to help them to come to this conclusion."*

Respondents outlined a number of other reasons for residents overstaying in stepdown beds, including:

- Existing tenancy may be in need of repairs and there are delays in the work being carried out to fixing problems in housing. This is mainly an issue in housing association and council properties.
- A tenancy that is no longer appropriate to the needs of a vulnerable resident may need to be closed down so resident can be offered a tenancy or supported accommodation elsewhere, e.g., a woman at risk of domestic violence or abuse who needs a high support placement.
- Stabilisation of residents e.g., residents with substance misuse issues that require support and treatment plans with Turning Point or other agencies.
- Institutionalisation of residents who are reluctant to move into independent accommodation.
- Lack of accessible housing in the borough (this is a challenge across London).
- Lack of availability of high support placements along the pathway. Respondents stated that there is a greater demand for high support placements than medium support placements. Respondents also stated that there is a waiting list for

supported housing from one to three months, so it can take time to get people into supported housing and matched to appropriate accommodation.

While respondents would like some flexibility around the 6 week period, many recognise the importance of moving residents on as quickly as possible, as one respondent comment:

> *"I think it should be flexible [rather than 6 weeks], I don't think it should be set, we should focus on clients' needs. But I think it should be limited to 2 or 3 months in stepdown beds and we should still aim to get them out as quickly as possible. If they're still there in 3 months, then there is some underlying issue as to why they're not being placed."*

The table below shows the number of days and cost of overstaying.

Resident	No. of Overstay Days	Cost of Overstays
1	25	£3,220.36
2	3	£386.44
3	38	£4,894.94
4	54	£6,955.97
5	161	£21,849.31
6	62	£8,414.02
7	3	£407.13
8	41	£5,564.11
9	38	£5,156.98
10	49	Block Funded
11	1	£128.81
12	73	£9,403.44
13	57	£7,735.47
14	1	£135.71
15	48	£5,485.44

The three case studies below provide examples of the reasons that vulnerable residents can become overstayers.

Case study one - 4 months in stepdown provision

- Y was discharged to a B&B but once this lapsed, he was without accommodation. There was agreement that suitable accommodation would be provided in 6 weeks, so a stepdown bed was used in the interim.
- Initially Y did well in the placement but then went missing and was sleeping rough.
- Y returned to the placement but had substance misuse needs and was struggling with his mental health.
- Y stated he did not wish to stop using drugs nor to move from placement. But the provider no longer wants him in the placement due to his non-engagement.
- A joint meeting is to be held to discuss his long-term needs - medical review carried out and Turning Point carried out substance use assessment to put support plan in place.

Case study two - 4 months in stepdown provision

- Z had her own tenancy, but she cannot return home.
- She is vulnerable and at risk from others.
- There are safeguarding concerns regarding her learning needs.
- Physical health is much improved and mental health is now stable.
- Discharged to stepdown bed while awaiting a long-term placement in a female only placement or a high supported placement, self-contained property.
- Z is engaging well with others and there are no current concerns.
- Z remains on waiting list for high supported placement due to her vulnerability.

Case study three - 2 months in stepdown provision

- W moved into stepdown while awaiting much needed repairs on his property.
- W is doing well in the placement and visiting his family regularly.
- His physical health is good and his mental health stable.
- Support is needed from the Housing Department to allow for works to be completed.
- W agreed to give the repairs team access to his property.
- Awaiting housing officer to confirm a date/time for repairs to commence.

4. Data and performance management

Effective performance management is about bringing together data and information from difference sources to enable the monitoring of trends and the progress of residents. This assists commissioners and providers to see if the desired outcomes are being achieved and to:

- plan, commission, oversee and improve services to suit local needs, including areas that need support or improvement.
- evaluate services and care, including capacity and demand, safety risks and good practice.
- identify barriers and to change systems and processes to bring about positive outcomes for residents.

Clear outputs and outcomes, as well as activity data, are required in to make an assessment of the impact of this provision. However, while information and data are being gathered by all agencies involved in the stepdown provision, it appears that the data is not being gathered and reported consistently or in the same way across all the organisations involved. This makes the monitoring of trends and progress difficult to assess and it was not possible to measure and assess the impact of the stepdown beds provision using the information provided for this review.

