KHP Pathway Homeless Team
Scoping Paper

Options for Delivery of Homeless 'Medical Respite' Services

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Contents

Thanks

Production of this scoping paper has only been possible thanks to the many contributors who have shared data and perspectives. Most collaborators are acknowledged at the end of the paper, with apologies to anyone omitted. However the key opinions and perspectives voiced in this paper are those of the authors.

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Executive Summary

Introduction

Pathway teams provide individual care coordination supported by multi-disciplinary teams, and use the opportunity of hospital admission to help patients into housing, support and care in the community. However despite this expert support, not all discharges are timely or to ideal destinations.

Medical Respite is an American term for clinically supported intermediate care for homeless people in the community. This includes peripatetic nursing and bed based solutions, and can range from low-level supported housing to comprehensive clinical care. Such services provide a safe, recovery based environment to discharge homeless patients to, and some already exist in the UK.

This paper considers the need for Medical Respite services to support the KHP hospitals: Guy's, St Thomas', King's, and the Lambeth and Maudsley hospitals. The paper summarises the latest evidence, outlines opinions from patients and stakeholders, and presents case studies and an analysis of KHP Pathway team data. The paper identifies 5 groups of homeless patients in secondary care with separate and distinct needs, and presents potential opportunities to improve services.

The paper aims to encourage discussion among stakeholders and enable a consensus to be reached, regarding whether action is currently needed to enhance services locally. If a consensus is achieved through this paper, a further exploratory phase with local leadership is recommended.

Literature review

Homelessness is strongly associated with multi-morbidity, premature mortality and frequent use of urgent secondary care.

There is strong international evidence for Medical Respite services showing benefit to patients and the health economy. Positive outcomes have been demonstrated in pioneering pilot projects in the UK including the Homeless Intermediate Care project based in Lambeth.

Local context

Published statistics suggest a homeless population across Lambeth, Southwark, Lewisham, Croydon and Westminster (the main boroughs that the 5 hospitals serve) of at least 16,491 people. This figure represents rough sleepers, clients living in homeless hostels, clients living in second stage supported accommodation, and Part VII statutory homeless declarations at the local authority, but does not include 'hidden homeless' people.

Emis Web (clinical computer record) data analysis for 421 Pathway patients across KHP who had a comprehensive health assessment completed between April and August 2015 confirms tri-morbidity. 78.4% of patients had a physical health problem, 49.9% had a mental health problem, and 60.3% had a substance misuse problem. Blood Borne Virus (BBV) prevalence was high with HIV at 5%, Hepatitis C at 8.8%; and 1.7% had a history of TB.

826 patients referred to the Pathway team at GSTT occupied an estimated 5981 bed days during Oct 2014-Sept 2015, with an average length of stay of 7.2 days. Re-attendance and readmission rates were high (21% and 19% respectively). At King's, the number of bed days occupied by 306 homeless patients for the same period was 4109, with an average length of stay of 13.4 days. SLaM data is still being collected, but prior research shows that the average length of stay ranges from 110.1 to 173.6 days for homeless clients who needed re-homing. 132 patients were referred at SLaM in the first 11 months.

Existing service review

Review of the existing UK services revealed some excellent practice, but also many challenges. Interviews with service providers uncovered difficulty maintaining flow when beds were in local authority control, a potential need for alcohol-free step down beds to support recovery, and a frequent need for relationship building with clinically informed social care coordination and delivery, rather than hands-on nursing care per se. A need for disability access and substitute prescribing provision was evident. All projects delivered clinical services via a Mon – Fri 9-5pm model.

Despite the challenges, the projects have all demonstrated reduced emergency care usage and improved outcomes. The project attributes that have been key to success have been identified in the report, along with the operational details of each project. It is hoped that this will provide a resource for all the projects, and a guide for any new project setting up.

Data analysis

Background data analysis was undertaken on three cohorts of patients seen by the Pathway team during 2015. This showed that a significant number of all patients seen by the Pathway team do not have a local connection (GSTT 64.2%, Kings 42.7%, SLaM 32.5%), although it appears that long stayers are more likely to have a local connection. About 14% at GSTT and King's have been confirmed to have no right to housing or welfare benefits in the UK, although as such, most patients do potentially have recourse to public funds. Around 12% of admitted patients at GSTT and King's are still being discharged to the streets for a variety of reasons.

Further detailed analysis was then undertaken on 30 randomly selected patients, and on 46 patients identified by the teams as likely to benefit from Medical Respite. Detailed analysis was partially targeted on those likely to benefit, in an attempt to clearly define the types of facilities that might be needed. In the detailed analysis the number of bed days that could be saved was identified first, followed by an estimate of the number of days that might be needed in a respite facility.

Key findings

Across the 3 Trusts an estimated total of 4410.2 bed days could have been saved in year if medical respite options were available.

Analysis of homeless patients across KHP who might benefit from Medical Respite revealed a variety of needs that have been separated into 5 groups, requiring different types of service provision. An estimate of the total number of bed days required to meet the needs of the KHP Pathway team has been made (by extrapolating the sample findings to fit the whole population). Sampling methods and the assumptions are explained in the main document. Within these groupings it has been assumed that clients with primary physical health and primary mental health diagnoses can be managed together. As most existing services allow direct admission from the community to avoid hospital admission (step-up), we also include additional capacity for this purpose where this is relevant, and set a target of 80% bed occupancy to support throughput and rapid admission (as suggested by many stakeholders). Additional figures, considering the needs of the population with a Lambeth and Southwark connection only, are offered at the end.

A Patients requiring hotel-type low level support - 30% of the 76 cases.

These are relatively independent patients with physical or mental health difficulties (sometimes with mobility issues) who are statutorily homeless, but would not normally be expected to become rough sleepers. They have often been evicted (as unable to cope due to their health problems), or have been sofa surfing with friends or family who can no longer cope. They don't usually have addictions. They can often be demonstrated to be in priority need, but are short term bed blockers while their housing case is argued with the local authority. **6.5 bed spaces per year.**

B Patients with serious health problems who have no recourse to public funds 11% of the 76 cases.

Conditions include cancer, diabetes, renal failure and late stage HIV. These patients often have mental health problems, but not addictions. There are complex debates about whether they meet the care needs threshold, and their support requirement increases over time. They are often severely delayed, so although only a smaller percentage of individuals, they are over represented in excess bed days. These patients have been allocated into group A or C in the report in terms of the respite support required (depending on disease progression).

C Patients with significant care needs requiring a care placement 8% of the 76 cases.

These patients are ex rough sleepers with acquired care needs and/or cognitive deficits with addictions. This makes them difficult to place due to a lack of appropriate social services funded accommodation. They need daily support, including with activities of daily living. They are often are severely delayed, and are thus also over-represented in excess bed days. **4.3 bed spaces per year.**

D Chaotic, tri-morbid patients requiring specialist hostel based support 51% of the 76 cases.

These patients have all been rough sleepers at some point, and are chronically physically and/or mentally unwell with addictions problems (most have alcohol issues, many also have drug issues). They have often received or been offered every service available to them. They are usually already in a hostel, or are still rough sleeping despite repeated attempts to get them in. They are often frequent attenders, although they can also be non-engagers. They rarely block beds initially, as they often leave prematurely or self-discharge, but they often block beds later as they become more unwell. They need an intense psychologically informed case management, and may need end-of-life care. Existing provision focuses on this group, and so far has been delivered in 'wet' hostel type environments (i.e. hostels that tolerate on-site drinking). **10 bed spaces a year.**

E Chaotic tri-morbid patients wanting to stay dry

Within the above group there are a significant number of patients who have had an unplanned alcohol detox as part of their acute hospital admission, and are expressing a desire to stay dry, and to not return to their hostel. As many of these patients' have had limited or no prior engagement with alcohol services, there is no possibility for them to have an urgent admission to an addictions rehabilitation bed. **These patients appear to need a rapid-access stand-alone dry unit where they can be stabilised and engaged with abstinence support. 3.8 bed spaces a year.** Note that if this provision were available, it would reduce group D to 6.2 bed spaces a year.

The adjusted figures for Lambeth and Southwark residents combined are: Hotel type low level support 4.6 days; Care environment 1.1 days; Specialist hostel 8.0 days; Dry provision 3.4 days (reducing specialist hostel provision to 4.6 days).

Case Studies

18 case studies of clients needing respite are presented in the report. These were selected by the Pathway and HIT teams. These case studies include clients needing step-up care, and end-of-life care, and one who needed community neuro rehabilitation. Two TB cases are also considered. The importance of adapting to the needs of the client group e.g. by providing support for couples, comes through in the narrative.

Patient and Stakeholder interviews and focus group findings

'I have been discharged and slept in the hospital grounds because I felt safer – I knew I wasn't very well. I went back and hoped I'd see a different Doctor'

service user

Service users and stakeholders all felt that although hospital discharge processes have improved since the KHP Pathway team has been in place, there is more that can be done to improve hospital discharge and stop the revolving door. Most interviewees were generally supportive of the concept of enhancing the local medical respite provision, although some wondered if other ideas should take priority, such as strengthening existing teams to offer post-discharge floating support. Several stakeholders pointed to ongoing funding practicalities around medical respite provision, if the intention is to continue to provide services in Local Authority controlled accommodation (thus requiring housing benefit entitlement).

Alcohol dependence was recognised to be the major health problem for this group. Service users and stakeholders alike talked consistently about the key issue of being able separate those aspiring to abstinence from continuing drinkers, and the near impossibility of providing a 'dry' environment within a 'wet' hostel. This was particularly important to service users, who favoured a bed-based model of medical respite. Service users also offered useful contributions regarding the staffing of potential respite provision.

Overall a number of key debates / dilemmas came through in this engagement work, and these were:

- Should there be an aim to provide services for all clients, or should there be a focus on clients with particular needs?
- Should a project have a 'bed blocking' or 'recovery focus'?
- Should a project be 'wet' or 'dry'?
- Should a project be provided in a homeless hostel or in stand-alone unit?
- Should a project manage out-of-borough and no-recourse clients or clients with a local housing connection only?
- Should a project provide step-down care only or include step-up and end-of-life care?
- Should a project manage clients with primarily physical health care and mental health care needs together, or separately?

Stakeholders repeatedly talked about the need for clarity of purpose, and often proposed piloting services for one or two of the 5 groups identified by the data analysis, rather than focusing on all 5.

Discussion

As outlined above, differing types of service provision will offer different outcomes. 'Hotel' provision is most likely to achieve immediate bed day savings, while concentrating on the 'chaotic tri-morbid' group is likely to foster recovery and provide long term value for investment. Providing an opportunity for alcohol dependent clients to stay dry, stabilise and engage with services seems important. London has higher excess mortality rates secondary to alcohol in homeless persons compared to other regions, and this provides an additional moral driver.

The main barrier to all provision is the siloed and depleted budgets that exist across the voluntary sector, housing and social care. Resolving this can be achieved by better integrated care within each Borough, but this does not provide help for the high number of hospital patients who do not have a local connection. A Locally Agreed Tariff may present a solution, and developing this could an aim for future work.

Recommendations/ opportunities

At the time of writing the London Homeless Health programme is developing pan-London priorities for homeless health care. This paper identifies local opportunities for change, and also opportunities to improve care by regional initiatives.

London wide commissioning

Provision for rough sleepers with significant care needs who need registered care home provision (group C) is a regional challenge, and is beyond the remit of this paper. However this was a consistent stakeholder concern, and probably justifies a separate project.

A Locally Agreed Tariff for Medical Respite Care would facilitate health care funding for most of the other groups, and overcome current problems regarding the need for dual housing benefit when hostel beds are in Local Authority control. This tariff would be paid by the patients' CCG, which in almost every case is already paying for the higher cost of repeated acute medical admissions, and could be tailored to reflect the different levels of care identified. Developing such a tariff would be a very useful contribution from London wide commissioners, and could lead to medical respite unit(s) that could meet pan London needs.

Local commissioning in Lambeth and Southwark

A number of possible options are outlined in the paper. It is important to note that full feasibility / operational details have not been worked out for all these options, and some relevant stakeholders have not yet been contacted. Interested parties will most likely wish to view all the options described to form their own opinions, however the projects felt to be most realistic for development by the authors are profiled here.

Stakeholder suggestions for strengthening discharge arrangements and improving existing community support warrant further consideration.

Discharge 'Hotel' with low level support. Piloting this might be eminently achievable using hospital or charitable funds. Such a project could be delivered in partnership with acute Trusts, working alongside any other projects in development aimed at bed-blocking in the wider hospital population.

Specialist hostel based support already exists for Lambeth residents at Graham House, supported by the Health Inclusion Team (HIT), but there is no rapid access to the beds, because they are in a Local Authority hostel which has very high bed occupancy. Additionally the hostel is due to move soon. Southwark has the recently renovated the Great Guilford Street hostel, and it now has 8 beds on the ground floor alongside two high specification medical rooms. This could be used as a medical unit within a hostel, and was designed as such. The beds are currently used as standard beds, because additional health input has not been commissioned. Extending existing HIT team medical support to this unit, and allowing access by both Lambeth and Southwark residents with a funding package that doesn't require housing benefit (so patients retain their original hostel bed), would make this possible. The HIT team obviously has existing expertise in this area, and would be ideally placed to staff, guide and lead this process if funding were made available. This might be achieved as a charitable pilot, whilst a Locally Agreed Tariff was developed.

Rapid access dry provision. Reorganisation of the Equinox community alcohol detoxification unit in Brooke Drive (or similar), might allow for direct admission from hospital to provide support to maintain abstinence, and move patients on towards recovery. This appears 'just' to need a change of protocols to allow the admission of carefully selected patients who have not previously fully engaged with addictions, and lack a clear discharge destination, but who have a definite desire and will to stay dry. A pilot project could be small, with patients receiving additional clinical and move-on support from extended Pathway / HIT teams. The Pathway and HIT teams could advise on the additional capacity required. A larger unit could be developed in the future if successful, again based on a Locally Agreed Tariff.

Proposed Next Steps

Further development work. Funding could be sought for a further 3 month exploratory phase. This phase would seek to work up a specific bid or Business Plan for a specific chosen option or options. This would involve liaison between health, housing and the voluntary sector to work out the potential operational details of a project, and develop specific staffing models. It would also in all likelihood require significant local cross borough liaison in housing and health. It might also involve examining property options in more detail, and starting work on the tariff concept. A potential partnership with the GSTT charity funded Assertive Outreach Alcohol project could be developed.

Facilitation funding from GSTT charity and/or other sources would be needed in order to develop these opportunities.

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Feedback and dialogue on this report is very much welcomed.

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Postscript:

One of the service user contributors to this project died in January 2016 aged 29 years old. This person articulated the difficulties they had experienced with the hospital discharge process extremely well, and offered some extremely useful insights and suggestions regarding medical respite. She is respectfully remembered as this report is published.

Options for Delivery of Homeless 'Medical Respite' Services

Introduction

The KHP Pathway Team has been operational across Guy's, St Thomas' and King's College Hospitals since January 2014 and extended into SLaM (with GSTT Charity funding) in February 2015. The team provides clinically led, multi-disciplinary care coordination for homeless patients with complex needs. In the first year across Guy's St Thomas' and King's the team received 1603 referrals for 1414 individuals. Data analysis for GSTT patients demonstrated improved housing outcomes for 56% of admitted patients, with a 9% reduction in A&E attendance and 11% reduction in bed days. However there was a 9% increase in admissions. This probably reflects a greater willingness to admit patients so that they can be 'sorted out' by the Pathway team, and so be less likely to present again to A&E.

It is felt that this initial success could potentially be built on, and experience suggests that there is a lack of step-up, step-down, end-of-life care, and rehabilitation services for this client group. Medical Respite is an American term for short-term community based care for people leaving hospital, or as an alternative to hospital admission. In the American context Medical Respite projects have been shown to reduce duration of admission and reduce re-admissions to hospital. Small scale attempts to replicate this type of service are being tried in UK settings. Generally these are enhanced hostels, with better facilities and visiting community medical teams – usually linked to local specialist homeless practices, with funding dependent on housing benefit entitlement and medical care commissioned by the NHS. Services exist in Bradford, Leeds, Manchester, Brighton, Camden, Hackney and Lambeth (in the case of Lambeth, with clinical care provided by the GSTT Health Inclusion Team). Westminster has also recently set up a new service.

In this scoping paper we have gathered and summarised the emerging data from these existing projects, and have also examined the local case to see:

- if there is a case for expanding the current services, and,
- what options exist to achieve this.

In the process we have interviewed many stakeholders and service users, and have identified a variety of opportunities, as well as some potential challenges and blocks. It is notable that the paper has revealed a great degree of funding and service delivery complexity, which provides some indication as to why this concept has not been developed further thus far. This paper has allowed many of the issues to be unpicked, but it has not provided a simple plan for taking a specific individual project forward. Rather it is a document to promote further discussion.

It is hoped that if a consensus can be built, this paper will become the spring board for next steps.

Literature review

Brief background / context

The annual cost of unscheduled care for homeless patients is eight times that of the housed population [1] and homeless patients are overrepresented amongst frequent attenders in A&E. Despite this expenditure, the average age of death for homeless patients is just 47 years [2] and patients have a reduced quality of life caused by multi-morbidity. Prevalence of multi-morbidity increases with deprivation, and has an onset 10-15 years earlier in deprived groups than in the most affluent groups. [3] Homelessness is an independent risk factor for premature mortality [4] and is associated with extremes of deprivation and multi-morbidity. The annual cost of health inequalities to the NHS is estimated by the Institute of Health Equity to be £5.5 billion.

Long-term homelessness is a mark of complexity and multiple exclusion with roots in early childhood. Neglect and abuse lead to personality issues and mental illness, and attempts to self-medicate with alcohol and drugs leads to dependency and contact with criminal justice services. Lack of social support and personal resilience often culminates in destitution and homelessness. A deterioration in physical health follows, and the combination of physical ill health combined with mental ill health and drug or alcohol misuse (tri-morbidity) is often central to the challenge of managing homeless patients in an acute hospital setting. [5]

The Marmot Review states - "To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism."[6] In line with this the vision of Public Health England expressed through the Outcomes Framework is "to improve the health of the poorest fastest." The Health and Social Care Act 2012 also imposes for the first time a statutory duty on all health care providers to "have regard to the need to reduce health inequalities" by means of the services which they provide. As such commissioners are further required to reduce health inequalities in access, outcomes and by means of improved integration.

Existing community services in health, housing and social care defend their budgets by rigidly restricting access to a defined 'local' population – this renders care coordination particularly challenging for homeless people, who often have weak or no ties to any locality and lack documentary proof of any entitlements. Hospital teams lack the knowledge and networks to coordinate care effectively. For some homeless people unresolved migrant status also adds to the complications.

Community services have responded to financial pressures by making it increasingly difficult to get help without proof of identity, legal status, local connection, vulnerability, or appropriate diagnosis. When homeless people are seen in A&E or admitted to hospital there is a huge task to unpick the decades long tangle of neglect, devise a care plan and advocate for the necessary funding and support to improve health and prevent another hospital admission, and appropriate move-on facilities are often unavailable. This paper considers the options within this context.

Medical Respite – the evidence base

There is now a substantial international body of research describing approaches, and confirming the benefits of Medical Respite – usually defined as intermediate care for homeless people leaving hospital, or at risk of imminent hospital admission.

Models of Medical Respite

One of the earliest examples of medical respite care in the UK was provided by Wytham Hall, which was founded in 1984 in collaboration with Great Chapel Street Medical Centre. However the project evolved on the basis of local need over time, and the centre now provides supported housing.

The issue has been on the agenda in and around Lambeth for the last 10 years. In 2005 Robin Lane of the Homeless Intermediate Care Steering group (Lambeth PCT) published 'The Road to Recovery - A Feasibility Study into Homeless Intermediate Care' [7]. The report did not find any replicable models of intermediate care in the UK at that time. A clear need was identified in the report, but there was not consensus on the ideal model.

However this thinking led to a hostel based homeless intermediate care pilot in Lambeth [8], which showed a 77% reduction in admissions and 52% reduction in A&E attendances. The project has continued on a small scale, but is only available to those already resident in the hostel that hosts the project (which is the current 'multiple complex need' hostel in Lambeth), so is unfortunately only available even to the majority of Lambeth homeless patients in KHP.

A similar case for Medical Respite was also been made for Dublin, as part of a comprehensive health care response [9].

Most of the publications come from the States. A monograph from the American health care for the homeless respite care provider's network [10] recommends a free-standing unit, rather than

a hostel based unit. Principal reasons are the challenge of maintaining sobriety in a hostel, and tendency for hostel based services to take clients with lower levels of health and social care need. However a free standing unit is inherently more expensive, as it does not allow for the sharing of staffing costs.

Reflections on what happens without Medical Respite are also helpful. Donna et al's [11] paper highlights the fact that, in the absence of a designated medical respite programme, a 'patchwork medical respite' emerges as staff find local work-arounds, which is very time consuming and of variable quality and benefit. This produced considerable frustration for service providers and users, with many instances of prolonged hospital stays.

Similar thinking has emerged in the UK, in a reflection on the 'Liverpool Protocol' [12]. This is a policy held by the hospital discharge team that maintains multi-agency relationships, and is supported by ring-fenced hostel beds provided by the Local Authority for hospital discharge patients. The study highlights the lack of intermediate care and palliative care beds, which diminishes the discharge opportunities for homeless patients.

The central importance of 'trauma informed care' or a Psychologically Informed Environment as a central approach to a supportive environment for long-term homeless people is also increasingly acknowledged [13].

Cost Benefit Analysis

Most studies have concentrated on the potential cost savings resulting from reduced use of secondary care, while highlighting the benefit to patients.

Research in Chicago has shown that intermediate care for homeless people leaving hospital reduces future hospitalizations by 49% [14].

A systematic review of American research into intermediate care for homeless people [15] showed that medical respite programs reduce future hospital admissions, inpatient days, and hospital readmissions. They also result in improved housing outcomes. Results for emergency department use and costs were mixed but promising.

A recent Lancet evidence review also confirmed these benefits of Medical Respite [16]. Medical respite programmes that provide homeless patients with a suitable environment for recuperation and follow-up care on leaving the hospital reduce the risk of readmission to hospital, and the number of days spent in hospital.

Early analysis from the Bradford Pathway team collaboration with Horton Housing's 14 bed medical respite unit projects annual secondary care cost savings of £280,000. [17]

The most recent national analysis was an evaluation of the homeless hospital discharge fund, carried out by Homeless Link with DH funding [18]. This found that partnership and multi-agency working were key components for success with housing and clinical staff in the team. Pathway teams were highlighted as good examples. Access to dedicated accommodation alongside link workers improved housing outcomes, with 93% of clients discharged to appropriate accommodation compared to 71% overall. They recommended a model where accommodation is either directly linked to the project (via bespoke units or ring-fenced beds in existing projects), or links are established with a local housing provider or rent deposit scheme so suitable accommodation can be easily accessed.

Summary

Current evidence suggests that Medical Respite can improve care for homeless people leaving hospital and reduce secondary care costs. There are also some tested models available for developing such services. Evidence suggests that established local partnerships with pre-existing skills and experience in this area are key to providing an effective service.

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Local context

Estimate of the size of the local homeless population

Homelessness statistics are presented for the main boroughs served by the 5 KHP Pathway Team hospitals (St Thomas', Guys, Kings, Lambeth, Maudsley). Namely: Lambeth, Southwark, Lewisham, Croydon and Westminster.

For the purposes of this paper 'homeless' people include all categories of clients that are seen by the Health Inclusion Team and/or Pathway team. These include:

- Rough sleepers
- Clients living in night shelters and churches
- Clients living in homeless hostels and supported accommodation
- Single homeless people placed in temporary accommodation
- Sofa surfers – those living with family and friends and acquaintances
- Clients living on buses, in cars etc
- Clients being evicted
- Clients at imminent risk of eviction (within 28 days)

It is impossible to get estimates of the size of all these populations, but a useful estimate based on existing published information for some of the above groups is presented.

Rough sleeping numbers

Rough sleeping numbers have increased 90% between 2010-2011 and 2014-2015 (CHAIN Greater London Report 2014-2015), after a steep decline in the 2000's. It is not known why this trend has occurred, although it is generally attributed to welfare reform, hostel closures and increased migration.

It can be seen from the data below that the KHP Pathway team covers an area that saw 3767 rough sleeping contacts last year.

Table 1: CHAIN data 2013-2014 and 2014-2015

	2013-2014	2014-2015	2014-2015 borough ranking
Lambeth	427	468	3rd
Southwark	391	373	6th
Lambeth and Southwark	818	**842**	
Lewisham	141	199	12th
LSL (Health Inclusion Team and START team coverage)	959	**1040**	
Croydon	155	157	16th
LSL and Croydon (SLaM catchment)	1114	**1197**	
Westminster	2197	2570	1st
All	3311	**3767**	

Clients living in homeless hostels and supported accommodation

There was been a 20% reduction in hostel bed spaces pan London between 2012 -2014, and a further 6% reduction this year (Homeless Link, 2015). There is some evidence that this may be contributing to the rise in rough sleeping.

It can be seen from the data below that the KHP Pathway team covers an area that had 3673 homeless hostel bed spaces and 2003 supported accommodation bed spaces in 2014.

It is interesting to note that Lambeth has a higher number of hostel bed spaces and floating support places than Westminster, despite having considerably lower levels of rough sleeping. This can partially be explained by the high number of people rough sleeping in Westminster that have no recourse to public funds or have no local connection.

Table 2: London Housing Foundation Atlas data 2014 - Homeless hostel and supported accommodation bed spaces

	Lambeth	Southwark	Lewisham	Croydon	Westminster	TOTAL
First stage beds	136	110	118	21	336	721
Second stage beds	513	445	209	395	418	1980
Specialist hostel beds	265	136	264	155	152	972
All hostel beds	**914**	**691**	**591**	**571**	**906**	**3673**
Floating support	494	565	398	146	400	2003
Total	**1408**	**1256**	**989**	**717**	**1306**	**5676**

Single homeless people placed in temporary accommodation

Single people placed in temporary accommodation by the local authority are also homeless, and are generally awaiting a decision from the local authority regarding whether they have a duty to house.

The following table outlines the number of people placed in temporary accommodation in 2014-2015. It is also important to note the number of those people that were refused temporary accommodation, and their reasons for refusal. Those who were found 'intentionally homeless' will have e.g. been deemed to have not taken appropriate to avoid getting into arrears, or have been evicted due to anti-social behaviour. These decisions are sometimes appealed by the Pathway team if it is felt that a clients' health problems have not been taken into account appropriately in the decision making.

