A Needs Assessment for Homeless Medical Respite Provision in North Central London

July 2019

Pathway 4th Floor East, 250 Euston Road, London, NW1 2PG www.pathway.org.uk

1 Introduction

1.1 Pathway is a charity that works to improve access to quality healthcare care for people experiencing homelessness. A core function of Pathway is to provide individual care co-ordination for homeless patients through a multi-disciplinary team approach. Pathway teams work with patients during their admission to support them into housing, support and social care.

1.2 However, despite this expert support, not all discharges are timely or to ideal destinations. Pathway conduct needs assessments to support hospitals around the UK in setting up 'in-house' teams. They also carry out assessments to ascertain demand for specific homeless services, including, for example, intermediate healthcare provision such as medical respite.[1]

1.3 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, ranging from low-level supported housing to comprehensive clinical care. Such services provide a safe, recovery-based environment to discharge homeless patients to. There is a growing international evidence base which shows that such services result in more positive outcomes for patients.

1.4 Based on Pathway's work to consider demand for medical respite provision in south London hospitals, the charity has conducted a similar needs assessment for acute Trusts located in North Central London.[2] The study also includes analysis of the needs of homeless patients in the Barnet, Enfield and Haringey (BEH) Mental Health Trust. Data was not available for Camden & Islington Mental Health Trust.

1.5 The report sets out the findings from the assessment based on an analysis of hospital data, detailed patient audits, stakeholder interviews, a review of relevant literature and learning from existing and past medical respite projects.

1.6 This report presents a range of options for stakeholder consideration around the ideal focus for medical respite in North Central London and the most appropriate service design to meet the needs of patients. The report also touches on the optimum size and location for a medical respite facility and makes recommendations for funding and operating provision.

[1] S. Dorney-Smith & N. Hewett, Options for Delivery of Homeless Medical Respite Services: KHP Pathway Homeless Team Scoping Paper, April 2016.
[2] London Boroughs of Camden, Islington, Haringey, Barnet & Enfield

2 Needs Assessment Report: introduction

Rationale

2.1 Having completed a needs assessment study for South London acute and mental health Trusts - on behalf of Guy's & St Thomas's Charity (GSTT) – Pathway turned its attention to understanding what demand looks like in north London, using residual grant funding from the Department of Health (Homeless Hospital Discharge Fund).

2.2 The South London experience revealed a need to expand provision for intermediate, step-down homeless healthcare immediately after discharge from hospital. It also suggests that beneficiaries of homeless medical respite support cannot be treated as a homogenous group. There are some clear and distinct patient categories with varying levels of health, housing and social care requirements that warrant different approaches and support solutions.

2.3 In order to develop or improve intermediate care options for discharged homeless patients across London, Pathway opted to repeat the needs assessment exercise for another part of London known to experience high instances of homelessness. It is also an area where acute and mental health Trusts experience high aggregate volumes of A&E (re)attendances and hospital (re)admissions by homeless patients.

2.4 Taken together, the findings from Pathway's needs assessment work will help to build a picture of the need for and inform the future direction of partner actions to increase medical respite provision across the capital.

North Central London STP

2.5 This research is focused on the area of London which comes under the jurisdiction of the North Central London Sustainability Partnership (STP). The North Central London STP comprises membership from all the Clinical Commissioning Groups (CCGs), local authorities and acute and mental health Trusts located in the boroughs of Camden, Islington, Haringey, Enfield and Barnet.

2.6 The full list of North Central London STP health providers is:

- Barnet, Camden, Enfield, Haringey and Islington CCGs
- Barnet, Camden, Enfield, Haringey and Islington Councils
- Barnet, Enfield and Haringey Mental Health NHS Trust
- Camden and Islington NHS Foundation Trust
- Central and North West London NHS Trust
- Central London Community Healthcare NHS Trust
- Moorfields Eye Hospital NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Royal Free NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- Tavistock and Portman NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- Whittington Health NHS Trust

2.7 A key objective of the STP is to reduce health inequalities amongst its population. There is a clear link between this objective and the medical respite agenda for homeless people.

2.8 Sections 4.1 to 4.9 show the extent of homelessness across the STP area. Sections 4.19-4.22 outline statistics for homeless patient use of acute secondary care services, including the costs to STPs of A&E attendances, hospital admissions and missed outpatient appointments.

3 Background & Assessment Context

Why worry about homelessness?

3.1 Recent research published in The Lancet conducted a systematic review of mortality and morbidity rates amongst categories of the population who are most often excluded from (or not engaging with) healthcare in wealthy countries.[3]

3.2 The research findings revealed that those groups on the margins of society, including homeless individuals, have much higher mortality ratios compared to the population as a whole. The study also shows that women in these groups have an all-case standardised mortality ratio of 11.86 whilst the male ratio is 7.88.