Therefore, a structured approach to performance and contract monitoring needs to be established, including clear progress and outcomes data and information. The table below provides an example of the progress and outcome measures that may already be gathered by the various agencies. This is in no way intended to be definitive but simply provides an example of the data that could be collated to provide performance management information and oversight.

Example of progress and outcome measures		
Issue	**Process Measures**	**Outcome Measures**
Check and balances	No. of stepdown beds purchased No. of patients from each inpatient bed moved into a stepdown bed, duration of stage, discharge pathway	Patient reported outcome measures: No. of residents showing good improvement No. of residents showing moderate improvement No. of residents showing no improvement e.g., lack of engagement
Improved flow within the pathway	No. of referrals to stepdown beds No. of assessments No. of discharges, including destination No. of discharges within 6 weeks No. of overstayers (more than 6 weeks)	Discharge from across pathway to: • Home • Supported living • Independent living No. of beds occupied by overstayers No. of reduced delays in discharge due to housing issues.
Improved resident/carer experience	Process in place to record/monitor resident experience	Residents and carers reporting a positive experience of service – examples of proposed questions: Q1 What was good about the experience? Q2 What could be better? Q3 What else would you like to tell us? Potential tools: Patient Reported Outcome Measures (PROMs): Adult Social Care Outcome Toolkit (ASCOF)
Institutionalisation/ independence	No. of residents engaged in structured community activity No. and type of wraparound clinical and social care interventions commissioned and delivered in stepdown beds	No. of residents readmitted to an inpatient setting from a stepdown bed
Reduced costs for system	Reduction of overstayers	Lower readmission rates Cost efficiencies by reducing number of overstayers.

5. Moving forward and recommendations

Respondents were asked whether the stepdown beds were the best use of resources and how they would like to see the provision develop going forward.

Many respondents stated that they understood the necessity for the provision but had concerns and were not convinced that the resources were being used in the best possible way, as the following comments demonstrate:

> *"It is working, it is increasing bed capacity, but it shouldn't need to exist, but there are less beds than there were five years ago so I can't see this ending."*
>
> *"I'd like stepdown not to exist, I don't think it's a safe process in terms of discharging people into the community."*
>
> *"We are reacting to a situation rather than trying to resolve issues for clients in the community before they actually happen, and they fall into crisis again."*
>
> *"I'd like to scrap it and use the funds to get people moved on and to have proper community support packages."*

Several respondents stated that they would prefer to see a focus on developing an integrated pathway/system where residents go directly to their permanent homes or placements in the community, rather than an interim placement like the stepdown placements. Respondents stated that to make this work the following factors would need to be in place:

- Pre-emptive support/action to stop people getting into crisis situations.
- Supporting people within their own housing to sustain tenancies and avoiding evictions.
- More targeted wrap around community support packages focused on the people's needs to prevent readmissions to hospital, including floating support/ assertive outreach to bring services to individuals.
- Peer support – shared non-judgemental experiences from people with lived experience to help improve engagement with services and prevent people from deteriorating.

Therefore, the recommendations below are divided into:

- **short-term recommendations** – including changes and actions based on the lessons learnt in this report.
- **longer-term recommendations** - actions for future development based on respondents' suggestions to change the current model and provision.

Short Term Recommendations		
Recommendation	**Issue**	**Action**
Clear oversight and management of stepdown beds	There are a range of organisations involved with the stepdown provision but there is no single person or organisation with overall responsibility.	There is a need to establish an agreed joint management/oversight framework/system that will effectively coordinate, communicate, align and manage the stepdown beds and all relevant activities.
Establish data and information sharing system to monitor trends and progress of residents	Data and information are being gathered by all agencies, but it is not being gathered and reported consistently or in the same way across all the organisations involved. This makes the monitoring of trends and progress difficult to assess.	Co-produce a set of data/information measures that reflect the required outputs and outcomes (see example in section 4 of this report).
Addressing the issue of overstayers	Residents should only remain in stepdown beds for 6 weeks, but clearly some are remaining for longer periods.	Planning needs to commence before a resident enters a stepdown bed and they should not enter a stepdown bed without a plan or an allocated worker to take responsibility. Plans and agreements need to be in place to address the challenges of people overstaying in stepdown beds.
Obtaining the views of residents	This was a time-limited rapid review so was unable to gain the views of residents, but it is vital that the views of residents are taken into account.	Consideration should be given to getting the views and experiences of residents who have moved on from stepdown beds to inform the future direction.