All those not awarded temporary accommodation may end up rough sleeping or sofa surfing – although experience suggests that sofa surfing will be more likely for those who have also had the capability and skills to actual take a homelessness application to the local authority.

It can be seen from the data below that in the area that the KHP Pathway team covers there were 7049 homeless applications, and 3653 acceptances in 2014-2015.

Table 3: Gov.uk – Local authorities' action under the provision of the 1985 and 1996 Housing Act - summary for 2014-2015

	Lambeth	Southwark	Lewisham	Croydon	Westminster	TOTAL
Homeless applications	687	1745	1227	2412	978	**7049**
Homeless and in priority need acceptances	504	857	769	880	643	**3653**
Homeless, and in priority need, but homeless 'intentionally'	63	261	41	125	123	613
Homeless, but found not to be in priority need	67	247	30	363	135	842
Found not to be homeless	53	380	387	1044	77	1941

Total homeless population

Adding these figures up gives a total homeless population of **16,491,** which does not take account of many of the other hidden homeless groups described above. The overall population of this area is around 1.5 million.

Table 4: London Housing Foundation Atlas data – population figures 2014

	Lambeth	Southwark	Lewisham	Croydon	Westminster	TOTAL
Population	314,242	298,464	286,180	372,752	226,841	1,498,479

Current homeless health service provision across Lambeth, Southwark and Lewisham

KHP Pathway Homeless Team

The KHP Pathway Homeless team works across the Kings Health Partners In-patient and Accident and Emergency Services to provide advocacy, support and quality discharge interventions for homeless clients attending or admitted to any of the Kings Health Partner hospitals. The Pathway Homeless Team works in close collaboration with the wider hospital discharge teams. The team currently operates within the St. Thomas', Guys, Kings, Lambeth and Maudsley hospitals. The dual aims of the Pathway Homeless Team are to improve the quality of care for homeless patients, whilst reducing both delayed and premature discharges. There is an overarching aim to reduce future unscheduled admissions and A&E attendances. The Pathway Homeless Team is affiliated to, and forms part of the Pathway network of 'Homeless Ward Rounds' in acute care settings nationally. The team is GP led, multi-disciplinary and multi-agency team, employing 12 full and 8 part time staff. Last year the team received 1603 referrals across GSTT and Kings.

The SLaM element of this project is a 3 year pilot funded by the GSTT and SLaM charities. The rest of the team has ongoing funding from Lambeth and Southwark CCGs. The SLaM team worked with 97 individuals in the first 8 months.

Health Inclusion Team

The Health Inclusion Team is a specialist community nurse practitioner led team that supports vulnerable people to access primary care services e.g. homeless people, refugees, asylum seekers or people with addictions. The team runs outreach clinics in day centres, hostels and drug services across Lambeth, Southwark and Lewisham. The team delivers primary care services where this is appropriate, but also enables access to other primary and secondary health care services where this is more appropriate. The team employs 22 staff. Most of these are nurses, but there are also case workers, GPs, and a health improvement specialist who works specifically with torture victims. Lambeth, Southwark and Lewisham CCGs fund the homeless health element of the service. The team saw 1438 individuals last year.

Homeless Intermediate Care Project

The Homeless Intermediate Care Project (HICP) is part of the Health Inclusion Team and commenced at the St Mungo's Cedars Road Hostel in January 2009 (originally as a Pilot Project). In 2011, the HICP project was granted mainstream funding via Lambeth CCG. The service moved after Cedars Road hostel closed in 2012, and now provides intense clinical and social case management to a select group of clients residing within two Lambeth Thamesreach hostels (Graham House, 69 bedded; and Robertson Street, 42 bedded). The team consists of a Nurse Practitioner, a Health Support Worker from St Mungo's funded by the local authority and a GP in-reach session at Graham House provided through a locally enhanced contract from the Lambeth CCG. 29 clients were managed last year.

START team

The START team is a multi-disciplinary outreach and assessment team that works with homeless people with severe and enduring mental health problems in Lambeth, Southwark and Lewisham. The team engages, assesses and provides short-term interventions. It does not provide long term care coordination, but refers clients to mainstream services after the initial period of engagement. The team works specifically with street homeless people, or those rough sleeping in cars, abandoned buildings etc. It also provides input into 2 hostels (one in Lambeth, one in Southwark) that see a high proportion of clients who have just come in off the street and need assessment. The team has 7 staff, including input from a Consultant Psychiatrist and Registrar. The team currently has 130 clients on its caseload.

Supported Living Team

The Supported Living Team is a specialist CMHT that works with around 120 clients in supported accommodation in Southwark. This includes clients living in homeless hostels. The team has around 8 staff including the input from a Consultant Psychiatrist.

Psychology in Hostels Project PIE (Psychologically informed environment)

The psychology in hostels project provides a fully 'Psychologically Informed Environment' at the Waterloo Project (a 19 bedded homeless hostel in Lambeth), and outreaches to two other hostels in Lambeth. It is staffed by two Psychologists.

The PIE provides individual and group therapy for clients, as well as staff training, support, and reflective practice. This is a pilot project that aims to demonstrate that psychological input will improve engagement and independence in clients, and help them to find meaningful occupation. The project is funded by the GSTT charity.

Locally Enhanced Service GP practices

A number of GP practices across Lambeth, Southwark and Lewisham have Locally Enhanced service contracts for homelessness. Currently 2 of these GP practices currently in-reach into 3 hostels. Previously there was in-reach into 2 more hostels, but these hostels closed down. In-reach into 2 further hostels in Lewisham is currently being planned.

Barry House

Barry House is a Home Office commissioned Initial Accommodation hostel in Southwark that provides very temporary accommodation for destitute clients submitting immigration claims. Most clients are dispersed from this accommodation within a few weeks. This service has an NHS England-funded full health team working on site, that is managed by the Health Inclusion Team.

Other Borough services

The teams above have considerable links with the following homeless health services:

Westminster – Westminster Homeless Health Team, Dr Hickey Practice, Great Chapel Street Practice, Joint Homelessness Team, and Homelessness Prevention Initiative.

Croydon – Rainbow Practice

Pathway Team Contact / Demographic Data

Contact data for Pathway Team is presented below.

Contact data for the Health Inclusion Team and START teams can be found in Appendix 1, as an adjunct to this data.

Pathway Team

During 2014 the team received 1603 (GSTT 1086, Kings 517) referrals for 1414 individuals. 60% of clients at GSTT, and 45% of clients at Kings reported being rough sleepers. Only 47% of clients seen at GSTT and 63% at Kings had a 'local connection' with one of the three surrounding boroughs, indicating a high level of transience in the population. 17.4% of the referral population were confirmed to have no recourse to public funds during this time. The mean age of those referred was 43.8 years. Women are rather over represented (compared to mainstream homeless populations) e.g. comprising 24% of referrals at GSTT and 31% at Kings during the pilot phase.

Table 5: Housing status of Pathway referrals 2014

	GSTT	Kings
No Fixed Abode	60%	45%
Homeless hostel	15%	13%
Sofa Surfing	11%	17%
Housed (including threat of eviction)	10%	18%
Other (e.g. temporary accommodation, B&B)	2%	3%
Unknown	2%	4%
Total	100%	100%

KHP Pathway team – SLaM

During the period 23 Feb 2015 – end Feb 2016 the SLaM Pathway team had worked with 132 clients.

However in an experimental search for Feb to Oct 2015, a considerable 24% of 2285 patients admitted to the Trust had either 'homeless' 'NFA' or 'no fixed abode' recorded somewhere in their notes. Although all these patients were clearly not NFA during this period, this does suggest that homelessness is a very common experience for mental health patients that have been admitted, and the clients seen may be the tip of the iceberg.

The SLaM team sees a lower proportion of rough sleepers, and higher proportion of sofa surfers and clients being evicted.

Pathway Team Prevalence Data

KHP Pathway Homeless Team

The following table gives an aggregate of coded data for clients seen by the Pathway team across all three sites for the first 5 months of operation of the EMIS Web system.

Table 6: Pathway team prevalence data 01/04/2015 – 31/08/2015

	Clients seen (N=622)	Clients coded as 'Health Assessment complete' (n=421)
Physical health	70.4%	78.4%
Mental health	44.4%	49.9%
Alcohol dependence and/or drug dependence	51.4%	60.3%
HIV	3.7%	5.0%
Active Hep B	1.1%	1.7%
Active Hep C	6.9%	8.8%
Active TB	1.6%	1.7%

Although the EMIS Web system is new for the Pathway team this data seems broadly consistent with past Pathway team data. The data is also in keeping with Health Inclusion Team data over the years, although it is interesting to note there is a higher prevalence of HIV, but lower prevalence of Hepatitis C in the hospital population. Prior data, and data for the Health Inclusion Team (which includes some data on chronic disease prevalence) and START team data can be found in Appendix 2.

SLaM team

The following tables give an additional breakdown of the primary mental health diagnosis of the clients seen by the SLaM team, and the Section status they were admitted under.

Table 7: Primary diagnosis of SLaM Pathway team patients

	N=77	%
Schizophrenia /Psychosis	26	33.5%
Bipolar	5	7%
Depression / anxiety	20	26%
Personality Disorder	6	7.5%
Substance misuse	13	16.5%
Other	2	2.5%
No primary diagnosis recorded	5	7%

Table 8: Section status of SLaM Pathway team patients

Legal status	N=77
Informal	61%
Section 2	22%
Section 3 and forensic sections	17%

Morbidity data

The 2011 Crisis report provides some in-depth analysis for London regarding the mortality of people who are homeless. For example the report shows that although London accounts for a quarter of England's homeless people during this period, nearly a third of the deaths (30.9%) identified were in the London region (2000-2009).

Table 9: Cause of death in homeless people (percent) by Government Office Region, 2000-09

Distribution of causes of death	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorks & Humber
Cardiovascular	17.8	12.7	24.5	19.0	14.6	12.2	12.2	19.8	18.0
Cancer	6.7	5.9	11.8	11.0	10.7	9.4	7.7	12.6	3.3
Respiratory	8.9	9.8	8.8	10.0	10.2	6.1	7.7	9.2	5.7
Other diseases and disorders	15.6	14.7	15.0	*	10.7	10.8	11.5	17.4	13.1
Due to alcohol	8.9	11.8	16.3	17.0	14.1	15.5	14.7	12.6	11.5
Due to drugs	24.4	26.5	12.5	22.0	24.3	24.9	30.1	20.8	36.9
Suicide/ undetermined intent	10.0	7.8	6.9	11.0	11.2	13.1	9.0	4.3	7.4
Other external causes	7.8	10.8	4.3	*	4.4	8.0	7.1	3.4	4.1

Note: * denotes data suppressed to comply with data disclosure rules.

Source: Thomas, B (2012) Homelessness Kills - an analysis of the mortality of homeless people in early 21st Century England. Crisis.

NB: The mortality records available to Crisis did not include information about housing status and so the authors used a number of data sources to arrive at an estimate of homeless deaths. A dataset of 1,731 deaths were drawn from the 4,573,667 deaths recorded between 2001-2009. Based on this method they found 535 deaths in homeless people for London. The data used includes people who were definitely homeless and those where there was a high probability that some of the additional deaths were of homeless people.

Importantly London had the second highest rate of deaths in homeless people caused by alcohol, where deaths due to drugs account for an eighth of all homeless deaths in London compared with a fifth of all homeless deaths nationally.

This suggest that alcohol management treatment strategies should be a key focus for any respite based programme.

Admission / Length of Stay DatNote on data extraction: GSTT and Kings

Two sources of data exist for the GSTT and Kings Pathway teams – data produced from internal team recording about patients seen by the team (previously via Excel, in future via EMIS Web), and data produced by the hospital performance teams which aims to consider all homeless patients across the hospital (whether or not seen by the team), in order to assess the overall impact of Pathway. The GSTT and Kings hospital performance teams currently extract data differently.

As 'homelessness' is not routinely recorded on hospital databases, the method piloted by the GSTT is to use NFA (no fixed abode) or known local hostel addresses, or registration with a specialist homeless primary care team, in order to identify a group of likely homeless patients. The Kings team alternatively extracts data on any client with the ICD-10 'Homeless' code on the notes. In order to support this the Kings Pathway team forwards lists of clients to the in-hospital coding team to ensure that this ICD-10 code is added to the records of the clients they have seen. Unsurprisingly the latter method has recently been shown to be more effective at correctly identifying the clients seen by the team. There is a relatively small number of other clients have this code who have not been referred to the team, which is to be expected.

It has recently been demonstrated that the crossover between the clients identified by the search, and those seen by the team is around 35% at GSTT, but around 90% at Kings. As such, in the data presented below, there is considerable discrepancy between the internal team and performance team data at GSTT. On further examination of the GSTT records it has been noted that many clients who would be expected to be picked up by the 'homeless group' search (because they are known to be NFA or living in a homeless hostel), actually have a standard residential address on their hospital notes. This can be because they have a previous address recorded, but more importantly this can be because they have subsequently been housed, and thus the address on their records has since been changed. Unfortunately the system does not attach previous addresses to prior activity – all address data is over-written permanently. This is a huge problem, because it is likely that clients staying longer are more likely to have their housing situation resolved, and are thus more likely to leave the data set.

The GSTT team are now considering moving over to the ICD-10 code method of extraction. These data issues illustrate the challenges of monitoring services for this client group.

GSTT
Pathway team Excel spreadsheet analysis for Oct 2014 - Sept 2015

1110 clients referred, 826 admitted of which 613 seen, 24 removed as data inadequate (no discharge date recorded)

589 admissions remaining – **Average Length of Stay - 9.51 days**

Total bed days all clients seen – 5601 days

Staying more than 5 days – 265 admissions – Average Length of Stay - 19.1 days

Total bed days clients staying more than 5 days – 5061 days

However this bed day total does not include the admissions that were *not* seen by the team (where no discharge date was recorded). In order to get an estimate of the total number of bed days for all the admissions (including the 237 clients not seen by the team), a further calculation was undertaken.

First the average length of stay of those staying less than 5 days was examined. As can be seen from the calculation below the average length of stay of those seen that stayed less than 5 days was low at only 1.6 days. Although initially surprising, this can be explained by the fact that we already know there are a lot of EMU admissions in this group from previous and existing performance team data. It was then postulated that the clients not seen by the team might also be expected to have the same low average length of stay i.e. because they were there a short time, they were not seen. As such this average length of stay has been using as

the multiplier for the remaining 237 clients not seen. The calculation and new estimated bed day total is presented below.

Calculated estimate of bed days for all 826 admissions:

- 5601 (bed days for clients seen)
- Of which – 5061 (bed days for clients seen staying over 5 days)
- This leaves 540 bed days for patients staying under 5 days
- To calculate numbers staying under 5 days: 589 (admissions seen) – 265 (admissions seen staying over 5 days) = 324 admissions seen staying under 5 days
- 540 bed days / 324 admissions staying under 5 days = 1.6 days average length for remaining admissions (of which many will be EMU)
- To then include patients admitted, but not seen (and thus the discharge dates and duration of stay data is missing): 826 (total admissions) – 589 (admissions seen) = 237 admissions not accounted for in previous bed day total
- 237 (admissions not accounted for) x 1.6 (assumed more likely to be short admissions if not seen) = 380 bed days

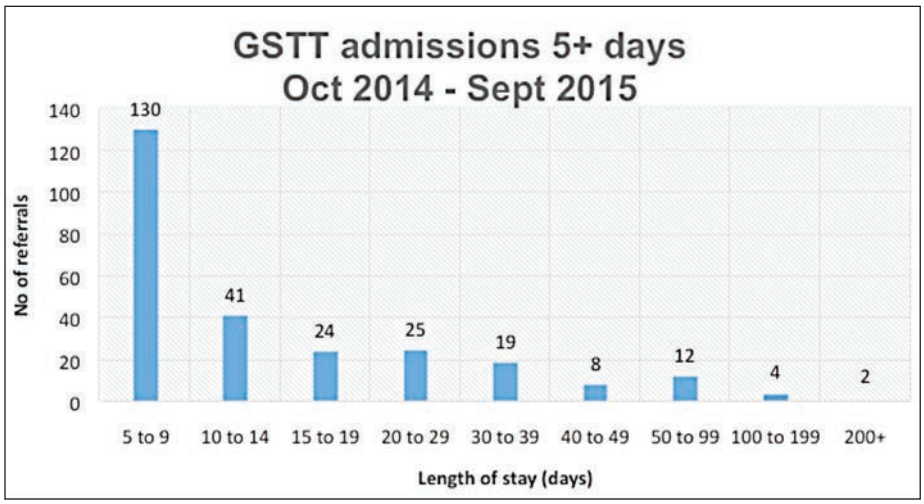
Adjusted estimated bed day total = 5601 + 380 = 5981 bed days

If this total is then divided by the number of admissions (826) the estimated length of stay is 7.24

It should be noted though that as a result of the methodology above, this total may still be an underestimate, and definitely only focuses on clients actually referred. Performance team data (see below) suggests a total number of admissions around 1100, so the overall total is likely to be higher.

The graph below shows the split of the number of admissions staying over 5 days.

Graph 1: Clients staying longer than 5 days at GSTT (Excel data)



Performance Team data 2013 / 2014 comparison

As suggested this data differs somewhat from the GSTT performance team data which is presented below. In fact the estimate of bed days provided above is actually double that suggested by the performance team data (and is more reliable).

However the high re-attendance rates and readmission rates that are available in the below data set are very worthy of note, and felt to be accurate.

Table 10: GSTT Performance team data – 'homeless' dataset

	2013	2014
A&E total	4322	3936
LAS total	2499	2114
% via LAS total	57%	54%
Admissions total	1058	1158
% admitted total	24%	29%
Bed days total	3339	2984
LOS	3.2	2.6
% re-attendance in 7 days	19%	22%
% readmitted in 28 days	19%	21%

What this suggests is that the Pathway team at Guy's and St Thomas' is referred a subset of the whole homeless population in the hospital, concentrating on those who stay longer (and so are more likely to be complex and unwell). This appears to be an appropriate use of a valuable resource.

Kings

Excel spreadsheet analysis for Apr 2014 - Mar 2015

At Kings Excel spreadsheet collection stopped in March 2015, as data collection changed to Emis Web.

587 referrals, 288 admitted, 229 seen. However discharge data was available on 276 admissions.

276 admissions – **Average Length of Stay – 18.34 days**

Total bed days 5062 days

Staying more than 5 days – 162 admissions – Average Length of Stay – 29.5 days

Total bed days - 4788 days

Kings – Performance Team data Oct 2014 - Sept 2015

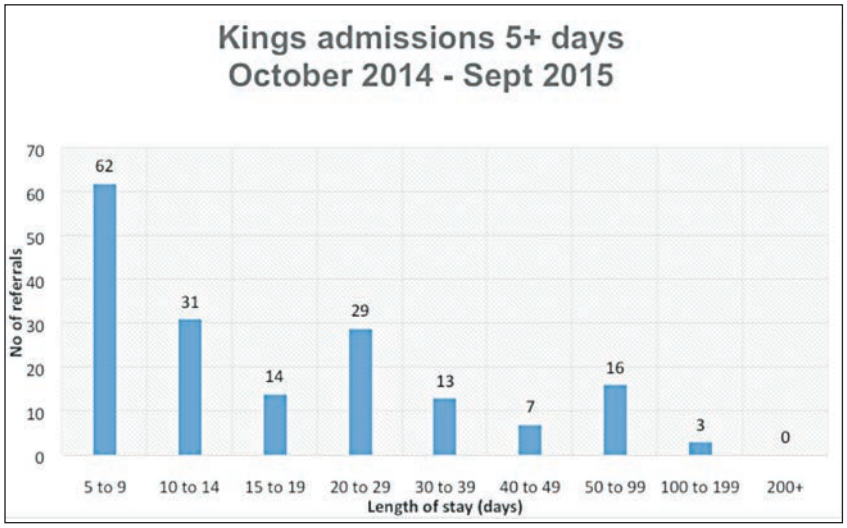
306 admissions from 276 individuals with homeless read code – **Average Length of Stay 13.43 days.**

Total bed days - 4109 days

Staying more than 5 days - 158 patients – **Average Length of Stay 24.08 days**

Total bed days - 3805 days

Graph 2:Clients staying longer than 5 days at Kings (Performance team data)



SLaM

No data is yet available for average length of stay of homeless clients that have been seen by the SLaM team. This will be published with other evaluation data for this new service as the data is collated.

In terms of the homeless admissions overall, work by Alex Tulloch looking at all homeless admissions between 1st January 2010 and 31st December 2014 outlined that of 17,641 admissions during this period 4% (705 admissions) had a recording of homelessness at some point during the admission. However more recent work suggests the percentage of homeless admissions may be considerably higher (up to 24%).

The table below has been published with direct permission from the author (Alex Tulloch).

Table 11: Margins (Average Predicted Values) for Length of Stay For Levels of Homelessness, Residential Mobility and Borough Served by Ward of Admission

	Length of Stay / Days (95% Confidence Interval)			
Housing and homelessness	Borough			
	Croydon	Lambeth	Lewisham	Southwark
Not homeless, no home move	45.9 (42.1 to 49.6)	36.2 (32.9 to 39.5)	40.2 (37.6 to 42.9)	37.4 (34.9 to 39.9)
Homeless, no home move	45.6 (33.6 to 57.7)	57.1 (41.1 to 73.0)	50.1 (41.2 to 59.1)	46.6 (29.2 to 64.0)
Home move, not homeless	107.0 (89.6 to 124.4)	92.4 (77.0 to 107.8)	79.9 (67.2 to 92.6)	85.1 (70.3 to 100.0)
Homeless and home move	122.5 (92.0 to 153.0)	173.8 (116.8 to 230.8)	110.1 (75.7 to 144.4)	117.8 (89.7 to 145.9)

Note. Margins calculated based on a linear regression of LOS with person-level random-effect and including age, diagnosis and most restrictive legal status as covariates. N = 16,628.

The table suggests that length of stay for homeless people tend to be longer than for non-homeless people, although there is some borough variation in this. The table also considers the influence of home move (i.e. needing to move to a different address / placement), as well as the influence of homelessness per se.

What the table shows is that being 're-homed' during admission causes an increased length of stay whether or not the person was initially homeless. However it also shows being homeless on admission, and needing re-homing (i.e. not being discharged to the streets) generates the longest lengths of stay between an average of 110.1 days (Lewisham) and 173.8 days (Lambeth).

Review of existing models of Homeless 'Medical Respite'

In this section some of the main current models of homeless medical respite care that are being delivered in the UK are reviewed, with an operational description, and an overview of strengths, weaknesses and key outcomes.

This information has been obtained in partnership with the service providers, and the write-ups have been reviewed by them.

At the end of this section there is a review of learning, and a summary of what appeared to be the best aspects of each project.

The London projects (reviewed by Samantha Dorney-Smith) are:

- **Homeless Intermediate Care Project, Lambeth** – Health Inclusion Team, Guy's and St Thomas' NHS Foundation Trust
- **Hospital Discharge Network projects, Camden and Hackney** – St Mungos Broadway
- **Pathway to Home, Camden** – UCLH Pathway, University College London Hospital
- **Westminster Integrated Care Network for Homeless Health, Westminster** – Westminster CCG based partnership of Great Chapel Street, Dr Hickey Practice, Joint Homelessness Team and Westminster Homeless Health Team

The projects outside London (reviewed by Dr Nigel Hewett) are:

- **Bradford Respite and Integrated Care and Support Service (BRICSS), Bradford** - Bevan Healthcare CIC
- **Homeless Accommodation Leeds Pathway (HALP), Leeds** - York Street Medical Practice

There is also information provided about 3 services that have closed: Lewisham HDN, Westminster HDN and Southampton Breathing Space

Homeless Intermediate Care Project (HICP), Lambeth

Contact Kendra Schneller – Service Lead – kendra.schneller@gstt.nhs.uk

OPERATIONAL ASPECTS	STRENGTHS	WEAKNESSES	KEY OUTCOMES
Supports two hostels: one 69 bedded hostel one 43 bedded hostel	Staff have been in post for 6 years – a wealth of experience	Limited control over move on plans – mainly managed by Lambeth pathway (although influence over this is increasing)	This project was originally piloted at a 120-bedded hostel in 2009. During the year, 34 hostel clients were taken on. At the end of the year, the number of hospital admissions from the hostel had dropped 77% relative to 2008, and the number of accident and emergency (A&E) attendances had dropped 52%. Hospital 'did not attends' (DNAs) were 22% lower. The pilot project was deemed cost neutral overall, and there was some evidence that health outcomes improved long term. The service has not been comprehensively evaluated since, however the service has achieved a 35% reduction in A&E attendance and 39% reduction in admissions at Graham House between 2012 and 2014.
Only open to existing residents of the hostel (which has very high levels of morbidity)	Service is embedded within a community nursing team with 23 years experience	Limited possibility to maintain abstinence within wet environment	This has happened at a time when the complexity of the client group entering the hostel has increased.
8 max (currently over capacity at 10)	Good partnership working	Limited move on opportunities within pathway	KPIs currently focus on: • Achievement of the health goal agreed on admission • BBV screening • TB screening • Hep A, B and flu vaccination • Engagement of clients with appropriate services • % of DNAs
12 week stay – often longer (clients are generally very unwell)	Environment familiar to clients	Limited help with developing independence	The project took on 20 clients in 2014-2015. The shortest stay was 7 weeks, the longest stay 69 weeks. There were 3 deaths, 2 were expected with those patients being palliative.
Step down and step up (50:50 approx)	Excellent support from hostel staff with support objectives	Engagement has been a problem in the past, but much better recently	
0.8wte Band 7 nurse 1wte Band 5 health support worker 0.1 wte from 8a nurse manager	Hostel manage behavioural contracts etc		
Out of hours support – limited support currently due to capacity issues in community services	Addictions in-reach works really well. Addictions consultant review once a month.		
Nursing care Engagement with relevant health services e.g. GPs, addictions, mental health Escorting to appointments Encouragement to engage with hostel groups	Good relationship with addictions social workers regarding treatment and move on		
Medical support provided by Mawbey Brough – 1 x 4.5 hour session per week	Psychologist attends client case review meetings.		
Addictions support provided by Lambeth Consortium – in-reach Methadone support twice weekly, alcohol support worker once a week	Psychologists from PIE see some clients 1:1, but more importantly give project staff support and direction regarding how to manage clients		
Psychology support provided. Can be 1:1 – however Psychologists have limited capacity, and it takes time to build up relationships. Has been fairly limited.	Both clinical services on EMIS Web, and on site access to both records although no formal sharing agreement in place to allow on screen sharing at present. This is being looked into.		
Case meeting fortnightly	HICP team now has access to hospital EPR from office		
Steering group meeting quarterly			
Commenced operation – Jan 2009 (moved location in Jan 2012)			
Funding provided by Lambeth CCG indefinitely			

Case study

Martin 48 – step up

HIV, Hep C, alcohol dependence, previous substance misuse, chronic leg ulcers. Frequent hospital attender. Previous eviction from lower support housing due to neglect. Referred primarily for management of leg ulcers.