3.3 There has been a noticeable ramping up of local and national press coverage around the plight of the UK's street homeless in recent months. These stories are not just confined to the health risks associated with sleeping rough in the winter months. Reports have ranged from the worrying statistics on the rise of street homeless deaths in the UK to specific case studies of individuals struggling with life on the streets and their experiences of hospital admissions and discharge.

3.4 One recent street death in Camden occurred close to UCLH hospital on Tottenham Court Road. This person was known to UCLH, and other central London hospitals, and he died with a cast on his leg. He was well known to a large number of services, but his case has been referred to the Camden Safeguarding Adult Review board to examine whether anything more could have been done to avoid this outcome.[4]

[3] Aldridge, R. et al (2017). Morbidity and mortality in homeless individuals, prisoners, sex workers and individuals with substance misuse disorders in high-income countries: a systematic review and meta-analysis. Lancet 11 Nov. 391 (10117), pp. 241-250.

[4] https://www.huffingtonpost.co.uk/entry/rough-sleeper-death-london_uk_5aba0749e4b054d118e67edc?guccounter=1

What is medical respite?

3.5 Medical respite is defined as:

> *"Step up or step down intermediate health care for clients that do not need to be in hospital, but are not well enough to receive the care they currently need in their pre-existing accommodation."*

3.6 As mentioned earlier, homeless medical respite care is most prevalent in the United States with widespread provision in major cities across the country. The UK is slowly beginning to see provision appearing in major urban areas with large street homeless populations. The Department of Health's Homeless Hospital Discharge Fund resulted in the creation of pilot medical respite type projects around the country.

3.7 These pilot schemes met with mixed success. Some have survived and continue to provide intermediate care to homeless patients. Others have fallen by the wayside, despite achieving some notable positive outcomes for services users. Lack of access to sustainable sources of revenue funding is a common issue for projects seeking to maintain their services. Similarly, many projects were only able to operate at a small scale at the pilot stage and have struggled to secure funding to expand the number of beds available. Finally, short pilot periods with insufficient time for projects to adapt and develop have also been a major issue.

3.8 Section 7 describes some examples of current or past medical respite projects along with details of the types of support and care provided to homeless patients on discharge from hospital. One project is up and running in the North Central London area. Another project was also commissioned locally, but was recently decommissioned after it was perceived that it was not meeting the local need – largely due to the beds being under Local Authority control. Others projects are successfully running elsewhere and offer some insight into what might be possible for North Central London.

Needs Assessment for NCL: the Brief & Study Methodology

3.9 The brief for this piece of work was to conduct a needs assessment to scope potential demand for medical respite provision in North Central London.

3.10 Following a similar approach to Pathway's options analysis for South London, the assessment includes:

- Mapping of specialist healthcare provision and homeless hostels
- Data on homelessness/rough sleeping and health needs within the five boroughs
- Analysis of headline patient data from acute and mental health NHS Trusts

- Detailed audit of selected patient notes from UCLH
- Learning from existing/previous medical respite projects
- Views of key stakeholders on the requirement for homeless medical respite
- Conclusions, options and recommendations for service design and operations

3.11 Pathway researched homeless hostels, day centres and specialist homeless healthcare provision in each of the five boroughs to provide an updated mapping of accommodation and healthcare options. The mapping was used to assist NHS Trusts with their data searches.

3.12 Pathway also trawled published statistical data on the extent of rough sleeping and individuals living in hostels, supported or temporary accommodation (see 4.1-4.5).

3.13 Each of the main NHS Trusts has provided headline data on homeless patients accessing secondary care as either A&E attendances or hospital admissions. Patients were identified through a combination of No Fixed Abode (NFA) and postcodes of known homeless hostels and homeless day centres (whose addresses are sometimes used as a 'care of' address). In addition, clients with addresses, but registered at specialist 'homeless' GP services were included. Trusts also provided information on average length of stay and cost of admissions where they were able to do this, and where these costs were charged. Where direct cost data was not available, this was estimated using average costs from the other Trusts. Missed outpatient appointment data was also provided. Findings from the headline data analysis are set out in Sections 4.19-4.22).

3.14 As stated earlier, it has only been possible to include findings from one mental health Trust – Barnet, Enfield and Haringey (BEH). If possible, Pathway will seek to update this report to include corresponding findings from Camden & Islington Mental Health Trust at a later date.

3.15 A detailed audit was carried out on 35 patient notes of homeless patients at UCLH. This audit allowed a more forensic analysis of patients to understand how they might have benefited from access to medical respite and how this would impact on length of stay, cost and other factors. The results of this audit are explained in Sections 4.23-4.32.