Long Term Recommendations		
Recommendation	**Issue**	**Action**
Strategic focus and direction need 'rethinking'	There is a need to co-create a long-term vision and strategy, so all organisations know where they fit with bigger picture.	• Develop a 'headline outcome' e.g., supporting people to go home is default pathway, with alternative pathways for people who cannot go straight home. • Clarify roles and responsibilities e.g., use Memorandum of Understanding (MoU) to manage risk, roles and responsibilities, including who has overall charge. • A collective approach to monitoring and performance management, including the sharing of data and information to enable trends to be monitored and issues discussed in regular reviews.
Voluntary sector provider collaborative and lead provider arrangement established	It is vital to avoid the number of disparate agencies 'doing their own thing' if there is to be consistency in quality and standards of care.	• Encourage a provider collaborative and a lead provider arrangement i.e., one provider taking contractual responsibility for delivering in partnership with the other providers. • Ideally the lead should be taken by an organisation with a supported housing and community based remit.
Greater engagement with housing services	Greater integration and engagement with housing services is essential to ensure the flow along the pathway i.e., from stepdown beds into the community.	• Developing a share approach and understanding of risk and quality of care to enable consideration of housing needs and options at each stage of the pathway.
Resident centred approach adopted	Stepdown provision means residents living in shared accommodation with strangers and with staff who have 'authority over them'. So, it is important to strike a balance and to engage and empower residents as far as possible and to ask them what they want and need i.e., providing patient choice.	Put residents and their families at centre of decisions, respecting their knowledge and opinions and working alongside them to get best possible outcome by: • Understanding perspectives of residents, their families, their needs, aspirations, values and their definitions for quality of life. • Ensuring residents and their families receive clear information about their care, what will happen on discharge and who to

		contact if there are any problems after discharge. • Ensure continuity of communication so all members of the team are working to the agreed care plan, until the resident is discharge from the pathway.

Appendix A - Interview Questions for Professionals

1. Introductions *(Everyone should introduce themselves and state their roles)*

    - Name(s) of interviewee(s):
    - Job Title(s):
    - Overview of current role(s)/position(s):

2. Please describe the current stepdown service – how does it actually work. When the worker come into post - tell us what do you understand as being as the main objectives service? What are the health or wellbeing outcomes the service is aiming to deliver? Are there any innovations in the service compared to other services that you may have knowledge or experience with? Are there any difficulties in recruiting and retaining staff? What training and support is provided to staff?

3. What is the caseload – numbers? How many have step-down? Where have they stepped down to. What, if any support has been put in place for them. Have any of your stepdown client been readmitted to hospital? Are there people that are unable to step-down – overstayers – lack of beds

4. How are families and carers involved in the service? Are there any particular support needs for families and carers? How should they be involved in the service?

5. In your view, what aspects do think work well – which aspects of the service are particularly effective – and which aspects are you less happy with?

6. What partnerships have been established? How effective is the current approach to interagency working/integration across West London (CLCH, LA, WLT)?

7. What collaboration is there with the voluntary sector? How long have any partnerships with the voluntary sector been establish?

8. How do you think that the provision could work better to improve outcomes and support people to step down quicker from inpatient units into stepdown services/supported accommodation or their own home?

9. What is the current profile of residents – which groups have accessed or used the services successfully? Which groups are currently not accessing or using services? In your view, how diverse have the residents been? Has the model encouraged resident involvement from a variety of backgrounds? What (if anything) needs to be done to increase access by a wider range of residents?

10. How does the service address the wider factors that impact on people's mental health e.g., dual diagnosis, perinatal mental health?

11. Do you think the current resources and investment are focused 'in the right place'?

12. What are the performance management measures currently in place for the individual and partnerships? What do you think are the outcome measures that would demonstrate positive impacts for both individuals and partnerships?

13. If you had to choose up to three improvements which you would like to see happen over the next year – what would they be?

That's all my questions. Is there anything else you would like to say you or any other issues you want to raise?