Hostel were concerned that client was deteriorating, so referred to HICP. With HICP support has been referred into co-infection, nutrition, orthotics and optician services. Leg ulcers have shown marked improvement, and client medication adherence has also improved. In-house alcohol, substance misuse and psychological teams have worked together to stabilise the clients, who is now attending substance misuse appointments consistently. Has been reconnected with his family in London and Sudan. Health Support Worker has worked in partnership with client keyworker to address personal care issues. Has now been moved to another hostel, with a smaller capacity and less chaotic clients, and is doing well. Time on caseload 14 weeks.

Pathway to Home (P2H) Camden

Contact Emma Thomson – Project Manager emma.thomson@uclh.nhs.uk

OPERATIONAL ASPECTS	STRENGTHS	WEAKNESSES	KEY OUTCOMES
Within a 32 bedded hostel	Set in hostel with an excellent track record of dealing with clients with complex needs	Unable to take patients with significant mobility issues as stairs up to reception, and down to dining rooms	April – December 2015 – 20 patients benefited from the @home service, saving 136 bed days. An additional 15 patients have benefited in the later months using the project for B&B support only, saving an additional 85 bed days. Interestingly (due to the short stays) this has still only resulted in 42% bed occupancy of the 2 beds overall.
2 beds allocated on a block purchase base (access to further 2 beds if necessary)	Can take people without a local connection	Admission not controlled by Pathway. In fact admission objectives have been a point of difficulty. @home team provides clinical support to discharge patients early, and thus reduce bed days. Homeless patient often aren't suitable for early discharge, and the type of support required on discharge is often of a convalescent / support variety rather than the intensive clinical support that can be provided by the @ home team. Thus patients who might normally benefit from medical respite type projects were not originally eligible under the initial terms of the project (although the criteria has since been relaxed – see KPIs). As the project has progressed some 'B&B patients' have been taken, increasing the occupancy rates.	It is estimated that a further 20 patients could have benefited from the project during this time but didn't, either due to blocks at the time that have now been resolved (Methadone provision / not using beds for B&B), or other blocks that are not currently resolvable (access issues / Consultant not signed up), or a combination of factors. An extra 59 bed days could have been saved for these patients, with bed occupancy rising to 53%. (Notably 8 were related to Methadone provision only, emphasising the importance of this provision).
Only open to patients admitted to UCLH	Very close to hospital with allows direct link to Pathway team	In line with the above this project has been short stay only – average stay of 6.9 days – as previously stated not really a recovery based model, much more focused on reducing bed days. Range 2-21 days so far.	Most admissions so far have been medication support and dressings. TB medication support x3.
Step down only	Patients continue with Pathway team support whilst in hostel	Not aimed at very unwell clients either, as no onsite support	KPIs: LOS 5.1 days Occupancy 80% Hospital has not set a housing outcome
Have to be eligible for the UCLH@home service – NRPF and people without local connection are included (because Consultants retain responsibility)	Can take Methadone patients (dispensing issue resolved – inpatient team takes FP10 directly to dispensing pharmacy, patients do daily pick-up)	Admission is also currently limited by the fact that some speciality teams do not refer to the @home team. Relationship not yet formalised.	Qtrly report – health outcomes and housing outcomes reported
0.2 wte support from 8a NHS manager	Now also taking B&B patients (potentially people being discharged to early)	Not able to take step-up patients	
Hostel staff	Length of stay pre-set by Consultant and @home team		
Clinical care provided by @home service on as required basis	Patients can access support services in hostel if required		
Medical support provided by Consultants – remote – liaison via @home team			
Housing support / case management provided by Pathway team			
Target length of stay - 5 days			
Out of hours support – @home team works 7/7			
Referral via UCLH Pathway – weekly case meeting in which clients would be discussed. UCLH@home are also a private contractor and do their own case finding			
Project Board meeting every 2 months			
Commenced operation – March 2015			
Funding provided by DH Hospital Discharge Fund Grant plus small amount from GLA. Money estimated to last until April 2016. Project is currently in pilot phase. Hospital Finance Directors are aware of project, and will be informed of pilot findings.			

Case study

Marek 46 – step down from UCLH

Alcohol dependence, brain injury, frequent attender, no recourse to public funds.

Had already agreed to return to Poland, but was awaiting Home Office paperwork, and no repatriation bed was available on the discharge day. Was then initially discharged by the hospital with no support to await repatriation bed. Was later found sleeping in a car park in Roehampton, confused, and had to be encouraged to return.

Was subsequently put into Pathway to Home bed for 5 days, with UCLH@home support twice a day to help him understand his medication / treatment plan. This helped him stabilise outside the hospital environment. Was then transferred to the repatriation bed prior to a supported reconnection to Poland that happened 1 week later.

St Mungos Broadway Hospital Discharge Network (HDN) Camden and Hackney

Elin Jones - Service Manager (left in November 2015) Contact Andrew Casey - Director of Health – Andrew.casey@mungos.org

OPERATIONAL ASPECTS	STRENGTHS	WEAKNESSES	KEY OUTCOMES
CAMDEN			
Set within 40 bedded hostel	Staff are on-site all the time, and have a small caseload so can build very close relationships	HDN team office is at back of hostel – less visibility to clients	KPIs: 1 Reduction in number of people discharged from hospital without accommodation 2 Reduction in use of emergency hospital care by homeless population (each individual is measured, looking at A&E attendance in 3 months prior, and during time on the project) 3 Increase in planned and routine health care during stay at HDN 4 Clients will be engaged with community / statutory services
Access managed by Camden Pathway	Psychotherapy input is a very valuable part of the model	Clients get 'lost' in hostel environment as they are dispersed amongst usual hostel residents, and are thus harder to access	
6 beds	Project dedicated clinical management support	Overall less engagement from clients as a result	Running at essentially 100% occupancy
Registered with CQC for screening, diagnostics, treatment	Hostel has disabled access rooms with appropriate equipment	Health messages are lost	Average LOS in excess of 12 weeks. Average LOS in hospital prior to admission 8.6 weeks. Average referral to admission was 17 days in past 2 quarters underlining complexity.
12 week stay – often longer (some difficulties with move on)	Hostel has some ownership of the project	Clients not previously familiar with hostel environments might not suit this environment	Past 2 quarters – 14 clients, 13 with substance misuse issues, 4 on Methadone.
Step down and step up	Environment familiar to clients	No shared record with Camden Health Improvement practice	Physical conditions - Chronic liver disease, DVTs, leg ulcers / other wounds, COPD, diabetes, HIV, stroke, hypertension, fits, Most clients have at least 3 diagnoses.
1wte nurse 1wte health support worker Psychotherapy input ad hoc 0.2 wte from 8a nurse manager	Some support with move on from hostel staff (although most of this work is done by clinical staff)	Problems with move on – lots of verbal and e-mail communication needed	Mental health – ADHD, personality disorder, schizophrenia, bipolar, depression, anxiety.
Out of hours support – district nurses (generally works well)	Hostel assist with behavioural contracts etc	Sometimes feels as if there are limited move on options to work towards	
Nursing care Engagement with relevant health services e.g. GPs, addictions, mental health Escorting to appointments Encouragement to engage with hostel groups			
Medical support provided by Camden Health Improvement Practice on outreach when – HDN clients only, 2 x 3 hour sessions – could be reduced			
Commenced operation – June 2014			
Initially funded by the DH Hospital Discharge Fund. Funding provided by Camden CCG for 3 years			

Case studies

Danny 47 – hostel transfer after acute hospital admission

Surgery to femoral artery secondary to groin injecting. Surgical wound. Prior hostel felt that he had too high support needs on discharge. Intravenous drug user. 5 A&E attendances and 5 admissions in the 3 months prior to admission.

Wounds did not get infected, and healed completely during stay. Was linked into relevant services e.g. GP, substance misuse service, and probation and started to engage with them. Was supported to apply for PIP / other benefits. During admission reduced injecting drugs in favour of smoking, although was not willing to go on to maintenance. Considerable time was spent on harm reduction work, with a focus on images rather than written leaflet information, which was found to have more impact. During 3/12 admission did not attend A&E or get admitted. Was moved on appropriately.

James 38 – step up (local connection case proved by HDN team, was rough sleeping with serious medical issues)

Infected pins from past fractured hip with osteomyelitis. Dependent on crutches. Orthopaedic team unwilling to treat further while not in stable accommodation. Alcoholism, intravenous drug use, Hepatitis C, syphilis (diagnosed just prior to admission). Came to Camden after experiencing violence and threats related to substance misuse relationships elsewhere, and felt it was unsafe to return (case accepted by Camden after advocacy). Rough sleeping for 3/12 prior to admission.

Within 2 weeks of admission halved alcohol intake, and significantly reduced injected. Engaged well with substance misuse services, and commenced on substitute prescribing. Completed syphilis treatment. Re-engaged with Orthopaedics. Wound healed with regular dressings. Engaged with liver services including discussions re Hep C treatment. Given full set of vaccinations. Engaged with probation services during stay. Was stepped down within hostel.

St Mungos Broadway Hospital Discharge Network (HDN) Camden and Hackney

Elin Jones - Service Manager (left in November 2015) Contact Andrew Casey - Director of Health – Andrew.casey@mungos.org

OPERATIONAL ASPECTS	STRENGTHS	WEAKNESSES	KEY OUTCOMES
HACKNEY			
Separate floor of 40 bedded hostel with restricted access Access managed by Hackney 8 beds Registered with CQC for screening, diagnostics, treatment Step up and step down referrals – hospital referrals mainly from the Homerton, although also Royal London and UCLH 1wte nurse 1wte health support worker 1 wte assistant support worker Psychotherapy input ad hoc 1:1 and support to staff around behavioural issues Hostel worker overnight Support from 8a nurse manager Nursing care Engagement with relevant health services e.g. GPs, addictions, mental health Escorting to appointments Encouragement to engage with hostel groups 2 weekly Housing Worker in-reach from Housing Options 2 weekly involvement in housing panel meeting Medical support provided by Greenhouse Practice – relationship building, no wait, Commenced operation – June 2014 Initially funded by the DH Hospital Discharge Fund. Funding provided by Hackney CCG until April 2016.	Staff team visible Admission criteria allows more versatility – clients have to been seen rough sleeping in Hackney, but do not have to have a demonstrable housing connection Nature of environment and larger team allows higher support need clients Easier to take non hostel based clients Robust move-on procedures Greenhouse practice next door, good relationship. Nurse able to access EMIS at Greenhouse via data sharing agreement – good clinical outcomes	Project still set within hostel, so some mixing of clients with mainstream hostel residents Less ownership from hostel / less support from hostel staff overall Triple documentation in order to communicate with hostel and practice – EMIS Web link in hostel promised, but hasn't occurred Nurse and support workers quite isolated from rest of hostel staff team	KPIs: 1 Reduction in number of people discharged from hospital without accommodation 2 Reduction in use of emergency hospital care by homeless population (each individual is measured, looking at A&E attendance in 3 months prior, and during time on the project) 3 Increase in planned and routine health care during stay at HDN 4 Clients will be engaged with community / statutory services Reporting sheet covers a number of markers of the above KPIs Running at about 80 - 90% occupancy Average length of stay 2015-2016 Q1 - 10.4 weeks, Q2 – 12.4 weeks. During Qtr 1 and 2 – 13 clients, 12 with substance misuse issues, 6 on Methadone. Physical conditions - Chronic liver disease, DVTs, leg ulcers / other wounds, COPD, diabetes, HIV, cancer, anaemia, acquired brain injury, fits, renal failure. Most clients have at least 3 diagnoses. Mental health – personality disorder, depression, anxiety.

St Mungos also previously ran similar projects in Westminster and Lewisham that have now closed, and these projects are discussed below.

Case studies

Mary 33 – 'remote admission' – case worked, but never actually came to unit

Emotionally unstable personality disorder, poly substance misuse. Under the care of a Hackney CMHT. Binge drinker, serious suicide attempts (e.g. resulting in fractured vertebrae), eating disorder, acute pancreatitis (requiring ITU intervention). Recently admitted to women's hostel from the streets, but episodes of incontinence, alcohol related collapse, and LAS call outs were making this challenging. Multiple A&E attendances and admissions.

Team assessed and did referral to the Hackney Substance Misuse Team for residential detox. They initially refused as the client had not been previously engaged with services. The team pressed on and did Adult Safeguarding and Social Care referrals, and eventually a re-referral to the Hackney Substance Misuse team. Mary went from hospital to detox to rehab.

Steve 60 – step up / step down (referred by both Homerton and Hackney outreach team)

Alcoholism, acquired brain injury, reduced capacity, self neglect, occasional incontinence. Multiple frequent attender. Frequent minor offences.

Client was deteriorating on streets prior to intervention. Now has carer, has been linked into memory clinic, has had medication monitored. Has been linked into dentist, optician and podiatry. Now has a 'routine', and is engaging with hostel groups. Has been referred to supported housing through Hackney Social Services. Significant reduction in A&E attendance.

Lewisham and Westminstar HDN projects - now closed

St Mungos Broadway had pilot HDN projects in Lewisham and Westminster which did not receive ongoing funding.

A brief summary of the two projects, and the associated learning, is presented below.

Lewisham
Ran from June 2014 - November 2014

OPERATIONAL ASPECTS & OUTCOMES

- 10 beds within an existing homeless hostel – rooms renovated with electronic beds and medication cabinets. (However on the first floor and lift was not working a lot of the time.)
- Admission required processing through Lewisham SHIP
- Local GP provided GP input
- 13 clients were referred, 6 were accepted, average stay was 9.8 weeks (range 2.9 weeks to 13.6 weeks)
- 5 out of 6 clients had tri-morbidity. All had substance misuse.
- 3 clients were stepped down in the hostel, 2 went into supported accommodation, 1 was evicted from hostel due to challenging behaviour towards other clients.

COMMENTS

- There were no hospital readmissions when clients were admitted to the project, and there was a reduction in A&E attendance for individual clients whilst they were on the project, which was very positive
- There were not enough referrals to fill the 10 beds, however there was limited time for project to embed, market, partner etc. Lewisham SHIP paperwork was required for those not already in Lewisham pathway – this took a long time to process, and was a problem for any shorter stays that were proposed
- Several referred clients had mobility issues, and therefore the lift not working reliably was a problem
- Project was unable to take those without a local connection or those without recourse to public funds, and this also limited referrals
- There were too many beds given the limits to the referrals

Westminster
Ran from June 2014 - March 2015

OPERATIONAL ASPECTS & OUTCOMES

- 10 beds within an existing homeless hostel – rooms were renovated with electronic beds and medication cabinets.
- Admission process required processing through Westminster rough sleeper pathway
- Local GP provided GP input
- 14 clients were referred, 9 were admitted, average stay was 8 weeks (range 2 weeks to 12.8 weeks)
- Sources of referral: St Thomas, St Marys, UCLH, Royal London
- 1 patient was not admitted as wheelchair bound (hostel not suitable), 3 had too high care needs and went on to residential care, 1 client decided not to accept the service.
- Referrals were generally assessed within 2 days. Median length of time from assessment to admission was 3 days, and average was 4, but one client was delayed for 3 weeks. Delays in admission were generally due to organising Methadone scripts, getting care packages in place and/or getting admission approval from the GP.
- 5/9 were on Methadone (8/9 had a history of intravenous drug use), 7/9 had tri-morbidity
- Average length of hospital admission was 5 weeks
- Of the 6 clients leaving accommodation at the time of the report (mid-March) 2 clients had gone on to detox and rehab. 1 client had been readmitted, but the gone straight to rehab. 1 client went on to a complex needs hostel, another into supported accommodation. 1 client was evicted due to violent and aggressive behaviour towards staff.

COMMENTS

- Good outcomes were achieved for nearly all the clients on discharge
- Many clients being referred in had behavioural issues and/or very complex needs and had limited move-on options though – ? the project was plugging the gap of a more long term issue, and the project was sometimes unable to take clients because of this
- Step up referrals were not allowed, and this reduced potential referrals
- All referrals had to be reviewed by the GP – this delayed response time. It was also felt that a specialist GP practice might have been more beneficial.
- Westminster rough sleeper and hostel paperwork was also needed – this contributed to a long processing time
- The project did not have time to embed, market, or partner
- Overall it appeared there were too many beds given the referral criteria

Lewisham and Westminster HDN projects

Learning points from the final evaluation reports:

- Step up as well as step down should be considered
- Wheelchair accessible accommodation is needed
- Short stays are rendered very difficult if access to beds is managed by housing
- Ideally a formal needs analysis should be undertaken before expanding / developing new services
- Pilot services need time to embed before they are evaluated
- The clients being referred are often quite high risk – any project needs a robust risk management strategy, and clear policies on managing difficult behaviour, and ultimately evictions
- Chaos index / measure of engagement – it would be useful to have a measure of engagement as an outcome measure of medical respite type stays, as increased engagement is a key outcome we are trying to achieve
- Non-NHS services suffer from lack of outcome data / experience problems with sharing clinical data
- Follow up post discharge – it would be useful to follow-up clients to see if outcomes are sustained post discharge
- Case conferences make a big difference – case conferences are pivotal in moving complex clients on
- 12 week stays for Hep C treatment might be a potential good use for these types of beds in the future

Westminster Integrated Care Network for Homeless Health

Maxine Radcliffe – Service Lead - m.radcliffe@nhs.net

OPERATIONAL ASPECTS	STRENGTHS	WEAKNESSES	KEY OUTCOMES
Up to ten bed spaces (where voids are available) in hostels across Westminster for patients with physical health needs. Plus the block purchase of two beds for patients with mental health needs.	Assessment is rapid – no need to go through standard hospital paperwork	Project is only operable if Westminster hostels are able to run voids	EQ5D improvement – patient perception of health at entrance midpoint and exit of pathway
Access managed by Referrals Coordinator. Clients have to be registered at the Dr Hickey Practice, Great Chapel Street, any other Westminster GP, be a client of the JHT, or be rough sleeping in Westminster.	Assessment paperwork can be taken into hospital by assessor using laptop and dongle and immediately downloaded onto clinical system	Difficulties managing under 25s (this is actually true of all the projects, but this was mentioned specifically due to a lack of specific housing provision for this group in Westminster)	Clinically assessed improvement in health: each admission linked a health goal that the admission aims to achieve. Achievement measured as a) full, b) partial or c) not achieved
1wte project manager Band 5 2wte housing support workers (Band 4 equivalent) Clinical input from practices Some additional nursing input – around 0.5wte nurse at Dr Hickey and Great Chapel Street 0.1wte support from 8a nurse manager (no additional funding)	Behavioural agreement is signed by each patient on entry to the service	Clients spread over dispersed area, which uses valuable staff time on travel and results in significant travel expenses incurred by both staff and patients.	Discharge destination: aim for successful 'move on' for patients to a) alternative accommodation, b) duty accepted by housing option, or c) duty of care successfully transferred to other suitable organisation.
Out of hours/ outreach support from practices	Project is run with Business Manager and Housing Workers x2 – all clinical input provided by existing staff	As integrated into wider service (with little 'protected time' for staff) there are intense pressures on staff	***Initial outcomes – first 10 weeks:***
Partnership with existing Groundswell contract	Clinical manager is also a commissioner – therefore issues over community service provision may be much easier to unblock if these occur		38 referrals, 22 taken on (32 referrals for step-up and 6 step-down)
Monthly referrals / MDT meeting with all partners in attendance	Project brings together physical and mental health in the borough. Monthly MDT brings together the combined expertise of the Dr Hickey and Great Chapel Street practices (including the GPs and Psychiatrists), the Westminster Homeless Health team, the JHT manager and has inpatient homeless team input. Clinical review is very thorough. Clinical notes are drafted in the meeting and minutes are taken.		100% were rough sleeping prior to admission
Project provides nursing care, supports engagement with relevant health services e.g. GPs, addictions, mental health, and facilitates successful move-on. Groundswell support is facilitated as necessary. Medical input from existing practice Doctors. Hourly rate incentive available for Medical outreach.	All non-clinical workers have access to clinical system via honorary contract		12 discharged so far - 100% success rate of fulfilling the health goal plus successful move on. No patient has yet been discharged back to the streets.
Funding provided by Westminster CCG	Clinical support is provided as extension of main stream service		Project has brought together formerly unconnected homeless care services in the borough, forming a unique network that facilitates closer partnerships and better information sharing generally,
OOH support by District Nurses	Supporting patients with temporary B&B occupancy is available within funding envelope if no other suitable option exists. Also some contingency to provide subsistence where destitute		***Project is unique in the UK so far in that it accepts step-down from both physical and mental health hospitals, and step-up from both physical health care primary care settings and the Mental Health Specialist Outreach team. So far this has been successful, and beneficial to patients and professionals on both sides.***
Hours of operation Mon – Fri 9-5pm			

Case studies

Mark 47 – step up

Alcoholism, cerebellar atrophy, decrease in mobility. Recent need for zimmer. Frequent attender.

4 week admission enabled access to OT, physio, escorting to appointments, further blood tests, referral to Social care, 2 week wait referral for anaemia. Has now been stepped down with appropriate facilities in place, team is still negotiating with Social Care over future plan. Previous frequent attender, revolving door has now stopped.

Marek 38 – step up

Penetrating injury resulting in long term colostomy. Was discharged to the streets, and readmitted once before being admitted to project. Polish, no recourse, limited English, does not want to return to Poland, possibly due to shame/guilt related to perceived current circumstances.

On 6 week admission at time of report. Needs daily dressings / medication. Compliant with instructions to visit for dressings, as long as time is taken to explain. Staff are working on entitlements and reconnection options. Admission is allowing wound to heal, avoiding readmission, and allowing relationship building.

Anna – 46 step down from MH admission

Client with psychosis with morbidly obese, and hypertension

Admission allowed review of current physical problems, and a focus on quality care. Things that would often get missed for homeless mental health patients were enabled – sleep apnoea referral, exercise referral, pain review, nutritional advice, stockings, and referral for a pressure relieving bed.

Bradford Respite and Integrated Care and Support Service (BRICSS), Bradford

Contact: Gina Rowlands – Managing Director Bevan Healthcare – gina.rowlands@bradford.nhs.uk

OPERATIONAL ASPECTS	STRENGTHS	WEAKNESSES	KEY OUTCOMES
Stand-alone 14-bedded intermediate care facility for clients who are homeless or with inadequate housing and who have short-term healthcare needs, on discharge from hospitals.	Integrated care between Horton Housing Association and Bevan Healthcare – specialist homeless practice also providing the Pathway hospital in-reach.	Longer stay than some medical respite models. Appears to have evolved into a longer stay, temporary placement.	Average length of stay during initial evaluation 10 weeks. Most clients show reduced hospital admissions and improved housing outcomes.
Converted with money from DH capital grant (previously student accommodation)	Does not require eligibility for housing benefit for admission – as supported by CCG funding.	Service rarely has capacity to take brief short term admissions of patients with lower levels of support need, who are blocking beds while waiting for temporary accommodation.	Discharge analysis showed all clients had improved housing, benefits, primary care access, social support and ongoing support.
The Pathway Team is based in Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) and manages admission, and clinically supports the project.	Very active case management provided by Horton housing staff.	All admitted patients have significant health problems as primary characteristic. However still very valued in this role by commissioners and providers.	Independent evaluation by York Health Economics Consortium showed a high level of service user satisfaction with the service, and positive feedback from staff and stakeholders.
Staff members are on site 24 hours per day, 7 days a week. Staff members are from health, social care, and housing. Health care staff also work with the Pathway Team.	Collaborative approach to commissioning and funding between Public Health, Local Authority and CCG.		A benefit was identified of £2-4 for each £1 invested in the scheme. However one client had stay of several months for end of life care.
Support is available throughout the day, the service then has warden cover from 5 pm each night through to 9 am the next morning.	Service has won awards for health innovation and housing innovation.		After service embedded length of stay increased. Later data shows 31 discharges over 15 months, with median duration of stay of 60-90 days & 70% staying 90 days or less. 20% abandoned or evicted.
	Sharing existing Pathway, Bevan and Horton staff reduces costs of the service.		

Homeless Accommodation Leeds Pathway (HALP), Leeds

Contact: Catherine Hall – Head of Service – catherine.hall@nhs.net

OPERATIONAL ASPECTS	STRENGTHS	WEAKNESSES	KEY OUTCOMES
Hostel based service with 3 intermediate care beds. Hostel has 12 other bed spaces (funded by Supporting People). Service run in partnership with St George's Crypt (SGC) who provide the hostel service food, and support. Existing Pathway team provide oversight. Attached to York Street practice who provide medical and nursing support and the Pathway service. Two Care Navigators support with social needs and to assist in finding permanent accommodation (part of the overall Pathway team)	3 specified beds concentrate on most hard to place Intensive support for the 3 beds which provided useful flexibility and reduced average hospital length of stay for these patients. Pre-existing hostel next door to the hospital.	1 in 3 evicted from HALP bed for behavioural problems - particular challenge is ongoing drug and alcohol abuse.	Average duration of stay in HALP bed around 30 days. The average duration of stay for homeless patients admitted to the HALP project 10 days, compared to 20 days for those not on the HALP Pathway.

Breathing Space, Southampton (now closed)

Contact: Pamela Campbell – Consultant Nurse Homelessness and Health Inequalities – pamelacampbell2@nhs.net

OPERATIONAL ASPECTS

This service was funded short term by DH Homeless Hospital Discharge Fund, but not able to obtain on-going funding, so the service closed. Breathing Space cost £99-£136 per night depending on occupancy rates and whether housing benefit could be claimed. 14 people were helped over the 6 month period. Health support was provided by the homeless healthcare team, on the basis that the majority of patients were registered with this team. When this was not the case most patients were already registered permanently with a local GP. A small number were registered at the homeless practice as temporary residents. An example of the latter group was a homeless man from Kent who wished to return to his own area and GP when he had recovered from his head injury and surgery.

Case study

Vasile 36 – step down

Romanian, originally trafficked, in receipt of benefits, terminal cancer

Was admitted to Breathing Space for last 7 months of life. No friends and family. Was too unwell for mainstream housing without considerable support, and wanted to be in home environment. Care provided was cheaper and more appropriate than hospital, and was actually cheaper and more appropriate than a hospice at the end because the client died 'at home'.