3.16 Pathway looked at examples of medical respite projects of various ages and stages to identify those factors, which determine the level of success achieved, by individual projects. This analysis included projects that have been decommissioned, as well as newly established ones. A summary of the main learning points is included in Section 7.

3.17 Stakeholder views have been gathered via a series of one-to-one interviews, presentations at team meetings, focus group sessions and interviews with primary and secondary care service users. A list of interviewees is included in Appendix 1 (Section 10.1).

3.18 Interim findings from the research were discussed at a stakeholder workshop in April 2018. Discussions helped to shape this final report by: suggesting additional stakeholders for interview; agreeing a process for validating the data findings; informing the group of relevant projects, research or meetings; suggesting areas for further work; agreeing next steps. Workshop attendees are listed in Appendix 2 (Section 10.2).

4 North Central London: local context data analysis

Homelessness statistics and synopsis of health needs of people experiencing homelessness

4.1 This section includes headline homelessness statistics for the North Central London area. It provides an estimate of the total number of homeless individuals including the 'hidden homeless.' Finally, it summarises the major health needs of homeless individuals, based on published research.

4.2 Rough sleeping numbers – North Central London[5]

Borough	2014-2015	2015-2016	2016-2017
Camden	563	641	702
Islington	135	158	178
Haringey	100	135	146
Enfield	174	136	106
Barnet	125	88	106
Total	**1097**	**1158**	**1238**

[5] Chain Annual Report for Greater London, April 2016 – March 2017. https://files.datapress.com/london/dataset/chain-reports/2017-06-30T09:03:07.84/Greater%20London%20full%202016-17.pdf

4.3 Numbers of households in temporary accommodation – North Central London[6]

Borough	2014-2015	2015-2016	2016-2017
Barnet	2758	2941	2757
Camden	490	426	390
Enfield	2764	2987	3244
Haringey	2997	3164	3147
Islington	914	941	806
Total	**9923**	**10459**	**10344**

4.4 It is important to note this is the number of *households* in temporary accommodation. Therefore, the number can represent either a single person or a family household. Only the lead applicant is counted in a family household application. As such this is the minimum number of homeless individuals in North Central London – and the real number of individuals (including children) is likely to be at least 20,000. Although the number of single homeless adults will therefore be less than 10,344 we know that people living in homeless hostel accommodation are often not included in this number (see below).

4.5 **Homeless hostel beds and floating support provision 2016 – North Central London[7]**

Borough	1st stage	2nd stage	Specialist	Total		Floating Support
Barnet	0	0	18	**18**		**79**
Camden	380	300	304	**984**		**148**
Enfield	0	419	56	**475**		**219**
Haringey	23	232	0	**255**		**448**
Islington	69	489	242	**800**		**797**
Total	**472**	**1440**	**620**	**2532**		**1691**

4.6 Depending on how this information is gathered by each borough, people living in 'first stage' homeless hostels may or may not be included in the temporary accommodation figures. This appears to be related to local interpretation. Locally it appears they are not in the temporary accommodation figures (easily evident from the Camden and Islington figures). However, we have not added this figure on, to accommodate for some of the families in the temporary accommodation total.[8]

[6] Table 784: local authorities' actions under the homelessness provisions of the Housing Acts; financial years 2004-5 to 2016-2017. https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness.
[7] London Housing Foundation: Atlas of services for homeless people in London. http://lhf.org.uk/wp-content/uploads/2016/08/2016_lhf_report_final-vs11-5.pdf
[8] 1st stage refers to direct access hostels (i.e. direct from the street). 2nd stage means clients who have been referred to a hostel bed (usually a longer stay bed). Specialist refers to additional criteria other than being homeless e.g. women. Floating support refers to clients living in mainstream accommodation but requiring support e.g. support for those at risk of losing tenancy.

4.7 Taken together, these statistics suggest the number of homeless individuals in North Central London must be at least:

> **1238 (rough sleepers) +**
> **10344 (people living in temporary accommodation) = 11582**

4.8 As stated, this figure is an underestimate of all the individuals that are homeless, but a reasonable estimate of single homeless adults. In addition, we note that specialist homeless health services and Pathway teams estimate they see at least another 20% of individuals who are either sofa surfers or people threatened with eviction. As such, a more accurate estimation of homeless people across the five boroughs is:

> **11582 (homeless individuals) x**
> **1.2 (+20% allowing for sofa surfing/evictions) = 13898.4**

4.9 From this analysis, ***the final minimum estimate of homeless individuals within the NCL area is in the region of 14,000.***