Cost savings to NHS estimated by project:

126 hospital bed days at £500 / night (unclear where they came up with £500 / night) = £63,000

63 days in hospice environment £425 / night = £26,775

Total saving: £89,775 (costs of in-reach primary care were not discounted)

Key learning points from existing projects

- All of the existing projects have demonstrated that A&E attendance and admissions can be reduced in the client population served
- Projects with a high level of integrated planning with the Local Authority have been most successful
- Close links to homeless GP practices seem to be beneficial
- Most of the clients admitted to these projects have tended to been tri-morbid, with high support needs, and often on substitute prescribing (although this may also largely be a feature of the environment in which they are set)
- The projects have been primarily delivering complex case management interventions. Nursing care is not necessarily required for many clients on a daily basis.
- Several managers said that pilot projects need adequate time to embed before being evaluated (? 2-3 years minimum) as they may not have time to prove their worth without this
- Projects delivered in hostels (which are wet-allowing alcohol consumption on the premises) find it difficult to deliver sustained health outcomes for some clients (even though it may be possible to reduce unnecessary secondary care usage whilst the client is being supported by the project)
- Any model requiring housing assessed local connection cannot maximise the potential for usage of beds
- The hospital-managed project has struggled to deliver good bed occupancy, and has met some problems with buy-in from Consultants

Perceived best aspects of the key projects:

Lambeth HICP

- Same clinical team for 6 years – considerable clinical experience in this area. Has also allowed project to embed, and relationships with allied services to develop fully. Team feels that it takes a project like this around 3 years to embed fully.
- Good data collection / flows
- Addictions staff in-reach on site
- Good relationship with addictions social workers
- Psychology input is available for 1:1 work and staff support

Camden HDN

- Has funding for 3 years
- Psychotherapy input available
- Good relationship with district nurses

Hackney HDN

- All beds together, nursing / health support worker station by the beds
- Project sits adjacent to GP practice, making GP access easy at all times
- Short admission time, admission paperwork is light
- Excellent links with housing services within Local Authority, assisting with move-on
- Housing worker from Local Authority comes in 2 weekly to manage move on, and there is involvement in the complex needs panel
- Psychotherapy input available

Pathway 2 Home

- Can take patients who are non-local, or do not have current housing eligibility
- Very close to hospital making it easy for Pathway team to continue with case management

Westminster ICNHH

- Full integration of physical and mental health service
- Very effective MDT meeting
- Attempts to maximise use of existing community services, and challenge issues with service delivery
- Capitalises on voids in hostel system

Bradford BRICCS

- Joint Pathway, GP practice, housing and voluntary sector delivery which has won awards
- Stand-alone unit

Leeds HALP

- Small project allows for intensive support for a few individuals
- Very close to hospital allowing for ease of Pathway team oversight

KHP Data – cohort data and case analyses

The following section provides further detail on the three Trust admitted homeless populations. Firstly there is an attempted analysis of the total admitted cohorts, primarily for the purposes of looking at the client borough connections, eligibility for housing support or recourse to public funds, and whether clients have been discharged to the streets.

Secondly individual client cases have been examined at each site to establish whether they could have been candidates for medical respite, and if so, how many hospital bed days could have been saved. 76 clients were examined in total. When undertaking this analysis some 'categories' of patients were identified, and these categories are presented in the summary.

As data is collected and extracted in different ways at the different sites, the cohorts chosen for each sites are different, and the ways in which cases were selected was also different at the three sites. Although this might have introduced some bias, this was not intentional, but rather a consequence of pragmatic necessity in obtaining the data.

Cohort data – GSTT and Kings

The following table provides an analysis of the admitted cohorts at GSTT and Kings.

Key findings are highlighted in blue.

Table 12: GSTT and Kings Pathway team cohort data

	GSTT		KINGS	
Time period	12 months Oct 2014 – Sept 2015		12 months April 2014 – Mar 2015	
Number of referrals to the team	1110		627	
Number of patients admitted during time period	826		288	
Cohort of patients analysed	265 (all admitted patients that were seen that stayed 5 days or more)		229 (all admitted patients that were seen – unable to extract those staying 5 days or more)	
Average length of stay for this cohort	19.1 days		13.43 days	
Average age	44.4		45.2	
Female	49	18.5%	61	26.8%
NFA / rough sleeping	109	41.1%	87	38.2%
Sofa surfing	29	10.9%	49	21.5%
Being evicted	18	6.8%	14	6.1%
Hostel / supported accommodation / TA	76	28.7%	32	14%
Housed	19	7.2%	35	15.4%
Other / Unknown	14	5.3%	11	4.8%
On CHAIN (London known rough sleeper database)	138	58.2%	50	27.3%
Not on CHAIN	99	41.8%	133	82.7%
Unknown (removed from denominator)	28		45	
Recourse to public funds	224	86.6%	183	84.9%
No recourse to public funds	**30**	**13.4%**	**35**	**15.1%**
Unknown (removed from denominator)	11		10	
Registered with GP	231	88.8%	184	83.6%
Not registered with GP	29	11.2%	36	16.4%
Unknown (removed from denominator)	5		8	
Lambeth	51	19.2%	43	18.7%
Southwark	44	16.6%	69	30.1%
(Sub-total Lambeth and Southwark)	**95**	**35.8%**	**112**	**48.8%**
Lewisham	11	4.2%	21	9.2%
(Sub-total LSL)	**106**	**40.0%**	**133**	**58.3%**
Westminster	49	18.5%	3	1.3%
Other London	57	21.5%	58	25.4%
National	26	9.8%	9	3.9%
International	10	3.7%	2	0.9%
Unknown	17	6.4%	23	10.1%
Discharged NFA	**30**	**11.3%**	**29**	**12.7%**
Discharged insecure / night shelter / sofa surfing	56	21.1%	69	30.2%

Note: In this work 'No Recourse to Public Funds' includes undocumented migrants, patients that have a UKBA restriction on their eligibility, and EEA nationals who have acquired NRPF status by virtue of not exercising their treaty rights (although in most cases it would have been their intention to work when they arrived). We do not include EEA nationals are currently eligible for 3 months Job Seekers Allowance and/or those who are currently able to work.

Cohort data - SLAM

Recent data for SLAM is not yet available, however data was available for the first 6 weeks of the project which suggested a similar trend in borough connection (see overleaf), although a higher percentage overall with a local connection. In fact, as SLaM covers Croydon, the total percentage with a local connection totals 75%. It is unsurprising that there are more local clients in mental health services with a local connection, as admission into specific inpatient mental services is generally determined by GP registration. During this initial period one third of assessed clients had NRPF, but no-one was discharged to the streets..

Table 13: SLaM team first six weeks – Borough connection of discharged patients

	N=77	%
Lambeth	2	8
Southwark	10	42
Lewisham	3	12.5
(Sub-total LSL)	15	62.5
Croydon	3	12.5
International	2	8
Camden	1	4.25
Merton	1	4.25
Epping	1	4.25
Unknown	1	4.25

Case analyses - What type of provision is needed and how many bed days can potentially be saved?

In this section individual client records have been examined to see whether clients could have benefited from medical respite, and if so, how many bed days would have been saved, and what type of environment that would have required. Analysis has also been undertaken to separate out the boroughs the individual clients have come from, and whether they have had recourse to public funds.

Selections of clients were made using sampling strategies, outlined below. Where bed day savings have been identified, they have been multiplied up in line with the sampling strategies where this is relevant, to give a guide of the overall potential savings. 'Saveable' bed days were established by looking at the record, and establishing the point at which the patient was apparently fit for discharge – all days after were then viewed to be saveable.

Sampling strategies were chosen on the basis of the existing data that was available at the 3 Trusts. Unfortunately it was not possible to get permission to directly search the hospital databases themselves within the time constraints of the study, and thus pragmatic decisions had to be made about sampling methods – as a result the readily available data sources were utilised.

GSTT sampling - 34 cases were examined in 3 sets. 10 cases were selected randomly (every 20th patient), the 10 longest stayers were also looked at, and 14 frequent attenders were identified by the team from the 2 frequent attender lists that are maintained by the team.

Kings sampling - 20 clients were examined in 2 sets. 10 cases were randomly selected from 30 cases in total that had been readmitted during the year (every 3rd case). 10 cases were randomly selected from long stayers (every 10th patient down from the longest stayer from 158 stays).

SLaM sampling – 22 clients were selected as likely to benefit from medical respite, from 97 clients seen by the team at that point. This selection of 76 patients thus represents a potential group of people that might be referred into a medical respite, and includes groups of clients with different needs ensuring that those most likely to be referred in have their needs fully considered.

However it is important to acknowledge that the sample is small, and deliberately weighted to consider patients most likely to benefit from medical respite. The data improves our understanding of the needs of these patients, and the potential bed day savings, but can only realistically be tested by a carefully evaluated pilot.

The calculations that were undertaken to provide estimates for the bed day savings and medical respite days required can be found in Appendix 3. Anonymised individual case level data is not provided in this report, but can be viewed on request.

Summary findings from the individual client data

- For the 76 clients as a whole 77.6% were male, and the group had an average age of 46.9 years. 84.2% had a GP on admission, 77.6% had recourse to public funds, and 40.8% were verified rough sleepers.
- Overall 35.5% Lambeth, 26.3% Southwark, 5.3% Lewisham, 9.2% Westminster, 13.2% other London boroughs, 6.6% national, 1.3% international (this patient was returned), 2.6% unknown.
- These clients attended A&E and were admitted at high rates. Overall the 54 clients examined at GSTT and Kings had accrued 472 A&E attendances, and 181 admissions during the year October 2014 – September 2015, with total bed days of 2561 (although it is important to note that the sample deliberately included many long stayers). In the previous year there were 181 A&E attendances, and 55 admissions in the same group. The 22 SLAM clients accrued twelve 136 suite attendances (Police Power to Remove a Person to a Place of Safety under the Mental Health Act 1984), 28 admissions and 1634 bed days, and a further 91 bed and breakfast days. The 14 frequent attenders in this sample had accrued an average of 23.4 A&E attendances, and 9 admissions per person for the year October 2014 - September 2015.
- In terms of their needs of the 76 clients:
    - 81.6% had a physical health problem
    - 76.3% had a mental health problem
    - 60.5% had an addictions problem
    - 32.9% had some sort of mobility problem
    - 77.6% had experienced some sort of delayed discharge
    - 81.6% could have benefited from some sort of step-down
    - 32.9% would have needed ongoing daily nursing care
    - 89.5% would have benefited from ongoing key work support
    - 76.3% had a housing issue that needed resolving
    - 34.2% had a welfare / benefits / eligibility issue that needed work
    - 25% were on some form of substitute prescribing
    - 25% had a complex needs worker / care coordinator already
- The cohort of patients was found not to be homogeneous, with the needs of the sub-groups vary considerably. To help with data analysis it became useful to categorise patients into the following categories.

    A Clients with primarily either physical health care difficulties (sometimes with additional mobility issues) or mental health difficulties who are statutorily homeless, but who would not generally be expected to become part of the rough sleeping population. These clients have often either been evicted (because they haven't been able to cope on account of their health problems), or have been sofa surfing with friends and family who can no longer cope. These clients often don't have substance misuse problems. These clients can often be demonstrated to be in priority need with appropriate advocacy, but are shorter term bed blockers whilst their housing case is argued with the local authority. Their primary need is around housing, although they may also need low level support. **30% of 76 clients.**

    B Clients who are relatively unwell with No Recourse to Public Funds (NRPF) who either a) have care needs or b) don't have care needs. For our purposes this includes undocumented migrants, patients that have a UKBA restriction on their eligibility, and EEA nationals who have acquired NRPF status by virtue of not exercising their treaty rights (mostly unintentionally). Either way these clients are often delayed whilst the legal position is established. These clients often don't have substance misuse problems. It is important to note these clients are often quite unwell e.g. with cancer or later stage HIV, and some might need a high support environment to get them out. They are often severely delayed, so although they only represent a small percentage of clients, they tend to represent a greater percentage of excess bed days. **11% of 76 clients.**

C Clients who have been in the mainstream rough sleeper population who now have chronic care needs and/or cognitive deficits which make them difficult to place due to a lack of appropriate accommodation. These clients have substance misuse problems. These clients need daily support, including with ADLs. These clients often are severely delayed, so although they only represent a small section of clients, they probably represent a greater percentage of excess bed days in this group. **8% of the 76 clients.**

D Chaotic mainstream homeless clients who suffer tri-morbidity, and are often quite unwell from a physical or mental health care point of view, who have had all the services that are currently on offer without great improvement. Some will currently be resident in a hostel, others will be rough sleepers (sometimes despite repeated attempts to get them in). These clients are also often frequent attenders, although they can also be non-engagers. They rarely block bed in the initial phases of the revolving door, as they often refuse admission or self-discharge as soon as they are able. These clients nearly all have substance misuse problems. They often need intense psychological and other support, and considerable advocacy, and they may end up needing end-of-life care type interventions. Within this group there are clients with and without a local connection. Within this group there are also some clients who are ambivalent or pre-contemplative about their substance misuse. **51% of the 76 clients.**

E Chaotic tri-morbid patients wanting to stay dry. Within the above group there are a significant number of patients who have had an unplanned alcohol detox as part of their acute hospital admission, and are expressing a desire to stay dry, and to not return to their hostel. As many of these patients' have had limited or no prior engagement with alcohol services, there is no possibility for them to have an urgent admission to an addictions rehabilitation bed. **These patients appear to need a rapid-access stand-alone dry unit where they can be stabilised and engaged with abstinence support.**

- Across the 3 Trusts an estimated total of 4410.15 bed days could have been saved if medical respite options were available. (See Appendix 3 for calculations: GSTT - 1833.8 + 284 + 318; Kings - 207 + 1273.35; SLAM - 494)
- This is the equivalent of 12.7 medical respite spaces per year, assuming 100% bed occupancy. However the different types of clients articulated above need different types of environment so this has been further split down to:
    - B&B accommodation with low level support - 1895.5 (5.2 spaces per year)
    - Care environment required – 1264.8 (3.5 spaces per year)
    - Hostel with medium support required – 1463.2 (4.0 spaces per year)

Borough level data is available in the results table that follows.

- It was useful to additionally consider how many 'dry' respite beds would be required such provision were available. This accrued to 1123.2 days (3.1 spaces per year)
- If just the local area was considered the equivalent figures for Lambeth and Southwark combined are:
    - B&B accommodation with low level support – 1367.8 (3.7 spaces per year)
    - Care environment required – 322 (0.9 spaces per year)
    - Hostel with medium support required – 1177.2 (3.2 spaces per year)
    - Dry respite beds (if available) – 981.2 (2.7 spaces per year)
- In the case of the hostel with medium support option, it is likely that this requirement would double if step-up, and end-of-life care clients were taken (in the existing projects at least 50% of bed spaces are filled by clients receiving step-up care – that is admitted directly from the community with the aim of avoiding a hospital admission)
- The table below presents a full summary of the medical respite days estimated to be required by the data split by borough and service provision type.

It will be noted from the data that Lambeth is over represented in terms of the number of respite days required. This work is obviously a summary of the actual 76 patients examined where 35.5% were from Lambeth, and a considerable number of those had complex needs. In is also in line with local knowledge which tends to indicate that Lambeth has high local needs in this population. However this finding could also be result of the small sample sizes, where

multiplying findings can introduce considerable bias. Readers may wish to examine the data in detail and form their own opinions.

It will also be noted that a calculation has been made to allow for 80% bed occupancy. This has been done in consideration of the interviews undertaken in the professionals' interview section. It was emphasised repeatedly that 100% bed occupancy would generate a bed blocking scenario, and not allow flow, and 80% was consistently seen as the ideal.

Table 14: Summary of respite requirements by type and borough

	B&B	Care	Hostel, medium support	Dry	Total	Bed spaces annually
Lambeth	1149.6	107.0	768.8	680.8	2025.8	**5.5**
Southwark	217.8	225.0	408.4	300.4	851.2	**2.3**
Westminster		932.8	177.0	100.0	1109.8	**3.0**
Lewisham			14.0		14.0	**0.0**
Other London	528.1		74.0	42.0	602.1	**1.6**
National			21.0		21.0	**0.1**
Total	1895.5	1264.8	1463.2	1123.2	4623.5	**12.7**
Bed spaces annually	**5.2**	**3.5**	**4.0**	**3.1**	**12.7**	
Including step-up (x2 for wet hostel beds)			**8.0**		**16.7**	
Allowing for 80% bed occupancy	**6.5**	**4.3**	**10.0**	**3.8**	**20.8**	
Lambeth and Southwark	1367.4	332.0	1177.2	981.2	2876.6	**7.9**
Bed spaces annually	**3.7**	**0.9**	**3.2**	**2.7**	**7.9**	
Including step-up (x2 for wet hostel beds)			**6.4**		**11.1**	
Allowing for 80% bed occupancy	**4.7**	**1.1**	**8.0**	**3.4**	**13.9**	

- As such the final estimate to cover all patients combined is: B&B 6.5 bed spaces per year, Care environment 4.3 bed spaces per year, Medium Support (Wet) 10.0 bed spaces per year, Dry provision 3.8 spaces per year. If the Dry provision were provided, this would take the need for the provision of Medium Support (Wet) down to 6.2 spaces per year.
- For Lambeth / Southwark patients only the final estimates are: B&B 4.7 bed spaces per year, Care environment 1.1 bed spaces per year, Medium Support (Wet) 8 bed spaces per year, Dry provision 3.4 spaces per year. If the Dry provision were provided, this would take the need for the provision of Medium Support (Wet) down to 4.6 spaces per year.

Case studies

Outlined below are 18 brief case studies that the Pathway and Heath Inclusion Teams put forward as potential case studies of those needing respite when asked. They include step-up, step-down, end-of-life, and rehabilitation and TB cases. More information about the nature of these client cases is available if required.

Key thoughts on the case studies put forward:

- Several of the mental health cases put forward ended up in mainstream homeless hostels indicating there is clear potential to manage some mental health and physical health discharges together
- Several clients in the case studies had died – indicating professionals felt that medical respite might have avoided deaths
- Most clients suffered from alcoholism although they had differing support needs
- Several clients would have benefited from a dry environment after hospitalisation
- End of life and TB management were particular issues highlighted by these case studies which were not revealed in the rest of the data analysis

STEP DOWN CASES (NEEDING MEDICAL RESPITE ON HOSPITAL DISCHARGE)

Case 1

Male 46 (GSTT)

Alcoholism, alcohol related dementia, head injuries, pancreatitis, ex IVDU. Cognitive deficit. Uses wheelchair due to neuropathy.

39 A&E attendances, 14 admissions and 52 bed days over 2 years. Also a pan London frequent attender. Currently living in homeless hostel, but may need a care environment in the 'not-to-distant' future. No current intention to stop drinking. Has high support needs. Respite would be to maximise benefit of hospital admission, undertake intensive harm reduction work, and re-examine support packages available / review existing assessments.

Case 2

Male 48 (GSTT)

Alcoholism, ex-IVDU, Hep C, Methadone, pancreatitis, DVTs, infections, type 2 diabetes, hypertension.

Living in homeless hostel. 5 A&E attendances, 4 admissions, 47 bed days over last 2 years. During the first of these admissions he was in ITU, and was contemplating stopping drinking. Funding was potentially available, but the assessment process needed time to complete, and he was discharged from hospital to release the bed. He was also fully detoxed during the second admission with a similar outcome. Respite in either case would have potentially allowed for a stop-gap before returning to the hostel, and intensive input to see if he could stay dry. A dry environment would have been needed. However if he was not prepared to go to a dry environment, a hostel based respite would have been relevant to manage his medications, maximise his health status, undertake intensive harm reduction work, and avoid readmission.

Case 3

Male 38 (GSTT)

Alcoholism, ex-IVDU, HIV, bowel resection, stoma, leg ulcers, clots (DVTS), endocarditis. Personality disorder, previous psychosis, suicide attempts.

Previously street homeless, with a history of multiple moves and abandonment. 20 A&E attendances, 13 admissions and 110 bed days over the past 2 years. Moved into existing Borough specific hostel-based respite from hospital after a number of admissions. At this point wanted to stop drinking, and his respite GP stated 'there was a glimmer of serious hope'. However he was anxious about contact with other drinkers in the hostels, even asking for an escort when going out to get Methadone. Eventually he started drinking and disengaged from staff. A dry environment would have been needed. Before he abandoned some progress was made with his medication concordance, and with harm reduction demonstrating some benefit from hostel based respite.

Case 4

Male 63 (Kings)

Alcoholism, hyponatraemia, upper GI bleed.

Homeless as was not coping with depression and alcoholism – had been evicted. Admitted 3 times in quick succession, 18 bed days. Only seen by Pathway team on second admission. On second admission was sofa surfing, but was vulnerable, but was discharged to sofa surfing despite the casework being done to secure a supported accommodation space. He was then readmitted from the street after the sofa surfing option broke down. If admitted to respite whilst housing was sorted out, the next admission would have been avoided. Was given place in homeless hostel after discussion with local authority. Hostel based respite would have been appropriate.

Case 5

Female 42 (Kings)

Alcoholism, cirrhosis, umbilical hernia, asthma, mobility issues.

Threatened with eviction. Alcoholism, worsened after death of mother. Isolated, previous Alcohol Assessment Unit brief admissions. Failing to cope, and rented accommodation in very poor state – no heating, or hot water, and kitchen in state of disrepair. However wanting to return to independent living, and not drinking for several months after 'end stage' diagnosis given (and still dry on admission). Bed blocking issues occurred whilst accommodation was being sorted (issues of responsibility were being argued). Could have gone into respite while accommodation sorted, and been linked in with appropriate low level mental health support at the same time. Either low support B&B, or medium support dry environment would have been appropriate.

Case 6

Male 29 (Kings)

Alcoholism, anaemia, emotionally unstable personality disorder.

Recent rough sleeper after history of difficult relationships and behaviour. Ended up in Kings with physical problems secondary to alcohol. Initial decision of local authority 'not priority need'. Further investigation revealed history of 22 psychiatric liaison attendances, 7 x 136 admissions, 5 mental health admissions, 2 rejections from community teams, and previous frequent attendance at St Thomas during prior 5 years. Either low support B&B, hostel, or medium support dry environment might have been appropriate whilst supported accommodation case was argued, and client was engaged with appropriate services.

Case 7

Male 48 (SLaM)

Psychosis, past history of heavy drinking.

Had been living in supported accommodation, but abandoned this as unhappy with the other tenants. Since then had been sleeping out for 3 weeks with other rough sleepers. Was not alcohol dependent. Was 'home treatable' but had nowhere to be home treated. Housing case was resolved by Pathway team, and spent last week in B&B whilst waiting for low level supported housing. Could potentially have gone to respite for whole admission which lasted 49 days, and had no change in treatment for last 28 days. Could potentially have gone to low support B&B with home treatment.

Case 8

Male 52 (SLaM)

Psychosis.

8 year history of rough sleeping, and not engaging with services, had long admission to Maudsley. Long process to establish identity and eligibility. Case was then taken to complex needs panel, after which there was a wait for the supported accommodation place, but went into mainstream homeless hostel. Was completely fit for around 45 days. Could have been admitted to hostel based respite awaiting placement, with possible enhanced mental health support initially to smooth transition to discharge.

Case 9

Male 46 (SLaM)

Psychosis ex IVDU, Hep C, Methadone, prior alcoholism.

Prior to admission been evicted from accommodation, and had been rough sleeping for 3 days. Was accepted for supported accommodation, but spent 21 days in B&B waiting for placement. There was a break in Methadone treatment when transferred to B&B. Respite would have been a more suitable environment, and would have allowed for mental health and addictions harm reduction work in the community.

Case 10 **Male 25 (SLaM)**

Psychosis, history of cannabis use.

Went into temporary accommodation after first admission, but abandoned this, and was re-admitted. After second admission went into homeless hostel, after period of sofa surfing. Admission to respite might have provided appropriate support during transition, and would probably have avoided readmission. A need for supported discharge seems to be a recurrent theme in homeless mental health admissions.

STEP-UP CASES (DIRECT ADMISSION FROM THE COMMUNITY TO PREVENT HOSPITAL ADMISSION)

Case 11 **Male 57 (HIT team hostel client)**

Alcohol related liver disease, diabetes, pancreatitis, Hep B and C, type 2 diabetes.

Hostel client. Engaged with community health team around his health and outpatient appointments, but would have benefited from extra health support (e.g. with medications) on a daily basis. Health deteriorated over long period, but did not want to be admitted to hospital. Eventually collapsed outside hostel and refused to go in, died the following day.

Case 12 **Female 28 (HIT team hostel client)**

Alcoholism, IVDU, Hep C, DVTs, renal failure, asthma, anaemia.

Hostel client, although history of frequent abandonment. Avoided hospital for a long time while health deteriorated, and self-discharged several times when became unwell. Chaotic client, with complex needs worker. If the early stages of health deterioration had been managed better, acute renal failure might have been avoided. However it is important to note this would have needed quite intensive clinical and social support - higher than the levels that are currently available in the existing medical respite projects.

END OF LIFE CARE CASES

Case 13 **Female 29 (HIT team hostel client)**

Alcoholism, IVDU, acute hepatitis, encephalopathy, varices, diabetes, frequent sepsis. Depression.

In hostel after long period of rough sleeping. Frequent attendance since 2012, with multiple self-discharges. Complicated relationship with partner. Did not like staying in hospital. Accrued 31 A&E attendances and 14 admissions in 2 years across GSTT and Kings, but longest admission only 9 days. Essentially palliative without reduction in alcohol. Admission would have been to stabilise and access physical health and addictions treatment in negotiation with both of them. Both a hostel based respite, and a dry environment might be relevant. If the couple could be admitted together this might be more successful.

Case 14 **Female 34 (HIT team hostel client)**

Alcoholism, IVDU, acute renal failure, septic bowel, stoma. Hep C, anaemia, leg ulcers, self-neglect (e.g. frequent head lice). Had partner and dog, lived in hostel.

In hostel over long period. Very chaotic, intensely disliked being in hospital, but was happy in hostel with partner. Self-discharged from ITU on numerous occasions. Was in contact with family, and wanted to return to them. Had pain team input, but hospice not considered as was felt to be not palliative (i.e. palliatve care felt that she would not have been 'end of life' without her chaotic behaviour). Social workers did not assess until very late, as referral was bouncing between hospital and hostel. Hostel staff had to cope with client's pain, mobility, and difficulties with eating. Hostel based respite would have been relevant on several occasions, although quite high support would have been required. Died in hostel.

REHABILITATION CASES

Case 15 **Male 46 (HIT team hostel client)**

Alcoholism, IVDU. Insulin dependent diabetes, Hep C, DVTs. L above knee amputation, dressings, wrist drop.

Living in hostel. 89 bed days at Kings in 2014-2015. Attendances to A&E started in 2013, but not admitted (except an EMU stay), until the hospital stay in which an amputation was required. Admission to medical respite as step-up might have avoided above-knee amputation, and provided physical rehabilitation support. Admission to respite post amputation might have avoided re-admission, and did not go into formal physical rehabilitation despite this being suggested. Still has ongoing nursing needs. Lack of support led to a pressure area, which could have been avoided with physical rehabilitation input.

Case 16 **Male 45 (HIT team client seen in day centres)**

Alcoholism, IVDU, on and off substitute prescribing. Hep C, fits, self-neglect (e.g. frequent head lice). Brain injury, cognitive deficit. Lost partner to alcoholic liver disease. Depression.

Alternating between rough sleeping and supported housing. Easy to engage although relatively chaotic. Poor compliance with medications without support. Struggled to absorb information. Was considered for neurological rehabilitation. Frequent hospital admissions mainly secondary to fits, and alcoholic collapse. Sudden death in hostel after presumed fit. Admission to hostel based respite or a dry environment for community neurological rehabilitation might have avoided this death.

TB CASES

Case 17 **Male 43 (Kings)**

HIV - CD4 count 127. TB - isoniazid resistance, smear positive, previously treated 2011, and non-compliant then. Also Hep B.

Client with low educational attainment, never went to school, lack of understanding was contributing to compliance issues. Complicated immigration issues secondary to split in his relationship, no recourse to public funds. Essentially self-caring from an ADL point of view. 135 bed days at Kings in 2014-2015. Went to Olallo project (special project for NRPF patients with TB), but would have benefited from intensive work in medical respite to work on compliance issues. Could have been discharged earlier, and further admissions avoided. A potential saving of 93 hospital bed days was identified, with a better outcome.

Case 18 **Male 34 (Kings)**

New TB. Also had tapeworm.

Initial issues with medication compliance. Indefinite leave to remain, had worked in UK. Recourse to public funds, but not initially deemed 'priority need'. Was delayed 2 weeks whilst housing problems were resolved, eventually went to homeless hostel. Would have benefited from medical respite while this was resolved, and on an ongoing basis to improve compliance.

Service User Perspectives

Service user perspectives have been vital to shaping the conclusions of this work.

In the first part of this section three relevant historical pieces of work undertaken in this arena are profiled. This is followed by a write up of 2 focus groups undertaken in December 2015 to specifically support this piece of work.

In summary:

Key findings from service user work

- Service users are still having negative experiences during all phases of the hospital experience including discharge
- In general service users do not think existing homeless hostels are a good environment for respite
- Service users think respite facilities should be 'dry'
- Service users were split on whether controlled drinking for some could be applied successfully in a unit where other clients were trying to stay dry – but more felt this was not possible
- Service users were able to see the benefits of a variety of forms of respite provision, but felt that a higher support, dry, stand-alone unit was most needed
- Service users think specialist housing / benefits / employment support work would be necessary part of the provision
- Service users think mental health support should be provided in a medical respite
- Service users think end-of-life care can be improved
- Service users were spilt on whether mental health and physical health care clients can be managed together (particularly in the cases of very unwell mental health clients)
- Service users think medical respite should be available for all, not just local people. However it was recognised that non-local people might have time-limited intervention, and they might end up being discharged to the streets (as they would from hospital)

Historical Perspective

The Road to Recovery – A feasibility study into homeless intermediate care.

Robyn Lane. December 2005.

This prospective study, undertaken for a Lambeth based Homeless Intermediate Care Steering Group in 2005, examined the potential requirement for homeless intermediate care service within Lambeth at that time. The project was funded by Homeless Link. Within the study there was a service user consultation, although the report does not state how many service users were consulted.

3 intermediate care options were outlined within the study – a) making use of the general population intermediate care facility that existed at the time, b) having a specialist peripatetic nursing service, and c) having an 8-10 bedded unit within a hostel. In focus groups service users were asked about the three options, and their responses are outlined below.

Making use of mainstream intermediate care facilities

Clients were not averse to this in principle, but acknowledged that the behaviour of some homeless people might cause challenges in a primarily elderly care environment. The main concern however was around the effective management of substance misuse problems.

'They [the staff] would have to be trained to deal with the situations of the homeless, the drug users'

Peripatetic nursing services

Clients were mixed in their response. Some people thought this was a good idea:

'I'd rather them come here, I know it here, otherwise it's like going to another hospital, having to get to know other people.'

Others expressed concerns about the hostel environment perhaps being too familiar, and also that a once a day visiting nursing service might not be able to meet the needs of some clients:

'This would be a cop out for residents. They wouldn't have to do anything for themselves'

'This would only be ok if you had minor problems'

8-10 bedded unit in a hostel

There were strong feelings generated, both in support, and against. Management of substance misuse issues was the key focus.

'They need a sick bay here. Somewhere you could go and recover'

'If it was in a separate building, fine, but there's no way it would work if it was in a hostel unless only the staff could go in and out, otherwise of course your mates will come in and bring you a drink and you're right back there.'

However the general principle of a medical respite centre was welcomed, and it is evident that there was potential support for a stand-alone unit, although this was not the focus of the discussion.

'There should be places where we can go and recover. The longer you are off the drink your brain starts to be there again, they can start to talk to you…if you are straight out of hospital of course you go straight back for the nearest drink.'

'It would probably be better than a hospital because I think a lot of hospital nurses don't have the experience' (of substance misuse)

There was an interesting point raised about whether providing homeless intermediate care in hostels was essentially a route to providing second class health care – essentially diverting homeless people away from hospitals for the benefit of hospitals rather than patients. There was also a point raised about whether a unit would be used for overnight treatment 'after a bad night', and whether this might conflict with recovery objectives for some other patients.

Economic Evaluation of the Homeless Intermediate Care Pilot Project.

Chiara Hendry and Samantha Dorney-Smith. December 2009.

This report summarised the results of the one year pilot of hostel based homeless intermediate care undertaken in Lambeth in 2009. Two focus groups were undertaken with 9 and 4 clients during the project year. Focus group attendees mostly had experience of being patients of the pilot project, and were being asked for feedback on the project, which was generally very positive.

'I can think of one person who still wouldn't be here without the project, and I probably wouldn't be either'

'It made me conscious how bad my health was. It was a wake-up call…'

However the main focus of the groups was to establish potential areas for development and improvement. These included:

Weekend / out of hours provision – This was not provided by the project, which was identified as a key deficit.

Activities program / worker – Having distractions to distract away from substance misuse was identified as a key area for development.

'There's nothing to do here, my brain starts to burn'

'Having something to focus on every day would be useful'

Mental health provision – It was felt that this needed to be expanded considerably.

'There needs to be more in-house mental health 1:1 sessions… group work too'

Non-hostel based provision – This was key feedback. In the focus group with 9 attendees 8/9 clients said that clients should not go back to a hostel after a detox. This presented an interesting challenge to this type of model of care.

London Pathway Medical Respite Centre Feasibility Study – Advisory Panel Response.

Stan Burridge. May 2012

A service user consultation was undertaken in May 2012 to gauge service user responses to a Feasibility Study for a potential stand-alone Medical Respite Centre undertaken by Pathway in 2011. Twenty two homeless or ex-homeless people were consulted.

The report commences ***'The overwhelming feedback was… that a specialist medical respite centre is something homeless people feel is needed'***. However the report usefully focused on practical aspects of how such a service might be run, and these are outlined below.

Consultees felt that a medical respite centre should have the following staff - Doctors, nurses, mental health professionals (including low level counsellors), addictions professionals, housing workers, benefits advisors, a dentist, podiatrist, and a chaplain; and the following services - step-down from hospital, comprehensive health reviews, mental health and addictions treatments including counselling, AA/NA type groups, other types of support groups, arranged entertainment activities and clothing. Xray facilities were discussed suggesting that people perceived a quite clinical environment. A dental suite was also suggested. Finally a gym, swimming pool and spa type facilities were suggested.

Most people said that alcohol should not be allowed on the premises (or if it was this should be in own rooms, or in an allocated wet room). All said that the project should be able to provide 'replacement therapy' for drug users e.g Methadone.

People felt male and female areas should be separate. Single rooms were not seen as essential, but desirable. It was felt that if anyone was bed bound or in isolation they should have access to their own TV. It was felt that a communal / training kitchen should be provided

A displayed Code of Conduct was suggested. CCTV was suggested. All said that visitors should be allowed, but they should not be able to bring alcohol etc.

It was felt that such a project should ideally create employment and training opportunities for ex-homeless people.

Medical Respite Focus Groups – December 2015

Two focus groups were facilitated by Stan Burridge and Samantha Dorney-Smith at Graham House (where the current Homeless Intermediate Care project is located) and the Ace of Clubs day centre (both in Lambeth). Clients were given a £15 Sainsburys voucher for involvement. Notes were taken and the sessions were taped.

Graham House

11 clients attended for a full hour.

- 11 out of 11 had some experience of homelessness
- 7 out of 11 had been to A&E in the last year
- 4 out of 11 had been admitted to hospital in the last year
- 11 out of 11 said they had some kind of problem with drugs / alcohol
- 8 out of 11 thought they had a mental health difficulty

All felt that medical respite was needed:

'When you are ill, going back onto the streets just makes you more sick.'

One client described being discharged to the streets, and then being taken back to hospital collapsed in an ambulance three days later, because rough sleeping was making him drink more. It was also widely expressed that going back into a hostel could also be detrimental to health.

Several clients also described getting into hostels only as their health deteriorated, rather than earlier on in their homelessness career and felt this was wrong, and that hostel accommodation should have been available earlier.

'It shouldn't take for me to be on death's door to get housed'

Attitudes in hospital

Sadly clients still described attitudes in hospital being one reason for self-discharge, why things go wrong, or why people didn't want to go to hospital and might prefer an alternative to hospital:

'They accused her of being a dosser' ***'I felt picked on'***

'They don't care' ***'They judge people'***

'I was very aware I was different'

There was a feeling that hospital staff were not well trained ***'they are always agency staff who don't understand'***. It was felt that a medical respite needed specialist staff with experience of working in homelessness.

Opinion was split about where the best place to provide medical respite was:

In general a stand-alone unit was felt to be the best option. ***'A unit near a hospital – it needs to be separate from normal hostel life.'*** Hostels were described as too noisy, smelly, and unclean.

Accessibility was felt to be important ***'It needs to be completely accessible.'*** It was said that the lift in the hostel was often not working, and there were no ground floor facilities. ***'I see old men struggling to go upstairs to the fourth floor.'*** 5 clients in the group described existing difficulty climbing the stairs in the hostel.

However others felt that a respite could be provided in a hostel, ***'but with proper intensive care'***, and ***'separate from the rest of the hostel'***.

Confidentiality and communication

There were discussions about the fact that Doctor and Nurse conversations were sometimes overhead in the hostel.

It was felt communication between health staff and key workers could be improved - perhaps by having identified keyworkers for health work.

Respite provision

10 attendees felt that a stand-alone unit was best, although 4 thought that a step-down ward was an equally good idea, and 5 thought that hostel based project could be successful.

10 attendees felt that any new project should be dry (and they were quite vocal about this) ***'nobody is going to stop drinking when the first thing you see in reception is someone with a can of lager'***, however clients also recognised that a no drinking policy might exclude step up and end of life care people.

Suggestions were:

- Drinking outside only
- Drinking in rooms only
- No drinking at all in public areas
- Very careful contracts (although several people said their own experience of contracts was that they did not work – people get drink if they want to)
- Careful rules on aggression etc

4 attendees felt controlled drinking would work, 5 felt this couldn't work (despite the suggestions above), 2 were unsure.

End of Life care

Attendees said that they were not comfortable with End of Life Care taking place in the hostel. They described one palliative care client was ***'always sitting on the stairs alone'*** and the staff ***'didn't know how to cope'***. The provision of end of life care was a topic that generated a lot of passion, but could not be fully explored in the session. There was a definite sense that things could be improved.

Physical and Mental Health Care

Initially 11 attendees thought people discharged from physical health and mental health hospitals could not be managed together.

However as the discussion progressed 8 out of 11 attendees admitted they had mental health problems themselves, and so it would depend on the type of mental health problems, and some people with a mental health diagnosis might be fine. There was a feeling that people with mental health problems should particularly be supported to stay away from drugs and alcohol, and might need extra support with medication.

There was a recognition that if a facility could manage both mental health and physical health it might be more financially viable. It was felt that separate units were unlikely to be provided - ***'There wouldn't be enough money to do both'***.

Respite unit staffing

When asked about the staffing:

- Medical or nurse practitioner input was felt to be the most important (i.e it was felt there was a need for someone to be doing clinical management onsite)
- Mental health professional input was felt to be the second most important
- Benefits / housing / activities / training worker was felt to third most important – the group felt that one person should be able to provide all these types of support

- Physical health care nursing (i.e. to provide daily nursing type interventions), physiotherapy and dentistry were felt to be the next most important group
- All the other roles were felt to be ideal, but non-essential – Substance misuse worker, Podiatry, Occupational therapist, Optician, Lawyer (to worker on housing / recourse issues)

It is interesting that substance misuse worker came so low down, but there was a perception that the mental health worker and housing workers could do the work around staying stopped, and providing appropriate move-on.

Ace of Clubs

9 clients attended for a full hour.

- 8 out of 9 had some experience of homelessness
- 8 out of 9 had been to A&E in the last year
- 5 out of 9 had been admitted to hospital in the last year
- 6 out of 9 said they had some kind of problem with drugs / alcohol
- 3 out of 9 thought they had a mental health difficulty
- At least 3 probably had no recourse to public funds

All felt that medical respite was a good idea

- ***'I have been discharged and slept on the hospital grounds because I felt safer – I knew I wasn't very well. I went back and hoped I'd see a different Doctor'***
- ***'It would give more time to think through the options'***

All felt the facility should be dry

- ***'I'm an alcoholic, but there's no way I would want to go to a wet house after hospital'***
- ***'If you are trying to come off it, there's no way you want to see somebody else drinking'***
- ***'It's gotta be a dry house'***

When asked what should be done about hostel clients needing step-up care, or end of life care clients all the clients felt that these clients were different, and needed a different facility. They all felt it would be too hard to manage the two groups of clients together.

Type of Provision

When asked about how medical respite could be delivered 4/9 felt that expanding the existing community provision to be able to provide increased support to those leaving hospital would be a good idea. 4/9 felt that providing some sort of step-down ward on the hospital site would be a good idea. Interestingly nobody thought that providing respite beds in a hostel would be a good idea.

However 9/9 thought that a small, stand-alone facility would be a good idea. Attendees felt that clients with the same issues would benefit from being alongside one another, and the support services could be focused on that group. They felt that the atmosphere would be better (one of recovery), and more personal.

Physical and mental health

Interestingly 9/9 clients felt physical health care and mental health care clients could not be managed together, and this remained, even after this issue had been explored fully. The attendees felt that clients with physical health problems (e.g. liver disease or a broken leg), and mental health problems (e.g. suicidal intent, or psychosis) were fundamentally different and needed a different response.

Chances for those non-engaging with treatment

In general the group felt that clients not engaging should have limited chances

'the more chances you are giving, the more money you are wasting'

'There would be other people waiting to get in who should be allowed to benefit'

2 out of 9 favoured giving clients who did not engage with treatment 1 chance, and 6 out of 9 favouring giving 2 chances.

Respite staffing

When asked about potential staffing required:

- Medical input was felt to be the most important (i.e it was felt there was a need for someone to be doing clinical management onsite)
- Benefits / housing / training worker was felt to second most important – the group felt that one person should be able to provide all these types of support
- Mental health professional and/or substance misuse worker input was felt to be the third most important
- Physical health care nursing (i.e. to provide daily nursing type interventions), physiotherapy and dentistry were felt to be the next most important group

All the other roles were felt to be ideal, but non-essential – Physiotherapy, Dentistry, Podiatry, Occupational therapist, Optician, Lawyer (to worker on housing / recourse issues)

Service Provider / Commissioner Perspectives

Interviews have been undertaken with a variety of management leads, service providers, commissioners and services, to assist in considering the options available. A full list of those engaged, with summaries of the interviews and key thoughts is provided in Appendix 4.

Summary findings:

- There was a general recognition that mainstream intermediate care services were not meeting the needs of this client group.
- Those interviewed were broadly positive about the agenda of enhancing intermediate care services for homeless people, but thought that clarity of purpose was needed in order to progress the project.
- In particular many people thought there were a variety of different problems being considered, and that these problems didn't all have the same solution.
- There was a clear recognition that more than one type of solution is needed with potentially both 'wet' and 'dry' provision needing to be provided.
- People thought existing services should be built on wherever possible.
- Many felt it may be useful to concentrate on piloting one solution rather than all .
- Local capacity in services was felt to be an issue with regard to doing anything new, and caused considerable anxiety. Most staff feel that they could not do any more without increased staff support.
- Bed blocking of a unit that doesn't have a clear strategy or protocols was mentioned time and time again, as a potential risk to the project.
- It was frequently mentioned that pilots should try not to be based on 100% bed occupancy models (as this was more likely to prevent a 'flow').
- Many people mentioned that this discussion had been going on a long time!
- Several people thought a pan London solution is needed.
- Most people that there are a group of clients needing 'care' with ongoing high support needs for whom limited options exist, and that this needs to be looked at separately – however this need is ongoing, and not short term.
- There was considerable discussion about bed blocking related to waiting for Local Authority temporary accommodation, and what could be done about this aside from providing step-down facilities.
- Many people had specific ideas about projects that could work but these were all different – demonstrating the complexity of this project, and the wide variety of potential solutions.
- Several people said that they felt that hostels were not ideally suited for respite provision.

In terms of clarity of purpose some key themes came out that were discussed several times that concerned what the focus of the potential project should be:

Bed blocking focus vs recovery focus

A bed blocking focus would assume that all admissions to the service would need to demonstrate potential for reducing bed days, and that reducing cost would be the ultimate aim. A model with this focus might tend to focus more on clients with simple Local Authority housing provision blocks to moving on, but without a complex background of tri-morbidity.

However a recovery focused model might look at existing provision for this client group, and attempt to create a clinical service delivery model better than those currently existing - with the ultimate aim of delivering improved health and social outcomes for these patients. A model with this focus would tend to focus on the more complex clients who have poor health outcomes currently. This model would be hard to deliver with an overall cost reduction, although there

could be an aim to achieve cost neutrality over an extended period of time, and costs like criminal justice costs and eviction costs could be considered in the economic analysis. The end result would be more uncertain, and the model might need refining over time.

Wet vs dry

This refers to whether service users should be able to drink alcohol on site. Service providers and service users alike have all pointed to a lack of immediately available 'dry' accommodation in which to put clients with alcohol issues if they have become pre-contemplative or contemplative about reducing or quitting alcohol whilst in hospital. It is felt that this is a clear gap in current service provision.

However many clients that need intermediate care type facilities are unwilling or feel unable to stay dry – and clients who might need 'step-up' or 'end of life' care would be unlikely to be able to, or want to stay dry.

Although there are controlled drinking regimes in existence, and it might be possible to manage both groups with creative staff, this broadly indicates that two types of facilities might be needed.

Hostel vs not hostel

All existing models are based in hostels because this is the most pragmatic delivery option. Hostels provide an immediate, cheaper, out of hospital environment that is familiar to clients, and the pre-existing 24 hour staff teams available in hostels are able to provide low level out-of-hours cover.

However somewhat in line with the above point clients say that hostels are not ideal recovery environments, and respite should be provided outside the hostel environment. Yet developing a new stand-alone facility is potentially very expensive to pilot and provide, and there may not be a financial case for this on a single borough level.

Out of borough and no recourse vs local connection clients only

Around 50% of clients in this cohort that are blocking beds and/or need recovery support do not have a local connection. If the hospital provides for and pays for respite beds this is not relevant (assuming any project does not allow potential clients to develop a local connection in the borough in which it is hosted). However if local community health services and the Local Authority are to be involved in providing the respite beds that is extremely pertinent.

Conversely it is important to note that any facility which did provide for people without a local connection or recourse to public funds would need to deal with discharging people to the streets. For example, when the only currently available solution is help a client to return to an EU country of origin, but this is being declined by the client. This issue is a dispersed problem inside hospitals (i.e. only happens occasionally on individual wards), but would become a distilled issue for a respite team (possibly happening several times a week). Decision making would be an emotional drain, and a respite team might be inclined to make different decisions regarding when someone was ready for discharge to an acute hospital team. Thus admissions to respite might last longer than anticipated.

Step down only vs step down / step up and end of life

Ideally any project would be able to provide admission avoidance interventions as well as step-down provision, in order to maximise the release of hospital bed days, and undertake targeted prevention work – thus maximising advantage to clients.

However it is important to note that clients requiring step-up and e.g. end of life care interventions are not generally detoxed, so would either need a "wet" facility, or immediate access to detox and then a "dry" facility. In the existing projects being delivered pan London about 50% of referrals are generally step-up referrals. Again this tends to suggest that two types of facilities are needed.

Mental health / physical health

It is not fully clear whether clients with primarily mental health difficulties and primarily physical health difficulties can always be managed together. Although professionals have been broadly positive

about this, and homelessness is characterised by tri-morbidity, there are potentially some more vulnerable mental health clients (e.g. those who have never previously been rough sleepers) who do not have addictions or physical health problems who might not do so well in a mixed unit.

Discussion

This document appears to have evidenced a significant need for the enhancement of local medical respite facilities. Whilst the existing Lambeth Homeless Intermediate Care Project is an example of excellent practice, because all the beds are in local authority control within a hostel with very high bed occupancy, not all the patients that need support are able to benefit. Mainstream intermediate care facilities also do not seem to be meeting the needs of these clients. Additionally there are some clients with lower level support needs who could easily be managed outside hospital in their last days / weeks, and this opportunity is being missed. Finally a potential need for alcohol-free step down beds to support recovery is not being met.

The document has also uncovered a need to look at provision for homeless clients requiring on-going care provision, but this is not within the remit of this document. It is recommended that examining this provision forms the basis of another project.

Differing types of medical respite service provision will offer different outcomes. It is felt that it will be vital to agree the main driver for change. If it is to be mainly about immediate bed day savings, then looking into 'hotel' provision may be the priority. However if looking for 'recovery' and overall value for investment long-term, then concentrating on the 'chaotic tri-morbid' group will probably make more sense. It seems unlikely that both services could be delivered on the same site, although not impossible. Providing an opportunity for alcohol dependent clients to stay dry, stabilise and engage with services seems important. Thomas (2012) [19] pointed to the fact that London has excess mortality rates secondary to alcohol in homeless persons which provides an additional driver. Overall, it seems that more than one solution will be needed – projects to meet the needs could be developed alongside one another, or incrementally.

However the main barrier to all provision is the siloed and depleted budgets that exist across the voluntary sector, housing and social care in London. Hostel bed occupancy across the capital is currently at very high levels (not often allowing for 'emergency' admissions' to high support hostels with health in-reach), and either way this presents a problem for those who do not have a clear local connection. Improvements may be achieved by better integrated care within each Borough, but this does not provide help for the high number of hospital patients who do not any local connection. Even those who are entitled to housing benefit, and who have a proven local connection and who have a hostel bed, could not take a short placement in the current Medical Respite provision (currently part-funded by housing benefit), without losing their original housing benefit funded hostel place.

A Locally Agreed Tariff is an idea that has been developed by Pathway that might present a solution, and developing this could an aim for future work.

Medical Respite Locally Agreed Tariff for London Wide Commissioning

A Locally Agreed Tariff provides a potential solution to this well recognised, persisting and so far intractable problem. A Locally Agreed Tariff in this context would be a set amount of money that an accredited provider could charge local CCGs for providing medical respite services as an alternative to hospital admission. A Locally Agreed Tariff for medical respite could have different day rate charges depending on the dependency of the patient at discharge, and could go down over time. Potentially the new London-wide Commissioners of healthcare for homeless people could negotiate a new Locally Agreed Tariff for community based Medical Respite care. This tariff would be paid by the patients' CCG, which in almost every case is already paying for the higher cost of repeated acute medical admissions.

19 Thomas, B (2012) Homelessness kills – an analysis of the mortality of homeless people in early 21st century England. Crisis

To be effective the tariff would need a number of particular characteristics:

- It should require partnership working between an accredited provider of community housing support, and an accredited NHS primary care provider.
- The tariff would need to be less than the cost of repeated acute admissions, with diminishing returns for prolonged stay, but sufficient to provide for integrated care, move-on planning, and support to meet the needs described in the literature.
- To be successful the tariff would need to be sufficient to cover the rental and house-keeping costs usually covered by housing benefit, the primary health care costs of a specialist primary care outreach model, and case management for move-on planning and support. This will be close to the costs of repeated acute admissions, with the aim of reducing admission costs in future years.
- As a key requirement is rapid access, it would need to avoid the prolonged and slow assessment process that often accompanies NHS funding assessments for continuing healthcare in the community. This would need agreed eligibility criteria, screening by the accepting provider, and capped or severely tapered funding for each episode of care which removes the concern around uncontrolled access to prolonged high cost care.

The particular advantages of this model are that:

- It encourages the local market to provide the care.
- It encourages a diversity of provision, with the prospect of 'dry' units for those who wish to continue their detox and abstain from alcohol, or separate 'wet' units for those with severe health problems who cannot manage sobriety, or even cultural and language specific provision. This can happen because each borough does not need to have enough potential users in its own borough to justify provision.
- Provision can be placed anywhere, geographically.
- It does not require top-sliced or pooled funding, or complex re-charging agreements.
- Care is effectively 'spot purchased' because each CCG only pays for its own patients as and when required.
- It overcomes the local connection block because, this is short term health care provision, not housing provision.
- It could make use of established buildings, and experienced staff made redundant by cuts to Local Authority funding.
- The cost benefits from acute care savings automatically accrue to the particular CCG that is already paying the costs of repeated acute admissions for complex homeless patients.

To progress this idea there would be a need to 'pump-prime' any new service with sufficient funds to prepare a building, recruit and employ staff, put the tariff process in place, and provide a cash flow until the tariff funding comes through. This could be a role for Social Bond financing, or a charitable grant, and would need to be locally negotiated. This would have the further advantage of building some flexibility into the revenue system to cope with challenges such as disputes over funding, people later to found to be ineligible for NHS care, or less than 100% occupancy (necessary to provide rapid access). Not progressing towards a Locally Agreed Tariff does not make it impossible that existing provision could not be enhanced, but it would make this considerably easier.