Synopsis of health needs of people experiencing homelessness

4.10 People experiencing homelessness:

Die earlier

4.11 The Lancet article referred to earlier revealed the alarming statistics around male and female mortality rates amongst those most excluded from, or least engaged in, accessing healthcare.[9]

4.12 In a similar vein, a prior Crisis study in 2011, which was a large-scale study of the death certificates of homeless people, put the average age of death of homeless men at 47, and homeless women at 43. This study demonstrated that a third of deaths in this group are caused by drug and alcohol misuse, and that homeless people are 9 times more likely to commit suicide.[10]

[9] Aldridge R. et al (2017) Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance misuse disorders in high-income countries: a systematic review and meta analysis. Lancet 11 Nov. 391 (10117), pp.241-350

[10] Crisis (2011) Homelessness: a silent killer. London Dec 2011. Accessed at: http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf

Are more unwell

4.13 Homeless people are 2.5 times more likely to have asthma, 5 times more likely to have a stroke, 6 times more likely to have heart disease, and 12 times more likely to have epilepsy than the general population. They are also more likely to have more than one condition. (Story, 2013).[11] Brain injury is common, and in one recent study 45% of homeless people had a traumatic brain injury. (Topolovec-Vranic et al, 2014).[12] Homeless people also suffer more with mental health problems. e.g. it is estimated that 70% of single homeless people suffer from personality disorder (more recently called complex psychological trauma), versus about 4% in the general population. (Maguire et al, 2009).[13]

Suffer from more communicable diseases

4.14 In the UK, the prevalence of TB is reported to be 34 times greater in homeless people than in the general population, and the prevalence of hepatitis C viral infection is reported to be approximately 50 times greater. HIV prevalence has been found to be 1-20 times higher in homeless populations in the US than in the general population, but there are no UK studies. (Beijer, U et al, 2012).[14] Although many homeless people *are* registered with a GP, (quite commonly with specialist or LES GPs if they live in city centres), a survey of 2,500 people in 2014 by Homeless Link[15] revealed that 7% of those surveyed had been refused access to a GP within the past 12 months, because they did not have identification or proof of address or had missed a previous appointment or because of their behaviour. However, the rate of refusal can be much higher in some populations. For example, in a survey of 112 clients attending a specialist GP clinic for asylum seekers in Brixton, 54% had been turned away from another GP, some several times. (Nyiri, 2012).[16]

4.15 Worryingly a Project London report (2014)[17] recorded that 83% of the 1,454 clients they saw were not registered with a GP, despite living in the UK for an average of 6.5 years. 52% had not tried to register before because of perceived barriers. 12% reported being refused access. Project London recorded 109 instances of refusals by

[11] Story, A. (2013) Slopes and cliffs: comparative morbidity of housed and homeless people. The Lancet. Nov 29. Volume 382. Special issue. S1-S105.
[12] Topolovec-Vranic, J et al (2014). Traumatic brain injury among men in an urban homeless shelter: observational study of rates and mechanisms of injury. CMAJ Open. 2014 Apr-Jun; 2(2): E69–E76
[13] Maguire, N.J. et al (2009) Homelessness and complex trauma: a review of the literature. University of Southampton.
[14] Beijer, U et al (2012) Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. The Lancet Infectious Diseases; 12:11, 859–870.
[15] Homeless Link 'Health Audit Results' 2014 – accessed at: http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf
[16] Nyiri, P (2012) A specialist clinic for destitute asylum seekers and refugees in London:Br J Gen Pract. 2012 Nov; 62(604): 599–600
[17] Project London UK Report 2014

GP practices when they called on service users behalf. 73% of these clients had been involved in an asylum application at some point.

Are less likely to be receiving outpatient care

4.16 People experiencing homelessness are less likely to receive follow up care. For example, it is estimated that only 3% of homeless people with Hepatitis C receive treatment (Story, 2013). Reasons for this include out-patient appointments not being received, people not being able to get to the appointment as they have been placed too far away, appointments not being made because there is an assumption the person will not go and people needing support to attend an appointment due to mental health or addictions problems, or cognitive / other communication difficulties.

4.17 A 2010 Department of Health study[18] of No Fixed Abode (NFA) presentations demonstrated that homeless people attend A&E 5 times as much, are admitted 3 times as often, stay 3 times as long and have stays costing 8 times more than the general population.

4.18 This was echoed in a 2013 study[19] in the London boroughs of Westminster, Kensington and Chelsea and Hammersmith and Fulham, which showed that homeless people attended A&E at a rate 7 times the general population, and overall cost 5 times as much.