Set within this context the perceived options for enhancement of local medical respite services are presented below. There are a considerable number of options, with many pros and cons. The recommendation would be that locally led steering group is appointed to consider and review the options, and move forward in consensus. However the authors have filtered all the available options to come up with the options thought to be most viable, and these are presented in the Executive Summary.

Opportunities

Quick wins

During the process of the service provider interviews a number of alternative takes on the medical respite idea were suggested by the Pathway, HIT team and START team staff. These were:

- A suggested pilot of a Rapid Response post discharge follow up service, targeting frequent attenders and those at risk of readmission with a next day visit and 7 day follow up visit.
- A review of current floating support services, and a request for priority support from them where they exist.
- An extension of Groundswell work to cover more boroughs, and to escort people into mental health and substance misuse services (i.e. not just GP and hospital appointments). Possible expansion of the service to offer short-term floating support work (so helping with benefits and housing issues etc).
- The initiation of jointly funded link posts in reablement teams that provide the link between housing and in-hospital teams and thus inform and streamline the process.
- A homeless health training programme to be delivered to district nursing, enhanced rapid response and the @home teams and equivalent mental health teams.
- District nursing teams to have homeless specialists in each team
- Increased communication between the Pathway team, HIT team and START team e.g through monthly case reviews

Clients needing long-term care

The lack of appropriate provision for ex-homeless clients needing long term care has come up repeatedly during the progress of this project. It is important to note that these clients or this type of provision into the options appraisal below, because the type of care needed is long term by definition, and not respite in nature.

However this issue does potentially need to be addressed at a pan London level, as many current bed blockers come into this category, and some of the existing care home provisions have long waiting lists. A full pan London needs assessment of the potential care provision options for this client group and their current availability is way beyond the remit of this project, but would be a useful project in itself.

NB: In the following section an 8 bedded unit is mentioned on several occasions. The '8 beds' comes from the 6.4 estimated bed days required for a hostel based, medium support, but allowing for 80% bed occupancy to enable flow.

OPPORTUNITY 1

Do nothing: watch and wait...

OPTIONS	POSITIVES +	NEGATIVES -
This option involves staying with the existing options of Lambeth HICP and Westminster ICNHH and assessing further when more experience / data is available.	• Allows time to see how the extension of the Lambeth HICP to a second hostel (with no more staffing) works in practice • Allows for Westminster service to embed – this may have an impact on potential numbers anyway, and there will be learning from this project • Allows the existing Pathway team to embed further, and to establish some more comprehensive needs data • Allows for pan London commissioning model to develop further with a view to developing pan London solutions	• Data shows evidence of delayed discharges, and revolving door clients – this approach might miss out on potential financial benefits • Report shows evidence of inadequate care – allows inadequate care to continue

OPPORTUNITY 2

Deliver low support dry accommodation only

OPTIONS	POSITIVES +	NEGATIVES -
This option would look to provide B&B accommodation for clients experiencing housing delays with low support needs. This accommodation would preferably be disability accessible. This could be provided in a variety of facilities. **Could be achieved by:** **a)** Negotiating with current B&B providers at SLaM to provide enhanced service? **b)** Further progressing Simon hotel conversation to see if any possibilities exist to pilot some sort of scheme? **c)** Building on current ad hoc use of Backpackers facilities with Samaritan fund money to examine potential deals? **d)** Discussing with Olallo about use of some beds? **e)** Talking to provider such as Premier Inn about possibilities (in line with several local authorities)? **f)** KHP running its own step-down B&B facility?	• If viable option were found this would stop the short term bed blocking that comes from this group. • Would be relatively easy to deliver a pilot. • Could provide for clients stepping down from both physical and mental health environments. • Could accommodate those without a local connection or with No Recourse to Public Funds if there was a clear exit plan. • Could have quite low staffing levels e.g. one housing worker as access manager for the beds across the three Trusts if the beds were being provided independently. • Does not need medical management. • Premier Inn model (although the most expensive) would have the advantage of being suitable for all clients.	• Would not provide any kind of service to our most vulnerable / needy clients. • Might be difficult to find accessible B&B accommodation. • Might be difficult to get all beds in one place. • Would need to have robust management to ensure move-on. Also – would need to think carefully about when clients went in (i.e. only after local authority responsibility confirmed?) • KHP running its own facility seems like an excellent idea but no estate options have come to light during this project. • Even though low support may include a number of clients on substitute prescribing (experience of Pathway 2 Home and data suggested this). A plan for delivery of substitute prescribing would need to be made (which might be difficult in the absence of medical oversight)

OPPORTUNITY 3

3 Deliver medium support, wet accommodation only

OPTIONS	POSITIVES +	NEGATIVES -
This option would build on the current Homeless Intermediate Care Service and could involve several alternative sub-options **It could also have additional workers in order to increase the effectiveness of the service e.g. a dedicated move-on / benefits / training worker and a mental health worker.** **Would need GP practice to take clinical responsibility.** **Substitute prescribing would need to be provided.** **Delivery options:** a) Expand Peripatetic Service b) 8 beded-unit for one borough c) 8 bedded unit for two boroughs d) Creating a new stand-alone unit (see below for mor details)	• Provides care to the more vulnerable, needy clients • Options a), b) and c) build on an existing tried and tested model • Would ensure better care for clients in hostels on discharge, and might allow some clients to be discharged that would not previously have been discharged (because of the additional support) • Would allow for admission avoidance by providing provision for step-up, and could also be used for End of Life Care in some cases • Can manage clients being discharged from both physical and mental health environments if they are not too vulnerable to be in a hostel environment. • If mental health professional becomes part of the team, and the service includes some mental health step-down and step-up this would encourage greater integration between the existing physical health and mental health teams • If the Health Inclusion Team HICP team and Pathway team are expanded to provide the staffing this builds on existing capacity in an existing infrastructure. This is easy to deliver. There is also potential to move people around to maximise their current role benefits. • Expansion of team might allow for an expansion of types of clinical care provided and/or allow for new workers e.g. a dedicated move-on / benefits / training worker and a mental health worker to increase the effectiveness of the service	• None of the options would be likely to accommodate those with no local connection or no recourse to public funds in the short term if the beds remain in Local Authority control. However this might be resolved with a Locally Agreed Tariff. • The three options focus on providing care in existing 'wet' hostel-like environments – limited potential for substance misuse recovery (although putting the beds together in the 8 bedded unit options may convey some advantage)

See sub-options 3.a/b and 3.c below.

3.a Expand Peripatetic Service

OPTION	POSITIVES +	NEGATIVES -
a) Expansion of peripatetic nursing service (i.e. creating a homeless district nursing / rapid response team that could go into / support any hostel across a borough / multiple boroughs)	• Requires minimal planning / management on top of existing service. Just needs new staff team – easy to pilot. • Could deliver across 3 boroughs similar to HIT team or START team • Peripatetic service could be flexible and perhaps e.g. serve B&Bs and temporary accommodation.	• In peripatetic model clients would be spilt over a number of hostels, potentially over several boroughs – time consuming and possibly ineffective for clinical staff

3.b and 3.c Eight Bedded unit

OPTIONS	POSITIVES +	NEGATIVES -
b) Creating an 8 bedded unit in one borough that could flexibly take clients from across the borough (similar to Mare Street) e.g. by creating a unit in the soon to be built new Graham House or Robertson Street. A funding model would need to be created. **c) Creating an 8 bedded unit across 2 boroughs (this sharing the financial risk) e.g by using the pre-existing Great Guildford Street unit which is already totally fit for purpose.**	• Joint housing / health development and planning which will potentially make project more likely to succeed • If funding model developed process can be streamlined (as at Mare Street) and allow swift access from hospital and the street. • 8 bedded unit would stop time wasted by team moving around, and put recovering clients together (which has some advantages) • 8 bedded unit would potentially ensure disability accessible accommodation within hostels had maximal use. • 8 bedded unit could develop strong relationships with intensive treatment teams e.g. Home Treatment or @Home and allow these services to be effectively delivered in hostels. • Possibly hospitals could spot or block purchase beds in order to achieve earlier discharge. • The longer term aim might be run a unit paid for by CCGs funded by a Locally Agreed Tariff • If Great Guildford Street it already has a purpose built unit, that can be partly closed off, and is fully accessible	• 8 bedded unit option would be complicated to fund (due to potential need to run voids and keep beds open in both the unit and the pre-existing hostel in the case of some clients). However this has been achieved at Mare Street, so could be looked into further. • Unless funding issue is sorted out bed blocking might become an issue (e.g. if clients had to give up their existing bed spaces in order to access the bed) • If looking at a 2 borough option (to maximise clinical benefit, and bed use), a considerable amount of cross-borough liaison will need to take place. • Arrangement for substitute prescribing might also be complicated in a cross borough unit.

3.d Creating a new stand-alone unit

OPTIONS	POSITIVES +	NEGATIVES -
d) Creating a new stand-alone unit	• This is what clients say is needed. • Could be developed to be a calming, recovery-like environment which might be more conducive to working with clients considering making changes in their lives • May be more acceptable to those prone to self-discharge than any of the other options that they are already familiar with	• Unlikely to find unit already fit for purpose so would be expensive – would need to find unit and refurb it, which would be risky without a prior proof on concept • No property identified yet (although refurbing of Grange Rd has been suggested) • Would be expensive to pilot as would be likely to require a new staff team • Would not benefit from e.g. support of existing hostel staff if a stand-alone unit, rather than in a hostel. Dependency of clients would need to be carefully worked out. • Staff might be quite isolated. • Might be hard to make a case for this option on a single / two borough level

Deliver medium support dry accommodation only

OPTIONS	POSITIVES +	NEGATIVES -
Deliver medium support dry accommodation only a) Community Detox based b) Care Home based c) Ward based d) Stand-alone unit (see below for mor details)	• This is what patients say they want • Potentially easy to pilot if hosted within an existing service • Could be done on a small number of beds • Pre-existing staff on site are already trained to work with this client group • Night time cover would be available through existing staff team	• Will require a hearts and minds campaign to achieve this. Respite type interventions are not generally delivered in detox facilities. • Hard to staff appropraitely if not within an existing service

4.a Community Detox based

OPTIONS	POSITIVES +	NEGATIVES -
a) Sourcing some beds in an existing community detox facility, but running some concurrent medical respite beds	• Potentially easy to pilot • Could be done on a small number of beds • Pre-existing staff on site are already trained to work with this client group • Night time cover would be available through existing staff team	• Will require a hearts and minds campaign to achieve this. Respite type interventions are not generally delivered in detox facilities.

4.b Care Home based

OPTIONS	POSITIVES +	NEGATIVES -
b) Sourcing some beds in an existing care home facility, but running some concurrent medical respite beds	• Care home would definitely be fully accessible • Makes use of existing disused property if there is any • Night time cover probably available through existing staff team	• No current care home or similar facility identified. However this option has not been fully explored, and there are some indications that a care home could be found. • Unclear how it would work running homeless recovery beds next to elderly care beds. Existing care home staff would probably need considerable training to understand how to manage this.

4.c Ward based

OPTIONS	POSITIVES +	NEGATIVES -
c) Finding an empty ward of anything between 8-25 beds and run homeless or 'inclusion health' step-down ward (although no potential ward has been found during this project)	• If ward based would potentially benefit from the support of the on-site Pathway teams (and it would also benefit the Pathway team by having clients in one place) • If ward based there would be no problems with supporting clients with no local connection or no recourse (i.e. health funded so no issues regarding local authority funding) • If ward based could draw on on-site addictions workers (e.g. alcohol team at GSTT) and mental health liaison teams in order to resolve issues • All clinical interventions would potentially be possible	• No current ward available cross the Three Trusts • Would be expensive to open a new ward • Running a 'homeless ward' could be viewed to be discrimmatory - would need careful branding

4.d Stand alone unit

OPTIONS	POSITIVES +	NEGATIVES -
d) Sourcing (or renovating an existing property) to provide a new purpose built, stand-alone dry unit run by either KHP or more likely a voluntary sector partner	• See notes from previous option	• See notes from previous option

OPPORTUNITY 5

Deliver a mixed model solution locally

OPTIONS	POSITIVES +	NEGATIVES -
In this option one of the following two approaches might be taken: a) Wet and dry beds might be mixed but with a firm controlled drinking regime (e.g. contracts, no drinking in shared areas, no drinking outside the building etc) b) Dry clients with low support needs might use beds in a unit primarily designed to manage those with medium support needs in order to maximise bed usage	• By providing services for more than one client group the business model becomes more robust • As part of this might provide an improved financial argument for a stand-alone unit which is what clients say they want. Could potentially be purpose developed to be a calming, recovery type environment.	• Harder to manage and potentially more likely to fail if there is not a clear criteria for the service

OPPORTUNITY 6

Lobby for a single model or mixed model delivery pan London

OPTIONS	POSITIVES +	NEGATIVES -
In this option the pan London homeless health services commissioning programme takes this forward as a pan London issue	• Recognises this is a pan London problem, and clients are transient • Avoids repeated replication of pilot projects in each area • Would allow for the development of appropriate specialist support services on site • Would potentially allow hospitals / CCGs to purchase beds via a Locally Agreed Tariff • Could be linked to NSNO and NLOS models?	• Does not necessarily meet all local needs • Appropriate location needs to be found • Large project, would need significant preparatory project management • Revenue streams would need to be carefully worked out, and robust business processes would be required • Quite hard to pilot on a small scale

Next Steps

What needs to happen to progress this project?

This paper has demonstrated that there is potential for enhancing homeless medical respite services both in Lambeth and Southwark, and possibly more widely. Possible project development options have been suggested.

In order for any of the project ideas to be taken forward the following suggested actions need to take place:

- Relevant senior management leads, service leads and commissioners from health and housing need to consider this document, ideally in partnership
- Most likely project option(s) to take forward need to be selected
- Ideally a steering group and management lead for the chosen project (s) would need to be identified
- All parties need to understand the complex nature of the project being undertaken – it may be useful to have a short term pilot or pilots with a view to informing the longer term strategy
- Either way further development work would need to be undertaken in area(s) chosen. This may be quite considerable, and time consuming and e.g. involve promoting cross borough liaison in housing and health, developing specific staffing models and roles in liaison with existing service providers, examining property options, liaising with voluntary sector providers regarding proposed projects and/or liaising with pan London homeless health service commissioners / GLA. Further analysis might be considered as part of this.
- Further support from GSTT charity will need to be sought in order support the further development of concept(s)
- Connection of any clinical respite service to EMIS Web might be an additional project management consideration
- Allowance would need to be made for revisions to the project as practical issues might lead to considerable revisions of concept during the development phase
- Consideration needs to be taken to linking this project to other GSTT charity funded initiatives e.g. the Assertive Outreach Alcohol project

Interviews undertaken & people consulted:

- Nike Arowobusoye - Healthcare Public Health, Consultant in Public Health
- Michelle Binfield – Associate Director for Public Health Commissioning, Lambeth
- Sue Bowler - Director of Integrated Care and Partnerships / Interim Divisional Manager Women's and Children's, Kings
- Lisa Burnard - Health Support Worker, Homeless Intermediate Care Project, St Mungos Broadway
- Fran Busby – START Team Lead
- Pamela Campbell - Nurse Consultant, Solent NHS Trust
- Andrew Casey – Health Programme Director, St Mungos Broadway
- Bob Cook - Acute Medicine Deputy General Manager (now has new role)
- Florence Cumberbatch – Lead Nurse, UCLH, Pathway
- Colleen Daniels - Nurse, Hackney HDN, St Mungos Broadway
- Paul Davis - Lead Commissioner (Supported Housing), Lambeth
- Bernd Diegelmann - Manager, Deepdene House
- Chris Dutton – Housing Liaison Worker, St Mungos Broadway currently seconded to GSTT Pathway
- Sharron Erinle - Manager, Aspinden Wood (Equinox)
- Sue Field – Estates Manager, Kings
- Sooty Goraya - Deputy Manager, Chichester Road (St Mungos Broadway)
- Catherine Hall - Clinical Service Lead, York Street
- Paul Hamlin – Housing Liaison Worker, St Mungos Broadway currently seconded to GSTT Pathway
- Adrian Hopper - Quality Improvement and Patient Safety Director / Medical Consultant GSTT
- Fenella Jolly – Clinical Nurse Manager, Three Borough Services
- Elin Jones – Lead Nurse, St Mungos Broadway (now left)
- Zeenat Kazi – Data Manager, Performance Team, GSTT
- Mike Kelleher – Substance Misuse Consultant, SLaM
- Peter Kennedy - End of Life Care Lead, St Mungos Broadway
- Zana Khan - GSTT Pathway Team Clinical Lead GP
- Jenny Knott – SLaM Lead for Delayed Discharge
- Maxine Radcliffe - Lead, Westminster Integrated Care Network for Homeless Health / Chair, London Network of Nurses and Midwives / Board Member, Westminster CCG
- Adam Lewczynski – Manager, Property Department, Planning and Capital Projects, SLaM
- Karl Mason - Kings Pathway Team Manager
- Mike McCall – Estates Manager, St Mungos Broadway
- Jasper Mordhorst – GP, Mawbey Brough / outreach GP to Graham House
- Alex Newman-Burke – Programme Manager, Strategic Estates Development, GSTT
- Derek Nicoll – Head of Crisis Services, Psychological Medicine CAG
- Rose O Keefe - Discharge Team Manager, Kings
- Margaret Ogendengbe - TB team manager
- Nwamaka Okoye – Community Nurse Specialist, Health Inclusion Team
- David Orekoya – Lead Commissioner, Health Improvement, Lambeth
- Karen Proctor – Director of Adult Nursing Services, GSTT
- Ranga Rao – Clinical Director, Psychological Medicine CAG
- Tim Robson - Clinical Lead GP, UCLH Pathway
- Carmen Rojas – Service Manager, Three Borough Services
- Gina Rowlands - Managing Director, Bevan Healthcare
- Kendra Schneller - Lead Nurse, Homeless Intermediate Care Project, GSTT
- Caroline Shulman – Pathway team Clinical Lead GP
- Jeremy Swain – Chief Executive, Thamesreach
- Emma Thomson – Project Manager, Pathway to Home
- Karen Titchner - Deputy Lead Nurse Adult Community Services GSTT / Clinical Lead @Home
- Amanda Williams - General Manager, Adult Community Services, GSTT
- Laura Wilson - Senior Site Nurse Practitioner / Delayed Discharge Manager
- Nick Wing – Manager, St Mungos Broadway Great Guildford Street Manager
- Julie Winnington – Clinical Liaison Lead Addictions, SLaM
- Amy Wolfe - GSTT Trust Accommodation Manager

- The HIT team
- MAC (Consultant monthly meetings) meetings SLaM at Lambeth and Southwark
- The Pathway team

APPENDIX 1 - Additional contact / demographic data from community teams

Health Inclusion Team

1438 individuals were seen in homeless clinics by the Health Inclusion Team during 2014-2015, with 656 being new individuals seen that year.

The borough spilt of 1438 clients seen in homeless clinics is outlined below.

Table 15: HIT team - borough where clients seen 2014-2015 (note that some clients are seen in more than one borough)

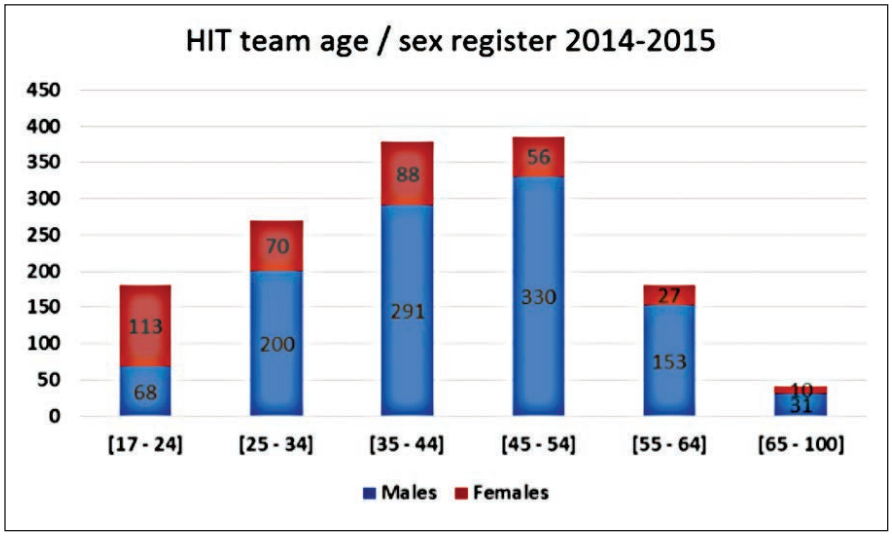
	Number	%
Lambeth	**731**	**45%**
Southwark	**494**	**31%**
Lewisham	**380**	**24%**
Total	**1605**	

A further 1684 individuals were seen in asylum seeker, refugee and vulnerable migrant clinics, and many of these people were also homeless. 1430 contacts were new during the year, although many of the new clients will have been seen in Barry House.

The following graphs present the age/sex and ethnicity profile for Health Inclusion Team clients seen during this period. This is useful because we don't currently have similarly prepared data for the Pathway teams, and the populations would be expected to be similar.

It is worth noting that both the HIT team and Pathway team see higher proportions of females that are generally noted in rough sleeping populations. In the HIT team this is skewed because the Health Inclusion Team sees a large amount of women in youth homelessness services, but overall it is probably true that women are more represented in 'sofa surfing' and hidden homeless populations that both these teams will pick up.

Graph 3: Age/sex profile for the HIT team



Graph 4: Ethnicity profile for the HIT team

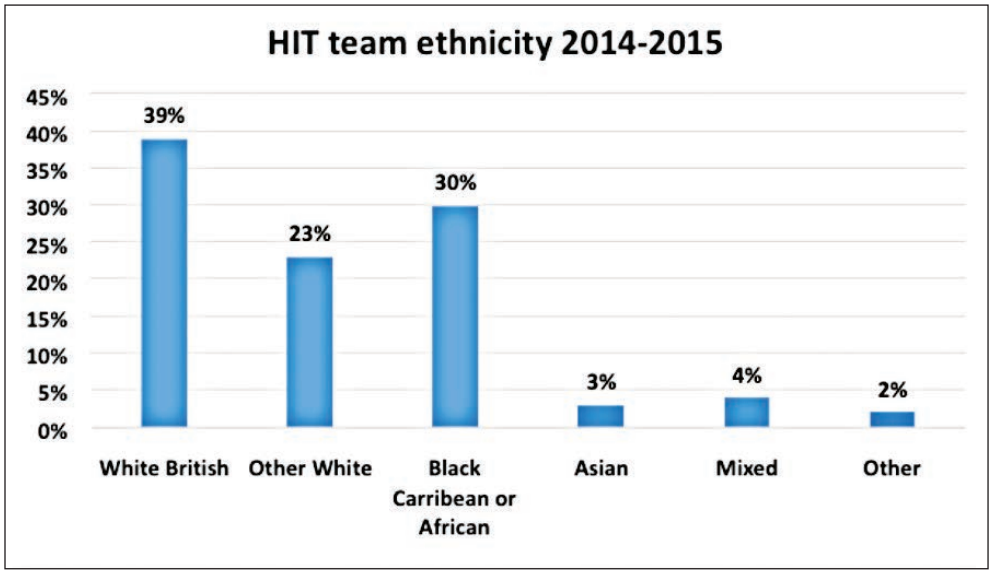


Table 6 outlines housing status for clients seen by the Health Inclusion Team. The team outreaches into hostels, which accounts for the high number of clients seen who have 'homeless hostel' as their housing status.

Table 16: HIT team – client accommodation status

	Number	%
NFA, squat, night shelter	363	26%
Hostel	706	50%
Sofa surfing	83	6%
B&B / temp accommodation	11	1%
Housed – previously homeless, or current risk of eviction	199	14%
Other	48	3%

START team

As of September 2015 the START team had 130 people on the caseload. All these clients were rough sleepers. In 2013-14, 5 out of the 14 assessments that were done on the street by START, were carried out on people with strong connections to other boroughs or other countries.

APPENDIX 2 - Additional prevalence data

Pathway Team

The table below presents data from a manual audit of codes on GSTT hospital records January to March 2014. 217 sets of notes were audited for that period. It is notable that mental health was lower in this audit than it is known to be, but this is because it was under-coded in acute physical hospital records.

Table 17: Pathway team condition code audit Jan – March 2014

Condition	No	Prevalence
Mental health problems including DSH, severe mental illness, depression and anxiety	51	24%
Alcohol dependence	95	44%
Current or past drug misuse	37	17%
HIV	6	3%
Hep B	4	2%
Hep C	22	10%
TB	3	1.3%
Malignancy current or past	14	6%
Chronic illness including CVD, Respiratory, Gastro, Endocrine and Skin	88	41%
Liver disease/cirrhosis	15	7%

Health Inclusion Team

Prevalence data is presented for a 5 year period. The average yearly number of individuals included in the cohort was 1355.

Table 18: HIT team prevalence data 2009 - 2014

	2009-2014
Alcoholism	48%
Drug misuse	40%
Alcohol and/or drugs	54%
Mental health problem	51%
HIV	2%
Hep C	13%
Past or current TB	2%
Past or current syphilis	1%
Asthma / COPD	16%
Hypertension	13%
Epilepsy	5%
Gastrointestinal problems	19%
Smoker	69%

Data from the Homeless Intermediate Care Project unsurprisingly shows an even higher prevalence of alcoholism and/or substance misuse than in the wider population, and a very high prevalence of mental health difficulty. BBV prevalence is also high. Average prevalence

data for 3 years is presented. The years included are 2009, 2011, and 2014 (for which there are complete data sets). The average number of individuals in the cohort was 26.6.

Table 19: Homeless Intermediate Care Project Prevalence Data

	2009, 2011, 2014
Alcoholism	72%
Drug Misuse	79%
Alcoholism or drug misuse	100%
Mental health problem	83%
HIV	19%
Past or current Hep B	22%
Hep C	61%
Past or current TB	9%
Asthma / COPD	38%
Gastrointestinal problems	54%
Musculoskeletal pain	100%
Smoker	91%

START team

On the START team caseload in 2015, the majority of the 130 START team patients come into the category 'Psychosis and Affective Disorders - Difficult to Engage'

APPENDIX 3

Detailed data and calculations

If you would like more details about this data and calculations or would like to view anonymised patient level data, please contact us:

Samantha Dorney-Smith (samantha.dorney-smith@gstt.nhs.uk)

GSTT

34 cases were examined in 3 sets.

10 cases were selected randomly (every 20th patient), the 10 longest stayers were examined, and 14 frequent attenders were identified by the team from the 2 frequent attender lists that are maintained by the team.