Secondary Care Data

4.19 All major acute NHS Trusts in North Central London provided data on all homeless patients A&E attendances, admissions and outpatient appointments over a period of one year[20]. The actual attendance /admission costs were provided in most cases, along with statistics on average length of stay for admitted patients. Where costs were not available, estimates were made. Section 5 provides a more detailed summary of UCLH data. This is possible due to the access available to the Pathway team undertaking the needs analysis.

[18] Department of Health (2010). Healthcare for single homeless people. Accessed at: http://webarchive.nationalarchives.gov.uk/20130123201505/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250

[19] Rough sleepers: health and healthcare. A review of the health needs and healthcare costs of rough sleepers in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster (Feb 2013

[20] January – December 2017 for all Trusts except UCLH where the study timeframe is October 2016 – September 2017.

Summary of A&E attendances, hospital admissions & average length of stay (homeless patients)

4.20 ***Summary data table: acute NHS Trusts in North Central London***

	Number of A&E attendances (1 year)	*A&E re-attendance rate (7 days)*	*Number of hospital admissions (1 year)*	*Re-admission rate (30 days)*	*Average length of stay (days)*
UCLH	3771	20.4%	602	18.3%	4.1
Royal Free	971	57.8%	234	9.4%	3.1
Barnet	277	48.7%	81	9.9%	2.2
Chase Farm	25	40%	4	0%	0.5
North Middlesex	606	7.4%	133	11.2%	4.2
Whittington	684	Not known	102	Not known	3.1
TOTAL	**6334**	-	**1156**	-	-

Summary of outpatient appointments & non-attendance rates

4.21 ***Summary data table***

	Number of outpatient appointments	*Number who did not attend (DNA)*	*DNA rate*
UCLH	2208	552	28.2%
Royal Free	1856	428	23.1%
Barnet	92	22	23.9%
Chase Farm	48	4	8.3%
North Middlesex	73	43	58.9%
Whittington	683	107	15.6%
TOTAL	**4960**	**1156**	-

Summary of secondary care costs: emergency attendances, acute physical health admissions, outpatient appointments & non-attendance

4.22 Summary data table of charges to individual boroughs within NCL

	A&E attendance and physical health admission (£)	*OPA/DNA (£)*	*Total cost (£)*
Camden	1,472,259	52,250	1,524,509
Islington	359,763	13,025	372,788
Haringey	355,790	8,500	364,290
Enfield	135,787	6,250	142,037
Barnet	134,223	2,875	137,098
TOTAL	**2,457,822**	**82,900**	**2,540,722**

Mental Health Data for Barnet, Enfield And Haringey (BEH)

4.23 Barnet, Enfield and Haringey Mental Health Trust sits within the North Central London area. The Trust provided homeless admissions data for the period 1 January 2017 – 31 December 2018 (see Table below). Patients were identified via NFA status, homeless hostel addresses or specialist GP registrations.

BEH 'Homeless admissions' 1 January 2017 – 31 December 2017

	Homeless Patients	**All admissions**
Number of admissions	21	1,937
Number of 28-day readmissions	0	169 (9%)
Average length of stay	56.6 days	66.5 days
Number of outpatient appointments / other appointments	107	228,665
Number of DNAs	17 (16%)	21,369 (9%)

4.24 For this cohort of patients, the BEH covered the cost of admissions as no address or GP was recorded. It was not possible to separate out costs of individual admissions due to block contract arrangements across the three boroughs.

4.25 Camden & Islington Mental Health Trust (C&I) also serves North Central London. It has not been possible to obtain data from C&I for this assessment work.

4.26 BEH Mental Health Trust has access to three Recovery Houses for step down provision. These services are used to provide short-term support to people in crisis, including homeless individuals with mental health issues. Patients can be stepped down from acute services (or from Home Treatment team referrals). People using the recovery houses tend to need more support than intensive home visits can offer or where hospital inpatient care is not the right solution.

4.27 The person-centred, therapeutic approach to recovery helps prepare individuals for the transition back to independent living – or to secure housing if this is required. Housing professionals are on hand to help clients with this.

4.28 During the year of 1 August 2017 to 31 July 2018, 571 patients were stepped down to the Recovery Houses. Of these admissions:

- 228 were recorded as NFA
- 311 had housing issues
- 118 were re-housed
- 193 patients went to a variety of destinations, including sofa surfing
- average length of stay in recovery houses was 20 days (all clients)

4.29 It is interesting to note the difference between the NFA /housing issue numbers at the recovery houses and the homeless acute admission figures supplied by the Trust. 228 patients arriving at a Recovery House after an acute admission were recorded as No Fixed Abode at that point while only 21 acute primary admissions were recorded as having NFA over one year.

Summary data from analysis of UCLH homelessness data (October 2016 – September 2017)

4.30 This type of detailed analysis could also be provided for other Trusts, but required special access and/or the data teams need to do more detailed work. Therefore, it has only been possible to provide a more detailed look at the findings for UCLH within this time period.

4.31 Key findings include that at UCLH:

- Nearly half A&E attendances and admissions arising from people experiencing homelessness are from people registered at the three

specialist homeless health practices – the Camden Health Improvement Practice, Great Chapel Street (Westminster) and Dr Hickey (Westminster)

- 1051 A&E attendances and 55 admissions were not GP registered.
- For the clients without a GP registration, charging defaults to Camden at a cost of £316,464
- 455 attendances and 121 admissions come from the top 5 hostel addresses (SHP Kings Cross, Endsleigh Gardens, Arlington House, SHP Arlington, Endell Street)

4.32 This broadly suggests that targeting support and/or referral rights at these practices and hostels would access a significant percentage of the population requiring respite care. Adopting a similar approach in the other boroughs (where such services are available) would help maximise the chances of hitting the right targets across North Central London.

Discharge to street

4.33 UCLH data is also available on discharge destinations, including patients discharged to the street. A brief audit was undertaken for clients seen by the UCLH Pathway team who were documented to have returned to rough sleeping.

4.34 346 clients were admitted and seen during 2017. 17.3% (60) were documented to have returned to rough sleeping on the team's discharge monitoring spreadsheet. A further 11 went to the street after a stay at Olallo House[21], taking the total percentage to 20.5%. This is similar to the rates currently being reported by other Pathway teams in London. The average length of time of potential engagement before discharge (i.e. the amount of time between referral and discharge) was 5.5 days (range 0-14 days).

4.35 For the 60 people discharged to the streets, the average age was 45, 11.7% (7 people) were female, and 80% (48 people) had an addiction problem.

4.36 It might have been expected that people being discharged to the streets would be less likely to have a local connection (be owed a housing or social care duty locally). However, surprisingly 40% (24) were identified to be Camden and Islington clients, and a further 20% (12) were identified to be Westminster clients. Some of those documented to have a local connection may have additionally had NRPF, but this is not available in the data.

[21] Local homeless hostel providing medical respite and hospital recovery service in partnership with University College London Hospitals (UCLH) and Pathway.

4.37 Summary of 'local connection' of clients discharged to the streets from UCLH in 2017

Borough	*No.*	*%*
Camden	17	28.3%
Islington	7	11.7%
Westminster	12	20.0%
Other London	5	8.3%
Other UK	11	18.3%
Overseas	8	13.3%
TOTAL	**60**	**-**

4.38 The key reasons for a return to rough sleeping seem to have been non-engagement or difficult behaviour rather than people not being eligible for support (as might perhaps have been expected). This has implications for any potential service design.

4.39 Reasons for return to rough sleeping on discharge

Documented reasons	***No.***	***%***
Refused support	11	18.3%
Actively self-discharged whilst team working with patient	8	13.3%
Absconded / away from ward for too long/ bed given up	5	8.3%
Violent / difficult behaviour	3	5.0%
Sent to housing but failed or unknown outcome	7	11.7%
Sent to another service for assistance	4	6.7%
Reconnection only possible option – facilitated as much as possible	8	13.3%
Practical support is only intervention logged (e.g. clothes, Oyster card); 5 were seen on the day of discharge, 4 were frequent attenders, only 2 were from Camden	14	23.3%
TOTAL	**60**	**-**

5 Detailed Patient Audit at UCLH Summary of Findings

5.1 A detailed audit was carried out on 69 patients at UCLH. Information was gained from the paper notes (which were requested from medical records), their live hospital computer records, and Pathway team records. This audit allowed a more forensic analysis of patients to understand how they might have benefited from access to medical respite and how this would impact on length of stay, cost and other factors.

5.2 The original target was to assess 80 patients. However 11 sets of the paper notes were unobtainable at the time of requesting, so it was decided to eliminate these.

5.3 Of the 69 patients studied:

- 55 were recommended by the UCLH Pathway team
- 14 were identified via a Frequent Attender search
- the UCLH Pathway team knew all but two
- individual admissions from 35 of the patients were examined in detail

5.4 These admissions were generally the longest admissions from each of the clients nominated by the Pathway team. In all these cases, it was possible to establish a medically fit for discharge date (MFFD). For the other 20 clients, it was not possible to analyse the notes in detail to identify an MFFD.