10 random cases (randomly selected from 265 stays over 5 days)

From Oct 2014 – Sept 2015 this group had a total of 31 A&E attendances (3.1 per client), and 30 admissions (3 per client, although 7 were EMU only), and a total of 559 bed days (55.9 bed days per client).

50% had some sort of mental health problem, 40% had addictions issues, 40% had some sort of mobility issue.

30% Lambeth, 20% Southwark, 10% Lewisham, 20% Westminster, 20% other. 20% had a local connection issue.

80% had some sort of delay, 90% could have potentially benefited from some sort of step down. It is worth noting that 1 of these went from hospital to a St Mungos HDN, but was readmitted.

In terms of client type 70% were A, 20% were C, and 10% D. **173 days** that could have potentially been saved in this group, which can be further split down by borough.

In summary:

Type A clients (requiring B&B type accommodation):

- Lambeth – 2 clients. 44 bed days could have been saved. 44 days required in B&B.
- Southwark – 1 client. 8 days could have been saved. 8 days required in B&B.
- Other London – 2 clients.14 days could have been saved. 11 days required in B&B.

Type C clients (requiring care / intermediate care type accommodation):

- Westminster – 2 clients. 74 bed days could have been saved. At least 88 days required in respite (one case unresolved at end of data collection period)

Type D clients (requiring wet medium support unless dry medium support available):

- Lambeth – 1 client. 28 days. 28 days required in respite.
- Southwark – 1 client. 5 days. 14 days required in respite.

Both of these clients might have taken up the opportunity of a dry 'detox type' if this were available – one from Lambeth, one from Southwark.

- Lambeth – 1 client. 28 days required in respite.
- Southwark – 1 client. 14 days required in respite.

If these 10 clients were representative of all 265 the resulting bed day savings that could be achieved could be calculated to be:

Type A clients (requiring B&B type accommodation):

- Lambeth – 44 days x 26.5 = 1166 days
- Southwark – 8 days x 26.5 = 212 days

- Other London – 14 days x 26.5 = 371 days

Type C clients (requiring care / intermediate care type accommodation):

- Westminster – 74 days x 26.5 = 1961 days

Type D clients (requiring wet medium support unless dry medium support available):

- Lambeth – 28 days x 26.5 = 742 days
- Southwark – 5 days x 26.5 = 132.5 days

Total potential bed day saving: 4.584.5 days

However this number of potential saved bed days seems too high, and it is important to note that from Oct 2014 – Sept 2015 this randomly selected group accrued a total of 559 bed days. 559 x 26.5 = 14,814 bed days (i.e. considerably higher than the number of bed days estimated to be actually taken up by this group - 5981). As such it is likely that this group may not representative of the whole, and it might be reasonable to reduce this estimate by multiplying these numbers by 0.4 to get a more accurate estimate. (The estimated number of bed days for GSTT was 5981 – approximately 40% of this total).

This the recalculation would be:

Type A clients (requiring B&B type accommodation):

- Lambeth – 1166 x 0.4 = 466.4 days
- Southwark – 212 x 0.4 = 84.8 days
- Other London – 371 x 0.4 = 148.4 days

Type C clients (requiring care / intermediate care type accommodation):

- Westminster – 1961 x 0.4 = 784.4 days

Type D clients (requiring wet medium support unless dry medium support available):

- Lambeth – 742 x 0.4 = 296.8 days
- Southwark – 132.5 x 0.4 = 53 days

Total adjusted potential bed day saving: 1,833.8 days

From this group the number of respite days required in each type of environment would be:

B&B type accommodation

- Lambeth – 44 x 26.5 x 0.4 = 466.4 days
- Southwark – 8 x 26.5 x 0.4 = 84.8 days
- Other London – 11 x 26.5 x 0.4 = 116.6 days

Care type accommodation

- Westminster – 88 x 26.5 x 0.4 = 932.8 days

Medium support, wet hostel type accommodation

- Lambeth – 28 x 26.5 x 0.4 = 296.8 days
- Southwark – 14 x 26.6 x 0.4 = 148.4 days

Medium support, dry accommodation (if available as alternative)

- Lambeth – 28 x 26.5 x 0.4 = 296.8 days
- Southwark – 14 x 26.5 x 0.4 = 148.4 days

10 longest stayers

From Oct 2014 – Sept 2015 this group had a total of 36 A&E attendances (3.6 per client) and 36 admissions (3.6 per client, 10 were EMU only). The total number of bed days for this group was 954.

30% had some sort of mental health problem, 40% had addictions, 60% had some sort of mobility issue.

50% Lambeth, 10% Southwark, 10% Lewisham, 20% other, 10% not possible to say, 30% had no recourse to public funds, 30% did not have a local connection.

90% had some sort of delay, 90% might have benefited from some sort of step down (the other client died in hospital prior to discharge, but was a delayed discharge at that point).

In terms of client type 40% were A, 30% B, 10% C and 20% D.

284 days that could have potentially been saved in this group, which can be further split down by borough.

In summary:

Type A clients (requiring B&B type accommodation):

- Lambeth – 2 clients. 39 bed days could have been saved. 39 days required in B&B.
- Other London – 1 client. 16 bed days could have been saved. 16 days required in B&B.

Type B clients (requiring B&B or care / intermediate care type environment):

- Southwark – 1 client. 37 bed days could have been saved. At least 37 days required, probably in care type environment.
- Other London – 1 client. 17 bed days could have been saved. At least 17 days required, definitely in care type environment.
- No borough established – 1 client. 29 bed days could have been saved. 29 days required in a B&B type environment.

Type C (requiring care / intermediate care type accommodation):

- Lambeth – 1 client. 107 bed days could have been saved. 107 days required in a care type environment.

Type D (wet, medium support)

- Lambeth – 1 client. 23 bed days could have been saved. 23 days required in respite.
- Other London - 1 client. 16 bed days could have been saved. 16 days required in respite.

It would not be reasonable to multiply these bed day numbers up, because these were the longest stayers, however it might be reasonable to suppose these numbers might be replicable.

Total predicted bed day saving for this group - 284 days.

One of these clients might have been able to benefit from a dry 'detox type environment if this were available.

Lambeth – 1 client. 23 bed days could have been saved. 23 days required in respite.

In summary from this group the number of respite days required in each type of environment would be:

B&B type accommodation

- Lambeth – 39 days
- Other London – 16 days

Care type accommodation

- Lambeth – 107 days

Medium support, wet hostel type accommodation

- Lambeth – 23 days
- Other London – 16 days

Medium support, dry accommodation (if available as alternative)

- Lambeth – 23 days

14 frequent attenders (suggested from approx. 60 frequent attenders in total at GSTT)

From Oct 2014 – Sept 2015 the 14 frequent attenders accrued 327 A&E attendances (23.4 per person), and 127 admissions (9 per person, 42 were EMU only), but only accrued only 498 bed days (thus demonstrating the point that these clients are often not the longest stayers).

86% had some sort of mental health problem, 93% had addictions, and 43% had some sort of mobility issue.

43% Lambeth, 14.2% Southwark, 21.4% Westminster, 21.4% other. 7% had no recourse to public funds, 21.4% had no local connection.

57% had some sort of delay at some point, 100% could have benefited from some sort of step down.

100% were in client group D.

159 days that could have potentially been saved in this group, although this is harder to assess than in the other cases. These would all be required in a wet, medium support environment – however it is important to note that ideally you would be aiming to admit these clients to a dry medium support environment if this existed. 5 out of 14 of these clients have made active attempts to quit in the last year, and 8 would have benefited from a supported dry environment on discharge from hospital at some point, so an estimate for dry bed days is made below.

Type D clients (requiring wet medium support unless dry medium support available):

- Lambeth – 6 clients. 73 bed days could have been saved. At least 94 days required in respite.
- Southwark – 2 clients. 30 bed days could have been saved. At least 37 days required in respite.
- Westminster – 2 clients. 24 bed days could have been saved. At least 58 days required in respite.
- Other London - 4 clients. 32 days could have been saved. At least 29 days required in respite.

8 of these clients might have taken up the opportunity of a dry 'detox type' if this were available:

- Lambeth – 4 clients. At least 61 days required.
- Southwark – 1 client. 30 days required.
- Westminster – 1 client. 30 days required.
- Other London – 2 clients. 21 days required.

This sample was suggested from around 60 frequent attenders on the lists at GSTT. They were identified as clients likely to benefit from respite, but it is likely that some others might also benefit. It was decided to multiply these numbers up by 2 to provide an accurate estimate (rather than 4, as it is likely that some of the clients not chosen would be less likely to benefit).

Total predicted bed day saving for this group would be 159 x 2 = 318 days.

In terms of the provision required:

Type D clients (requiring wet medium support unless dry medium support available):

- Lambeth – 94 days x 2 = 188 days
- Southwark – 37 days x 2 = 74 days
- Westminster – 58 days x 2 = 116 days

- Other London – 29 days x 2 = 58 days

The dry beds that might be required would then be suggested to be:

- Lambeth – 61 days x 2 = 122 days
- Southwark – 30 days x 2 = 60 days
- Westminster – 30 days x 2 = 60 days
- Other London – 21 days x 2 = 42 days

From this group the number of respite days required in each type of environment:

Medium support, wet hostel type accommodation

- Lambeth – 188 days
- Southwark – 74 days
- Westminster – 116 days
- Other London – 58 days

Medium support, dry accommodation (if available as alternative)

- Lambeth – 122 days
- Southwark – 60 days
- Westminster – 60 days
- Other London – 42 days

Kings

20 clients were examined in 2 sets.

10 cases were randomly selected from 30 cases in total that had been readmitted during the year (every 3rd case).10 cases were randomly selected from long stayers (every 10th patient from down from the longest stayer from 158 stays)

10 clients that had been readmitted at some point (from sample of 30 clients that had a readmission)

From Oct 2014 – Sept 2015 this group had a total of 49 A&E attendances (4.9 per person) and 30 admissions (3 per person, 2 were CDU only). The total number of bed days for this group was 170.

80% had some sort of mental health problem, 80% addictions, 20% had some sort of mobility issue.

80% had some sort of delay, 70% could have benefited from some sort of step down.

30% Lambeth, 40% Southwark, 20% Westminster, 10% other. 30% had no recourse to public funds, and a further 20% had no local connection (in this case Westminster is included as no local connection)

20% were client group A, 10% B, 70% D.

69 days that could have potentially been saved in this group, which can be further split down by borough.

Type B clients (requiring care / intermediate care type environment):

- Southwark – 1 client. 15 bed days could potentially have been saved. 15 days would have been required.

Type D (wet, medium support)

- Lambeth – 3 clients (1 with NRPF). 26 days could have been saved. 56 days would have been required in respite (although this includes 14 days for one client with NRPF)
- Southwark – 1 client. 12 days could have been saved. 14 days required in respite.

- Westminster – 1 client (with NRPF). 7 days could have been saved. 7 days would have been required in respite.
- National – 1 client. 9 days could have been saved. 7 days would have been required in respite.

4 clients would have benefited from a dry medium support environment if this were available:

- Lambeth – 3 clients. 56 days would be required, although this includes 14 days for one client with NRPF)
- Southwark – 1 client. 14 days would be required.

These bed days have been multiplied by 3 as this is a random sample of 10 of the 30 cases, as per the sampling strategy above.

For these 10 admissions the total number of bed days was 170 days. The total number of admissions for Kings was 288. If 170 is multiplied by 28.8 this comes to a total of 4896 bed days – very similar to the actual total of 5062. As such this sample seems fairly representative of the whole.

Thus total bed days saved:

Type B clients (requiring care / intermediate care type environment):

- Southwark – 15 x 3 = 45 days

Type D (wet, medium support)

- Lambeth – 26 x 3 = 78 days
- Southwark – 12 x 3 = 36 days
- Westminster – 7 x 3 = 21 days
- National – 9 x 3 = 27 days

Total potential bed day saving: 207 days

In summary from this group the number of respite days required in each type of environment:

Care type accommodation

- Southwark – 15 x 3 = 45 days

Medium support, wet hostel type accommodation

- Lambeth – 56 (or 42) x 3 =168 days (126 days used in table)
- Southwark – 14 x 3 = 42 days
- Westminster – 7 x 3 = 21 days
- National – 7 x 3 = 21 days

Medium support, dry accommodation (if available as alternative)

- Lambeth – 168 days (126 days)
- Southwark – 42 days

10 long stays (from 158 long stays)

From Oct 2014 – Sept 2015 this group had a total of 28 A&E attendances (2.8 per person) and 20 admissions (2 per person, 2 were CDU only). The total number of bed days for this group was 461.

80% had some sort of mental health, 40% addictions, 50% had some sort of mobility issue.

50% Lambeth, 50% other. 30% had no recourse to public funds, 10% unknown, and a further 30% had no local connection.

90% had a delay, 60% could have benefited from some sort of step down.

40% A, 10% B, 10% C, 40% D.

124 days that could have potentially been saved in this group, which can be further split down by borough.

Type A clients (requiring B&B type accommodation):

- Lambeth – 2 clients (1 with no recourse to public funds). 59 bed days could have been saved, 75 bed days would have been required (the NRPF client accounted for 15 days in both tables)
- Other London – 2 clients. 35 days could have been saved. 35 days would have been required.
- Type D clients (requiring wet medium support unless dry medium support available):
- Lambeth – 2 clients (1 with no recourse to public funds). 30 bed days could have been saved, 35 days would have been required (the NRPF client accounted for 21 days in both)

Two of these clients might have taken up the opportunity of a dry 'detox type' if this were available – both from Lambeth.

- Lambeth – 2 clients. 30 days (21 days was client with NRPF)

[N.B. the client with NRPF had worked, but was unable to prove his worker status, and wanted to return to work. After a serious suicide attempt, he needed follow up from the home treatment team. He was also expressing an active desire to stay off alcohol and move away from the drinking friends that he had been sofa surfing with and get back into work. If he could have been funded for a dry environment temporarily whilst home treatment had been delivered, and his options were explored, potential future deterioration and health costs might be avoided. This client stood out as someone where there would have been a clear business as well as humanitarian case for treating despite having no recourse.]

The bed days were multiplied by 15.8, as this is a nearly random sample of 10 of the 158 admissions over 5 days, as per the sampling strategy above. However it was known that the sample was slightly skewed towards the higher end, as every 10th patient was taken, counting down from the highest.

Type A clients (requiring B&B type accommodation):

- Lambeth – 59 x 15.8 = 932 days
- Other London – 35 x 15.8 = 553 days

Type D clients (requiring wet medium support unless dry medium support available):

- Lambeth – 30 x 15.8 = 474 days (21 client was Eastern European NRPF) [9 x 15.8 = 142]

For these 10 admissions the total number of bed days was 461 days. If 461 is multiplied by 15.8 this comes to a total of 7284 – larger than the actual total 4788. As such it is likely that this group may not be fully representative of the whole, and it might be reasonable to multiply these numbers by 0.65 to get a more accurate estimate.

Total potential bed days saved in this group is (932 + 553 + 474) x 0.65 = 1273.35.days

In terms of the provision required this would be:

Type A clients (requiring B&B type accommodation):

- Lambeth – 75 x 15.8 x 0.65 = 770 days (15 days was client with NRPF - with this client removed - 60 x 15.8 x 0.65 = 616.2 days - this number was used for totals)
- Other London – 35 x 15.8 x 0.65 = 359.5 days

Type D clients (requiring wet medium support unless dry medium support available):

- Lambeth – 30 x 15.8 x 0.65 = 308 days (21 days was Eastern European client with NRPF - with this client removed - 7 x 15.8 x 0.65 = 72 days - this number was used for totals).

Two of these clients might have taken up the opportunity of a dry 'detox type' if this were available – both from Lambeth.

- Lambeth – 30 x 15.8 x 0.65 = 308 days (21 client was Eastern European NRPF)

[With NRPF client removed - 9 x 15.8 x 0.65 = 92 days – this number was used for the totals]

In summary from this group the number of respite days required in each type of environment:

B&B type accommodation

- Lambeth – 770 days (616.2 when NRPF client removed)
- Other London – 359.5 days

Medium support, wet hostel type accommodation

- Lambeth – 308 days (72 days if NRPF client removed)

Medium support, dry accommodation (if available as alternative)

- Lambeth – 308 days (92 days if NRPF client removed)

SLaM

22 clients suggested by team as clients who might be eligible for respite (from 97 clients seen by the team at that point)

45% had some sort of physical health problem, 55% addictions, 9% had some sort of mobility issue.

22.5% Lambeth, 50% Southwark, 9% Lewisham, 4.5% Westminster, 13.5% other. 36% had a welfare / eligibility problem.

73% had a delay, 82% would have been suitable some sort of step down (1 went to temporary accommodation with the support of a rehab team, which could equally have been delivered in a respite, but was not actually included in analysis below because they did have existing provision)

Client type was 32% A, 18% B, 4.5% C, 45.5% D.

494 days that could potentially have been saved in this group (plus extra 91 days B&B), although in a few cases although it was clear the clients didn't need to be in hospital any longer it was unclear whether the current visions of respite would be appropriate. When unclear, these cases were left out.

494 days could have been saved.

Type A clients (requiring B&B type accommodation):

- Lambeth – 1 client. 21 bed days could have been saved (plus 7 days B&B). 28 respite days would have been required.
- Southwark – 3 clients. 133 bed days could have been saved. 133 respite days would have been required.
- Other London – 1 client. 28 days (plus 8 days B&B). 36 respite days would be required.

Type B

- Southwark – 1 client. 165 bed days could have been saved (plus 20 days B&B). 180 respite days would have been required.
- Type D clients (requiring wet medium support unless dry medium support available):
- Lambeth – 3 clients. 7 bed days could have been saved (+ 21 days B&B). 63 respite days would have been required.
- Southwark – 5 clients. 116 days could have been saved (+ 24 days B&B). 144 respite days would have been required.
- Lewisham – 1 client. 1 bed day could have been saved (+ 11 B&B days) 14 days respite days would have been required.
- Westminster – 1 client. 23 days could have been saved. 40 respite days would have been required.

4 clients in group D might have benefited from a dry environment if this were available.

- Lambeth - 21 days
- Southwark – 36 days (+14 days B&B)
- Westminster – 23 days

In summary from this group the number of respite days required in each type of environment:

B&B type accommodation

- Lambeth – 28 days
- Southwark - 133 days
- Other London – 36 daysAQ

Care type accommodation

- Southwark – 180 days

Medium support, wet hostel type accommodation

- Lambeth – 63 days
- Southwark – 144 days
- Lewisham – 14 days
- Westminster – 40 days

Medium support, dry accommodation (if available as alternative)

- Lambeth – 21 days
- Southwark – 50 days
- Westminster – 40 days

APPENDIX 4

Interview summaries

GSTT

Dr Adrian Hopper – Quality Improvement and Patient Safety Director / Medical Consultant GSTT

Felt that there needed to be a clearly articulated potential benefit in terms of reducing overall bed days in order for any project to be piloted – Adrian noted that the number of long stayers in the cohort was relatively small, so there would need to be a decent turnover of patients in order to reduce costs. Felt it was important to keep the focus on move-on within the facility. Also felt it would be vital to teach inpatient teams to prospectively identify candidates (Pathway could do this) in order to maintain this flow.

However also indicated that delivering 'value based healthcare' (i.e. delivering perceived greater value for patients) was an argument in itself – i.e. if a pilot achieved better health outcomes and clear value for patients, whilst still needing to demonstrate cost efficiency, and ideally being cost neutral, the pure cost argument would be less important.

After reviewing early results Adrian favoured looking at a dry, small facility, possibly stand-alone, possibly in a care home environment, with disability access, probably local people only (i.e. Lambeth and Southwark). Acknowledged the need to negotiate with Local Authorities about this project, and also acknowledged that any project providing services to non-local people would be harder to sell to a local Local Authority.

Discussed the minimum viable number of beds to run a stand-alone service – felt 10 should be the minimum considered. Also felt we should try to design around not 100% bed occupancy in order to ensure flow is possible.

However discussed prior initiatives where 6-8 beds had been purchased from care homes for the purpose of rehab, where this didn't really work, because ethos of the home was not empowerment / rehab. If placed within a care home, felt new staff would need to be put in to staff that wing / the chosen beds.

Discussed the fact the many Local Authorities are now using Premier Inn when they don't have disability accessible temporary accommodation. Could a business provider could be persuaded to do some social enterprise type project to support the three Trusts?

Felt that it was probable that provision for 'young olds' need to be revisited.

Karen Proctor – Director of Adult Nursing Services, GSTT

Very supportive in principle of a step down facility, and recognised the groups of homeless people identified in the data. Profiled some long term bed blockers with care needs.

Liked the step-down ward idea (with appropriate staffing to manage move on issues, help with mental health and addictions, and provide support), but recognised the current lack of estate.

Amanda Williams – General Manager, Adult Community Services, GSTT

Felt it was important to define what we are trying to achieve with this project.

Felt that 'medical respite' was inherently about improving services for the core homeless / rough sleeping population, and that local management staff could only really concentrate on the local population.

Felt that that current Homeless Intermediate Care Project in Lambeth is an example of good practice, and that we should ideally build on this project rather than create a new one. Felt we could look at expanding skills of HICP staff e.g. to be able to provide intravenous antibiotics if there was felt to be a clinical need for this.

However inherently felt that 'early discharge' wasn't really appropriate for core homeless patients. Referred to the revolving door and self-discharge issues in the early stages of homeless patients becoming unwell.

Felt that the @Home team would be not really be relevant in planning any mainstream options, because this service delivers a very specific 'early discharge', high clinical support type model. Felt our clients' needs are more chronic, and less clinical per se. Discussed the potential for the Pulross providing respite beds, but said there are plans for part of this to become a neuro rehab unit, so no current spare beds. Also noted that for clients to be admitted to Pulross overall they needed to have clear rehabilitation objectives – which is a different focus from respite per se.

Overall felt that a Pan London solution could and should be looked via GLA / NHS England specialist commissioning funding.

Karen Titchner – Deputy Lead Nurse, Community / Clinical Lead @ Home

@Home service is a high clinical support service providing 3-5 day input (mostly) to support early discharge or avoid admission, primarily in the older population.

Had no problem in principle with working together to improve services for homeless people in hostels, although said it was important to note that the current service is up to capacity. However with regard to supporting a facility that provided services to non-local people noted that the service only currently delivers services to clients with Lambeth or Southwark GPs (and the service is charged to that borough). If the service were to manage out of borough clients capacity a new charging model would need to be considered.

An example was given of a homeless client residing in a Lambeth Assessment Centre safe seat who had NRPF and no NHS number (and therefore could not be either handed on or charged). @Home team took the client on, but had no one to discharge them to (local District Nurse services will not take anyone without an NHS number because they cannot be added to their clinic system). As such the team ended up case loading the client for 4 months until the client was returned home (even though the clinical intervention was very low level - BD insulin administration and blood sugar monitoring). In all fairness this was a good result for the client, and the client case was resolved, but unclear who has paid in the meantime, and client was not suitable for a high clinical support service.

Described that the previous difficulties regarding delivering services in hostels have been:

- lack of clinic room, or safe/clean environment to keep equipment / medication stores
- clients not being in – wasted visits
- where to safely discharge patients to (see above)

Suggested in general that a model that would work would be similar to that with Learning Disabilities – where the Learning Disabilities nurse manages the appointments, and is there when interventions are delivered. In other words if a stand-alone unit had a full-time Homeless Intermediate Care Nurse who could facilitate relationships this would probably help.

Laura Wilson – Senior Site Nurse Practitioner / Delayed Discharge Manager

Noted increasing difficulties in finding care placements for certain client groups – in particular under 65s, clients with mental health problems, clients with behavioural issues (particularly Personality Disorder) and clients with neurological problems. As CQC has closed down some homes or given them improvement notices better homes have been able to be choosier.

Noted that next year a 'Discharge to Assess' unit is planned mainly for frail elderly. This will be for clients who might take weeks to 'rehome'. Such an environment would benefit from having an OT, physio, social worker input, and have carers to support with ADLs, but little or no nursing input. Would need to be accessible. Aimed broadly at those with care needs who definitely need a care home environment on discharge, but might be a suitable environment for those going into temporary accommodation with support.

Discussed possible use of Simon hotel for homeless patients awaiting temporary accommodation with low needs – said these beds are for patients currently undergoing booked low level treatments, so any voids might be complicated by future bookings.

Noted that occasional use of B&B (supported by Samaritan Fund) to get clients out of hospital was still going on.

Amy Wolfe – GSTT Trust Accommodation Manager

No problem in principle in considering use of Simon hotel for homeless patients with no mental health / addiction problems just awaiting temporary accommodation. However Simon hotel used for booked outpatient therapies for client having to travel in (e.g. radiotherapy). As such bed occupancy Monday – Thursday is often up to 98%, although is considerably lower at weekends, but beds are often pre-booked for the following week. Could only really be considered if the specific period of time needed was known, and might not be possible due to bookings.

All staff accommodation on and off site currently being used (i.e. flats / study bedroom accommodation etc).

Carmen Rojas - 3 Borough Services Manager and Fenella Jolly – Health Inclusion Team manager

(The Health Inclusion Team provides the Homeless Intermediate Care Service. The Health Inclusion Team sits within 3 Borough Services.)

Broadly supportive of this options paper, and can definitely see there are unmet needs. However concerned re Health Inclusion Team capacity to support additional projects without extra staffing. Acknowledged need for 'dry' step-down if possible, but also noted need for 'wet' step up. Favoured building on existing services as much as possible, rather than trying to create new ones.

Acknowledged role of Housing Workers on the Pathway team, and wondered whether one could be promoted to run whatever 'medical respite' option was chosen. Also felt that the use of Band 4 homeless support worker posts could be introduced.

Margaret Ogendengbe - TB team manager

TB team works across Lambeth, Southwark and Lewisham. Definitely thinks there is a need for appropriate temporary accommodation that can be used to monitor people taking Directly Observed Therapy for TB.

Ideally accommodation should be self-contained – you ideally wouldn't want these patients using communal facilities, even after their period of initial treatment. Ideal situation would be a number of self-contained bedsits. Ideal would be for a 4-6 bedded unit with self-contained facilities with support worker during the day. Note lengths of stay would be 6 months potentially.

Described a number of borough boundary issues, and difficulties getting housing departments to take responsibility.

Dr Zana Khan – GSTT Pathway Team Clinical Lead GP

Very disparate groups of people being discussed with a variety of needs – more than one solution is needed. Existing provision needs to be re-examined first.

There are a large number of young olds with cognitive difficulties that are very difficult to place. Gave recent example of client with past alcoholism. Now has MOCA of 7, and wanders at night time, and needs full care. No placement currently available in borough. This really is bed blocking, but would need full intermediate care type environment which would be expensive to provide.