Demographics

Age & Gender

5.5 The average age of audited patients is 48.3. 78% of patients are male.

Housing status

Housing status	***%***
NFA	46.4%
NFA – eviction immediately prior	7.2%
Hostel	13%
Hotel	4.3%
Sofa surfer	13%
Housed	14.5%
Unclear	1.4%

Nationality

Nationality	***%***
UK	68.1%
Eastern Europe	11.6%
Southern Ireland	4.3%
Other Europe	4.3%
Africa	8.7%
Asia / Arab states	4.3%
Other	2.9%

Recourse to public funds

Recourse to public funds	***%***
Yes	65.2%
No	24.6%
Unclear	10.1%

GP Registrations

5.6 92.8% of patients had a GP registered on their records. However, it was not clear the extent to which these GP practices were being used.

5.7 34.8% of patients studied were registered with a known specialist GP practice. The table below provides further breakdown.

GP registration	***%***
Specialist homeless practice	34.8%
CHIP (Camden)	11.6%
Dr Hickey (Westminster)	17.4%
Great Chapel Street (Westminster)	5.8%

Local connection

Borough	***%***
Camden	23.2%
Islington	15.9%
Haringey	5.8%
Barnet	0
Enfield	1.4%
Total NCL STP	46.3%
Westminster	13.0%
Other London	17.4%
National	5.8%
Clear non-UK	7.2%
Unknown	10.2%

Health needs

Health Need	***%***
Physical health need	91.3%
Addiction	60.9%
Alcohol	43%
Drugs	36.2%
Intravenous drug use	24.6%
Mental health	63.8%
Tri-morbid	39.1%

Bi-morbid	31.9%
Tri or bi morbid	71.0%
End of life care issues	18.8%
HIV	10.1%
TB	1.4%
Hep C	14.5%
Cancer	11.6%
Liver	13.0%
Renal	4.3%
Cardiac / vascular	17.4%
Asthma / COPD	10.1%
Diabetes	13.0%
Epilepsy	5.8%
Leg ulcer / wound	10.1%
DVT	4.3%
Trauma / ortho	15.9%
Mobility issues (at point of discharge, includes clients with shortness of breath)	44.9%

Additional complexity markers

5.8 71% of patients had a behavioural issue. This could be violence, aggression, chronic non-compliance, active self-neglect / putting self at risk or chaotic addiction leading to, for example, overdoses, fits or attention seeking behaviour.

5.9 21.7% patients had a communication issue. This could for example be related to mental capacity, limited English skills, and difficulties with literacy or sensory issues such as poor hearing or sight.

Access to medical respite

5.10 56.5% of clients audited had been placed in either the UCH step-down facility (at the Olallo House hostel) or B&B for short periods of time. In most cases these placements were successful, with relatively few evictions for challenging behaviour. However, the short period of time spent in Olallo / B&B has not always allowed sufficient time for needs to be treated holistically or to put together a recovery plan.

Summary of support needs required

5.11 The following table summarises the type of support patients would have required during a planned period of medical respite.

Support need	***%***
Mental health	63.8%
Addiction	60.9%
Intravenous drug use potentially requiring substitute prescribing	24.6%
End of life care issues	18.8%
Medication that would benefit from support / input of health care professional at least once or twice a week	76.8%
Medical issue that would benefit from support from a nurse / allied professional – e.g. wound dressing, condition monitoring, medication requiring injection at least once or twice a week	43.5%
Mobility issues (at point of discharge, includes clients with shortness of breath)	44.9%
Support with housing or reconnection to local area	92.8%
Support with eligibility	30.4%
Complex needs that need care coordination	76.7%
Care coordinator or support worker already involved	43.5%
Care or intensive support needs	13.0%

Patient categories

5.12 Patients audited broadly fell into four categories, matching those developed from Pathway's similar medical respite needs assessment for south London. The following table shows the breakdown of patients for each category.

Category	***%***
Low level or specific discrete medical needs - has recourse, housing requires resolution, not prior rough sleeper	17.4%
No recourse to public funds with significant medical problems e.g. cancer or HIV / TB. Needs housing and some support, mostly past sofa surfers	14.5%
Care needs resulting from medical problem plus chronic addiction or end stage cancer, mixed background	13.0%
Chaotic, tri-morbid clients – generally a chronic history of rough sleeping	55.1%

Secondary care usage

5.13 Admissions for this group of patients were tracked back to January 2016 to help build a picture of the history of this particular cohort and to understand the extent to which they accessed secondary care services during this timeframe.