Does think hostel system is failing to meet the needs of clients who are deteriorating and need increased support - an expansion of the current homeless intermediate care service might be useful to meet this need. Ideally build on existing capacity / skills and expand Graham House service (? opportunity in the re-build to influence design of the building).

Thinks any community based project needs to be managed by a GP practice, preferably one with considerable experience in this field e.g. Mawbey Brough or Waterloo Health Centre.

Felt there was a potential need for small number of B&B places for those waiting temporary accommodation. Felt there was a potential need for a small number of dry beds to give patients aspiring to abstinence a chance.

Kendra Schneller – Lead Nurse, Homeless Intermediate Care Project, GSTT and Lisa Burnard – Health Support Worker, Homeless Intermediate Care Project, St Mungos Broadway

Project has consistently achieved a reduction in A&E attendance and admissions, and is very well thought of by patients. However hard to achieve long term recovery outcomes due to a) lack of appropriate environment(s) for clients detoxed in hospital to go to b) lack of suitable move-on placements for other clients c) lack of meaningful activities for clients.

In principle would like to develop project to benefit more people, but would need more staff, and potentially other types of staff. Project also need the capacity to enable flow (i.e. not 100% bed occupancy).

Nwamaka Okoye – Community Nurse Specialist, Health Inclusion Team

Felt medical respite was much needed, but that hostels were not the best place for this. Favoured a 'homeless ward' or stand-alone unit, which could provide assistance with ADLs for those that needed it.

Felt that much could be achieved within existing services with improved communication between hospital and community services staff, and better trained staff.

Alex Newman-Burke – Programme Manager, Strategic Estates Development, GSTT

No estate in hospital (e.g. empty wards) or out of hospital (e.g. disused clinics / hospital environments available within GSTT.

However Alex said his department were happy to help with estimating / costing the running costs of a stand-alone unit, if this were the option that was chosen.

Kings

Sue Bowler - Director of Integrated Care and Partnerships / Interim Divisional Manager Women's and Children's, Kings

Broadly supportive, and recognises need, but noted the differences in the types of clients being discussed, and suggested it might be pragmatic to pick one group of clients and undertake a pilot on that group alone.

Commented on recent intermediate care project that failed (where Consultants maintained responsibility):

- Tried to do it too quickly
- Lack of clarity on purpose
- Mainly staffed by agency staff (not enough of the right kind of staff)
- Consultants didn't trust lower support ward and didn't buy in
- Ward too far away – contributed to lack of buy in

Suggested Pulross beds might be a good place for a small pilot (this was prior to the discussion with Amanda Williams). Also suggested looking at care home facilities in the community (felt that segmenting a facility might be possible) and this could be discussed with Local Authority Commissioners.

Rose O Keefe – Discharge Team Manager, Kings

Cases are often delayed due to lack of placement availability. As such social services / housing etc should be asked to contribute to funding of step-down facilities.

Many long stays complicated by NRPF issues, and different boroughs have differing approaches. Cited one case where the Trust had to go to the Court of Protection to acknowledge its responsibilities, and other cases where clients have eventually gone to charitable hostels where it might have been thought by health they would meet the care threshold.

General concern regarding the decreasing number of beds in hostels, resulting in an increase in rough sleeping, resulting in an increase in hospital attendance and admission.

Karl Mason – Kings Pathway Team Manager

Felt it was important to focus on what we are trying to achieve, and see if this can be achieved without creating new services.

Ideally need to stop the revolving door, and improve quality care. One pragmatic non-bed based initiative would be to pilot a Rapid Response post discharge follow up service. This could be piloted for a month with some additional support from a Band 6 or 7 nurse or perhaps OT linked in to both the Pathway and Health Inclusion Teams. This would be targeted at known frequent attenders and high risk temporary accommodation discharges, with a high possibility of readmission. The idea would ideally be to provide next day review by a clinician, and 7 day follow-up by the most relevant professional.

Next-day clinician would visit to do medication reconciliation, ensure the client was aware of the discharge plan, confirm / make arrangements for any OPD appointments, ensure GP registration, and screen for readmission risk. Robust transfer of care from the Pathway Team to the Health Inclusion Team would form part of the process.

Dr Caroline Shulman – Pathway team Clinical Lead GP

Feels there is a definite need for two environments – one wet, one dry.

Gave an example of one client for who there was a 'glimmer of serious hope' of giving up alcohol, who requested not to go to a hostel environment. Eventually went to a St Mungos hostel HDN. Was very disappointed to be back in a hostel, and even asked for an escort to get Methadone so he wouldn't be tempted. Relapsed and 'hated himself', and relationships with professionals became disrupted again after that. However some people are unable to give up alcohol, and still need extra support.

Felt there was a possible use of B&B for those who don't need a high degree of support – and who were just waiting for their temporary accommodation case to be resolved. Noted a high number of people 'messing around in the system until they become priority need'.

Personally felt that 8-25 beds could be filled, although several would be filled by people where there is a battle going on with social care.

Felt it would be very difficult for Pathway team GPs to hold governance for step-down beds as not they are not embedded within GP practice – hence there would be issues with cover / on call, governance etc. Possible practices for community projects might be Waterloo / Mawbey Brough / Princess Street.

Sue Field – Estates Manager, Kings

No current in or out of hospital estate that would be relevant to this project.

SLaM

Dr Ranga Rao – Clinical Director, Psychological Medicine CAG

Broadly supportive. Acknowledges current B&B arrangements are not entirely suitable for many patients, and there is limited governance around these placements. Any improvement on this might be beneficial for those with discharge related issues.

Jenny Knott – SLAM Lead for Delayed Discharge

At time of interview around 30 current delayed discharges across the Trust with 100 potential delays identified. However felt homelessness was a relatively low level factor in delayed discharge.

Felt 'medical respite' has different connotations to different people and this needed to be worked out. Said there is a need to think clearly about the mix of clients in a project, because this is what makes and breaks projects. Concerns re mixing mainstream homeless clients with some of the mental health clients managed by the Pathway team (who are often more 'hidden homeless') who may be quite vulnerable. Cautious about mixing mental health and physical health generally.

Concerned re not wanting to move people too many times as this can be detrimental to mental health (although acknowledged that many of our clients go into temporary accommodation before their final placement, but this might put in an additional move).

Felt that a step-down KHP ward with different staffing (who would look at complex move-on issues) might be valuable, but said there is no estate and even if there was it might require significant financial input to make it fit for purpose.

Felt there is a general lack of high support and medium support housing. Particularly identified a lack of suitable accommodation for ex-homeless clients with a history of substance abuse with too high needs for supported housing.

Could see the potential for a 'crisis house' for personality disordered clients.

Felt respite model in Lewisham needs looking at as an example.

Fran Busby – START Team Lead

Felt that delays for START team clients to get into accommodation are generally due to referral and assessment processes for supported accommodation (e.g. getting a place on Complex needs panel meetings), or due to Local Authorities identifying accommodation. The process can take months.

Could envisage an environment where clients could be discharged earlier to (whilst waiting for placement), with Home Treatment Support, but there would need to be clarity about the goals of the project.

Noted that there used to be a respite called Dove House which was closed because it had no referrals (although it wouldn't accept anyone without a confirmed discharge address).

Suggested that additional homeless nurses could be placed in key district nursing teams to support discharges, and/or look at up-skilling district nursing teams.

SLaM Lambeth Consultants meeting (Chaired by Dr Jonathan Beckett) – 6 Consultants in attendance

Group was able to identify two clear groups of people:

- Those with primarily mental health problems who are fit for discharge but who don't have a home to go to currently, and/or those who are home treatable, but don't have a home. These clients are sometimes awaiting a pre-identified bed in a placement, or need presenting at the local authority.
- Clients with tri-morbidity or complex interplay of mental health / physical health who need extra clinical support post discharge, and may also have complex needs and complex move-on issues.

There was considerable discussion about whether these two groups could be managed together, and whether they needed the same things. The two groups were broadly felt to be 'bed blocking' and needing 'recovery support'.

General consensus that a step-down unit for either purpose would get used, but criteria would need to be clear, and there would be a requirement for robust management to stop bed-blocking.

There was a discussion about current B&B arrangements – environment was considered inadequate, and too far away. Participants said they sometimes opted not to place people in B&B, because clients were considered too vulnerable. Also it is harder to manage the exit plan from a distance. Some issues were mentioned re clients running out of money in B&B, and not getting to pre-booked appointments due to lack of support / distance of B&B.

There was a broad consensus that both mental health and physical health care client groups could be managed together – given both sets of issues would be at a sub-hospitalisation level. There was a discussion about non-homeless people suffering tri-morbidity issues, and whether they could also be included.

One Consultant commented that it is possible that if you opened a facility like this people who would not normally end up in hospital might end up in here there i.e. you might create a new, quality service for a certain section of the population, but do nothing about the existing population.

There was a discussion about the need to have clear protocols to manage clients with high risk.

Soon to be new bed management strategy where each borough clients should ideally be in their own beds – i.e. Lambeth clients in Lambeth beds. This project needs to link in to that strategy.

SLaM Southwark Consultants meeting (Chaired by Dr Rob Harland) – 6 Consultants in attendance

As initial feedback felt that the Pathway team had been extremely successful, and that any extra resources should be pumped into supporting the Pathway team to do its work, rather than adding in extra services per se.

General discussion about lack of supported accommodation and appropriate care homes. CQC closures of some homes mentioned. Concern that any new facility would therefore just become bed blocked (i.e. it might cost less, but wouldn't solve the problem).

Felt that improved B&B facilities would be welcomed, and would get used, and there was discussion about some homeless clients who might otherwise be home treatable.

Discussion re tri morbid clients with high need, and if one facility had these clients only it would need to be well staffed with staff with the right skill set, and there would need to good risk management.

Felt there needed to be discussion with the dual diagnosis and psychiatric liaison teams. There was a discussion re diversion from psychiatric liaison, and what could be provided short term for clients in crisis.

Julie Winnington – Clinical Liaison Lead Addictions, SLaM

Recognised need for dry respite for some people who are ambivalent / pre-contemplative whilst in hospital, but who have not been properly engaged with services previously. Acknowledged that although commitment now exists to try to meet the needs of these people (at least in theory), process takes 2-3 weeks, and hospital needs bed spaces.

Wondered whether 'medical respite' service with Equinox (Brook Drive) or similar could work. Equinox is a 25 bedded detox serving more than one borough. 8 beds due to be made suitable for complex needs with nurse cover and Consultant input, in an area separate area to rest of unit. Will be disability accessible. Suggested perhaps with housing worker and Health Inclusion Team input into some beds (? 2), these beds could potentially be used for this client group for time limited interventions on discharge from hospital. Broadly working with hospital detoxed clients intensively to see if they can stay stopped, and be moved on appropriately. Cost of bed

is approximately £200 / night (less than hospital bed). Beds potentially could be spot or block purchased. Beds are currently used by people outside host borough.

Also had some comments about the Lewisham HDN when it was open. Felt 'environment totally unsuitable for hospital discharge – no food, first floor, view from the window was people drinking outside', and thus felt medical respite outside a hostel environment was more preferable.

Noted that Alcohol Assessment Unit was recently closed because not enough use – expensive at £400 / day, and only providing brief interventions; however AAU could manage complex needs, and the hospitals may consequently now have more alcohol related admissions. Community services are now going to be managing complex needs detoxifications (hence the potential changes at Equinox).

Dr Mike Kelleher – Substance Misuse Consultant, SLaM

Felt 'medical respite' was much needed to provide a stop-gap for substance misuse clients who have been detoxed in hospital, and are willing to try to stay dry.

However a high number of clients would be on Methadone maintenance etc, and if this needed to be picked up by a community team, the community team might be reluctant to do this and/ or require some financial re-numeration in order to provide this service, if there was a question of non-local clients being managed. Non-local clients might need to stay under hospital jurisdiction for substitute prescribing if this were possible?

Asked whether clients would be formally discharged, or in fact might remain admitted, but be in lower cost beds.

Adam Lewczynski – Manager, Property Department, Planning and Capital Projects, SLaM

No ward, or out of hospital estate currently available. Will let us know if anything comes up.

Partners

Paul Hamlin – Housing Liaison Worker, St Mungos Broadway currently seconded to GSTT Pathway

Felt there is a need for an accommodation project for medically vulnerable hospital patients who are not granted temporary accommodation immediately on first approach to a Homeless Persons Unit, but who otherwise face rough sleeping on discharge. Feels Local Authority bar is getting higher, and more people are being initially knocked back, but have cases that can be won. In some cases these clients are being discharged to fend for themselves, and sorting them out properly would stop the revolving door.

Things this could be done either locally, or on a pan London scale, and be linked to 'No Second Night Out', and 'No Living on the Streets'. Perhaps 'No Dying on the Streets' to emphasise the clinical need for these clients to be housed.

Also thinks that an extension of Groundswell work to cover more boroughs, and link people into mental health and substance misuse services (i.e. not just GP and hospital appointments) would be great - perhaps even offering short-term floating support work for those leaving hospital (so helping with benefits and housing issues etc) where there is a huge current gap in services. Felt access to, and provision of floating support services should be reviewed.

Chris Dutton – Housing Liaison Worker, St Mungos Broadway currently seconded to GSTT Pathway

Feels it would be beneficial to have jointly funded link posts in reablement teams that provide the link between housing and in-hospital teams and thus inform and streamline the process.

Dr Jasper Mordhorst – GP, Mawbey Brough / outreach GP to Graham House

Felt 'medical respite' provision would be much welcomed, particularly if not in a hostel environment, as it might provide an opportunity to turn around some clients. Particularly thought it made sense to provide step-down provision outside the hostel environment.

However had concerns about losing any of the current provision in hostels. Stated that current Homeless Intermediate Care Project has consistently reduced A&E attendance and secondary care usage, and this benefit would be lost if level of staffing in Graham House was reduced – i.e. felt new service should be additional, not alternative.

Feels current project provides step-up and end-of-life care effectively, and reduces morbidity and mortality. As such would also support increasing nursing / health worker support in hostels.

Discussed the difference in perspective between 'bed blocking' and 'recovery intervention' – and noted that recovery interventions require engaging clients in the long term, and tend not to be cheap.

Jeremy Swain – Chief Executive, Thamesreach

Recognises potential need for medical respite. Feels alcohol is probably the right focus (i.e. getting people to manage their alcohol misuse is the overriding problem).

Feels that entirely abstinence based projects generally don't work. There needs to be control, limits, and intent to stay dry, and support available to help with this - but an open environment to help deal with lapses / difficulties. Thamesreach's Brixton STEP project was identified as a project that could be looked as a potential model.

Thamesreach would potentially be interested / working with such a project, but no obvious environment for this. Did note that the re-build of Graham House, and/or renovation of Robertson Street might present some possibilities.

Noted that through IPSA Alliance (current partnership between SLaM, Certitude and Thamesreach to appropriately house clients with chronic mental health issues) there is a lot of knowledge about local properties that might be relevant for use as stand-alone services, and said he would let us know.

Andrew Casey – Health Programme Director, St Mungos Broadway and Elin Jones – Lead Nurse, St Mungos Broadway

Interested in being involved in any new South London project, but noted Local Authority needed to be involved from the outset.

Happy also to look into possibility of the hospital spot or block purchasing beds, but Local Authority would need to be happy.

On basis of past experience:

- Project needs steering group
- Pilot period needs to be at least a year
- Data flow for outcome measurement needs to be sorted from the start
- Admission process needs to be streamlined – hospitals do not have time to wait for supported accommodation applications to be filled in – admission probably need to be on basis of local connection, and benefits entitlement (which can be established quickly) with paperwork (except risk assessment) done later
- Needs overnight cover
- Needs to be wheelchair accessible
- It would be difficult to provide 'dry' services in a hostel
- Services should ideally be step-up and step down to maximise business potential
- Needs to accept many referrals will be high risk, and there need to be clear protocols to deal with this

- Needs good move-on workers
- To adequately test a pilot there needs to be provision for follow-up

Nick Wing – Manager, St Mungos Broadway Great Guildford Street Manager and Mike McCall – Estates Manager, St Mungos Broadway

Great Guildford Street Hostel recently renovated at cost of £5 million.

Downstairs area fit for provision of medical respite. 8 rooms on ground floor, access can be shut off. All rooms large and clean with own bathrooms. Two rooms wheelchair accessible, and one is a flat with kitchen. Also communal kitchen downstairs. 2 clinical rooms, with accessible shower in between adjacent to this floor, very well specified. However no food currently being provided on site, and only 2.6% voids, so beds would need to be blocked in some way.

Probably not suitable for non-core clients, and is still a hostel – would potentially be hard for clients to stay dry in this environment.

Regarding potential properties for a stand-alone project, there is a dearth of small projects that could be specified to be disability accessible in South London. Renovation of Grange Road was suggested.

Peter Kennedy – End of Life Care Lead, St Mungos Broadway

Felt palliative care for homeless people is improving, and that national conversations around end of life care have helped. Noted his end-of-life care provision has been mostly about alcohol, not intravenous drug use.

Feels hostel environment is not suitable for medical respite, particularly if it is aimed at end-of-life care. Noted that staff in hostels consistently say they do feel they have the staffing levels, support or training to deal with this.

Says clients consistently say they want a) homely environment b) perceived greater independence c) psychosocial support d) symptom control. Important to assist people to 'die in character'. Feels independent units are required, perhaps studios with en-suite. Feels psychosocial support could be provided by e.g. volunteers or perhaps even counselling trainees?

Importantly noted that he has only had one client go into detoxification and rehabilitation after being given an end-of-life diagnosis, who relapsed and later died. However also noted that the opportunity presented by hospital admissions in the pre-palliative, and early palliative stages is often not capitalised on. Felt it was not well tested what interventions might help at this point. Noted lack of dry hostels, and too low levels of support in hostels generally – staff need time and resources to work with these clients.

Felt that clear contracts can be used to manage wet environments e.g. alcohol only in rooms, not in shared areas, and that potentially drinking could be better managed in a respite environment than it generally is in main stream hostels.

Generally felt that these clients have nothing to live for, and providing meaning was a key issue that needs dealing with.

Generally felt that end of life care conversations needed to start sooner, to try to intervene sooner.

Coleen Daniels – Nurse, Hackney HDN, St Mungos Broadway

On basis of experience thinks two types of facilities are needed – 1 hostel based for step-up. 1 not hostel-based for step-down for those clients who want to stay dry and are vulnerable to relapse (and this facility could also then take non-core clients). Sees clients for assessment in hospital and notes client often have concerns about coming back to hospital environments.

Notes importance of good links with local authority / housing. Flow has been enabled by 80-90% bed occupancy.

Maxine Radcliffe – Lead, Westminster Integrated Care Network for Homeless Health / Chair, London Network of Nurses and Midwives / Board Member, Westminster CCG

Westminster project has just started – it would be useful to see some initial outcomes before commenting more extensively.

It is important to note that medical respite per se is not the only perceived gap in services. Some other gaps that are frequently discussed pan London that should perhaps be considered are:

- End of life care (St Mungos have an excellent service, but there are difficulties in many areas)
- Specialist services for homeless people with personality disorder (some exist e.g. in Lambeth, but many more are needed)
- Specialist services for homeless people with brain injury
- Responsive treatment services for clients with Hep C
- The need for more 'care type environments' for chronically alcohol dependent clients and clients with cognitive / mobility issues (again, only limited provision exists). This will involve liaison between Social Care and Housing.
- Low level counselling for homeless clients with substance misuse issues (Westminster and St Mungos have the only current services)
- Specialist health services for women potentially including sexual health and midwifery outreach services for homeless women
- Residential substance misuse treatment options for EEA Nationals not returning home
- Medical respite (some limited models exist, but this needs developing / formalising)

Local Authority

Michelle Binfield – Associate Director for Public Health Commissioning, Lambeth

David Orekoya – Lead Commissioner, Health Improvement, Lambeth

Paul Davis - Lead Commissioner (Supported Housing), Lambeth

Recognised the groups of people identified in this report. Recognised this is a long standing pan London problem, and needs to be brought up in a pan London forum. Also recognised the probable need for different solutions to different problems locally.

Clients detoxed in hospital who want to stay dry - Broadly interested in the idea of respite beds within an existing community detoxification facility.

Clients in hostels who need extra support – Broadly interested in examining options to expand and build on the success of the existing Lambeth project. The big problems with providing more flexible medical respite in hostels have been:

- Running voids in a hostel (in order to facilitate a hostel discharge unit which can accommodate a flow)
- The 'dual housing benefit' required for a client to be in a medical respite bed, but also to have their bed held open. Where this is not case stays tend to be long, and getting people in tends to be delayed
- The lack of hostels with appropriate facilities

Lambeth would support further work to examine options for dry and wet provision. If GSTT Charity money would allow test of concept to see whether it makes a difference, could be commissioned in future (part of project might be to work out details).

Funding streams / models need examining. The potential long term solution of having a new locally agreed tariff for community based Medical Respite care was discussed. This tariff would be paid by the patients' CCG, who would hopefully benefit from a reduction in repeated acute

medical admissions. This was viewed favourably, and it was felt that this could be brought in the pan London forum.

Recognition of lack of care environments for older drinkers with cognitive deficits.

Other Relevant Projects / Teams visited or interviewed

@Home team in Lambeth / Southwark

3-5 days of clinical support in home environments, sometimes longer. Support step down and step up. Up to QDS visits. Very large team – Consultant Geriatrician, GP cover 8-8, 7 days a week. 38 Nurses (6 at Band 8a), OTs (2), Physio (6), Social Workers (2), Rehab Support Workers (14). Daily caseload of 90 patients.

Types of interventions:

- IVABs
- Nebs
- Fluid overload management
- Falls rehab
- Wound infections
- Catheterisation issues

Step-down to enhanced District Nursing Enhanced Rapid Response service.

All patients have to have Lambeth or Southwark GP. Cannot support clients without a discharge address. Have supported clients in hostels, although this has been limited.

KPIs are numbers of admissions avoided, numbers of perceived early discharges, and response time and this might fit with a medical respite designed to reduce bed blocking.

Lambeth Community Care Centre - Pulross

20 beds, 4 x 4 bedded bays, and 4 single rooms.

Nurse-led with GP in-reach. 4 trained nurses, and 3 Health Care Assistants during the day. 2 nurses overnight. @home can provide additional nursing support for short periods if necessary. OT and physio on site.

Service delivers assistance with ADLs, medication, nutritional support, physical rehabilitation and dressings.

Currently do not accept anyone without an address to go to. Have provided a service to a couple of homeless hostel clients in recent years with no problems.

Homeless Treatment Team - SLaM

The Home Treatment Teams in Lambeth, Southwark and Lewisham provide an assessment and treatment service for clients with severe mental health difficulties as an alternative to hospital.

The teams include nurses, social works and psychiatrists. Can only provide services to clients in a home, although this could be e.g. at the home of a friend or family member, or in hostel.

GSTT Simon Hotel

The Simon hotel is a 24 bedded hotel that normally caters for relatives of in-patients, or patients who have to travel a long way to hospital for elective procedures and need somewhere to stay on the evening before. The facility is also occasionally used for early discharges, e.g. if patients are unable to go home on the day of discharge, but are self-caring. The hotel also had self-contained accommodation.

The hotel is staffed 24 hours, but by non-clinical staff, but is on-site at the hospital.

Currently patients without an address cannot use this facility, however this could be looked into.

APPENDIX 5

Additional visit summaries

SLaM Bed and Breakfast

SLaM currently uses a variety of local bed and breakfast facilities to facilitate discharge for clinically fit clients with no discharge address. Patients are frequently discharged to the street from these bed and breakfast facilities if no alternative accommodation is found.

Olallo

GLA funded hostel, 32 beds.

18 beds – work ready beds for Eastern European verified rough sleepers who have been here less than 3 months. Intensive support to try to get into work.

4 beds – TB 'find and treat' – all on one floor. Living room with TV and books. Hostel worker is also nominated TB support worker that TB professionals work alongside.

2 beds – Pathway to Home – all one floor. Pathway team visit up to daily – hostel is near to hospital. @home team support as necessary. Dedicated clinic room. @home team have keys for medication cabinet.

8 reconnection beds – for people agreeing to be reconnected.

Communal meals. No drinking in communal areas.

No disability access or facilities. Lift to all floors, but doesn't always work.

Manager was open to more low level medical respite facilities being provided on site.

Aspinden Wood

Residential care, 26 beds. 10 on waiting list, 3 from Lambeth, Southwark and Lewisham. Those on waiting list can wait up to 2 years.

Clients all have chronic alcoholism, and have experienced homelessness A number of clients in wheelchairs, including amputees.

Wet hostel. Care provided – assistance with ADLs as required. 3 meals a day. No nursing input. In-reach GP once a week. Activities include reading group, gardening group, and massage. No problems accessing community OT and physio through the GP.

Recovery approach. No substance misuse treatments on site however. Palliative detoxs are arranged if necessary. Clients do sometimes go to detox and rehab.

Numerous frequent attenders. 5-6 hospitals visits from clients each week. At time of interview 3 service users were in Kings College.

Manager felt Homeless Medical Respite was much required – particularly to give clients time to think about their alcohol use, and consider treatment after being in hospital.

Deepdene House

Residential care, 20 beds. Unsure how many on waiting list. Clients often come straight in from hospital – both from mental health and physical health care environments.

Clients all have difficult mental health issues, and many have dual diagnosis issues (around 40%). About 20% have experienced homelessness.

Those with alcohol issues have strict contract, 2 clients are currently allowed to drink on site. Care staff try to work out drinking triggers, and work to avoid these. There are consequences for breaking contracts. Clients sometimes reduce drinking and become abstinent as they age.

Care provided – assistance with ADLs as required. 3 meals a day. No nursing input. No GP in-reach. Limited group activities as not necessarily suitable, but 1:1 activities as required.

Nice environment with garden. Emphasis on providing a home, a stable, quiet community, and fostering respect.

Clients frequently go to hospital, but not generally as a result of substance misuse – more physical health care problems related to the aging process.

Manager noted that 'shame' was a big issue in this group, and helping clients deal with their unbearable emotions is key.

Chichester Road

Residential care, 26 beds. 3 on waiting list, pan London. Those on waiting list wait up to about 6 months.

Clients all have chronic alcoholism, and have experienced homelessness. Some clients have mobility issues, no wheelchairs.

Wet hostel. Care provided – assistance with ADLs as required. 3 meals a day. No nursing input. In-reach GP once a week. All clients under appointeeship or similar with contracts for drinking.

No current problems with frequent attendance.