5.14 The main findings from the secondary care analysis are:

- 247 admissions were generated from these 69 patients
- nearly all the admissions were emergency admissions arising from an A&E attendance
- the total number of bed days generated was 2801.5
- patients had an average length of stay of 11.3 days per admission
- total length of stay for all patients of 40.6 bed days per person over the 2.25 years, or 18.0 bed days per year
- total of 104 chemotherapy / radiotherapy visits

5.15 A similar exercise revealed the following results for A&E attendances:

- an additional 872 A&E attendances were generated which did not lead to an admission
- this equated to an average of 12.6 attendances per person over the 2.25 years or 5.6 attendances per year

5.16 As none of these attendances led to an admission, they can all be viewed as avoidable.

5.17 35 admissions were examined in detail in relation to medically fit for discharge dates (MFFD). For these admissions it was found that 252 bed days could have been saved for this group of patients if medical respite had been available to them; representing an average of 7.2 bed days per admission. However, it is important to note that these were inherently the longer admissions.

5.18 The estimate for saved bed days is derived from consideration of the number of days spent on support that could easily be dealt with within a step-down environment. Delayed discharge in these cases was almost always due to a lack of a suitable environment to discharge to. Some clients at this stage needed no further medical input but were not 'street fit.' Others had an ongoing need for support, for example, a need to arrange GP registration, to gain concordance with follow-up medication, to link in with follow up care or support for mental health and substance misuse issues.

Audit conclusions

5.19 56.5% of audited patients had had a previous stay in Olallo House, or in a B&B. Olallo House has generally served these patients well for a short period of time and resolved a specific problem. However, the short period of stay (target maximum 5 days for inpatients completing their treatment) has not allowed for a holistic approach to recovery e.g. focusing on mental health, and addictions support and medication compliance which might help stop the revolving door in this population (note the 30 day readmission rate of 18.3%, and 7 day attendance rate of 20.4% in the UCLH clients). It has also not allowed some clients to benefit from the step-down beds at Olallo House, because the target maximum 5 days automatically eliminates some clients.

5.20 If the length of stay criteria were relaxed, this could allow more patients to be discharged to medical respite beds rather than remaining in acute beds. For example, extending stays to a maximum of 30 days with added support could lead to more positive outcomes and reduce instances of the 'revolving door.'

5.21 Support might include a dedicated mental health/addictions worker, housing worker and nurse practitioner/GP sessions once or twice per week.

5.22 However, it is important that support is provided by staff with relevant expertise in coping with behavioural or communication issues. Staff will also require adequate supervision and an appropriate support infrastructure to enable them to work effectively with patients in a medical respite setting.

5.23 The eligibility picture is complicated with 34.8% of clients potentially having no recourse to funds and 55.1% of patients not having an NCL connection. Having local connection in order to access medical respite beds would disenfranchise a significant percentage of patients from accessing provision.

5.24 It is also important to note that 24.6% of patients were current or past intravenous drug users potentially requiring substitute prescribing; any provision would need to accommodate this.

5.25 Additionally, it is possible that the 13% of clients with care or intensive support needs may not be suitable for a medical respite setting depending on the provision available.

5.26 However 65.2% of patients are entitled to benefits, and could feasibly be supported to make a housing benefit claim. This is a potentially strong argument for longer stays (around 30 days) to make such a claim worthwhile.

5.27 44.9% of patients had a potential or actual mobility issue, although some of these mobility issues would improve over time, and others might be transient (like shortness of breath). However this does underline the need for any medical respite environment to be fully accessible, or to at least have as many accessible rooms as possible.

6 Stakeholder & Patient Interviews

Introduction

6.1 A series of interviews (one-to-one sessions and focus groups) was held with a wide range of stakeholders to seek their views on the level of demand for homeless medical respite based on their experiences of dealing with homeless clients in a range of settings. Contributors came from a range of organisations including:

- Local authorities (housing, homelessness prevention)
- CCGs
- Hospital Trusts (discharge teams, Pathway teams, mental health, addiction/substance misuse)
- Specialist services (GPs, community mental health & addition services)
- End of life care specialists
- Service users
- Hostel providers

6.2 Interviewees provided input on the level of demand, examples of individual cases that might have benefited from access to medical respite, ideas for service design and focus, location and staffing models. Views were also sought on how a service could be funded and managed.

6.3 Service users were asked about their experiences of spending time in hospital, the discharge process, accessing services after leaving hospital and how they were supported into accommodation.

6.4 A list of interviewees is included as Appendix 1 (Section 10.1).

Views on medical respite

6.5 Stakeholders are clear there is a need for medical respite in some format. It is imperative that any service is aimed at supporting physical *and* mental health needs and also those with substance misuse issues. Disabled access is also vital to ensure no one is excluded on the basis of mobility problems.

6.6 It is acknowledged that there have been a number of homeless medical respite pilot projects over the years, the majority of which have worked to some degree. However, some projects have faced challenges, which have been difficult, or in some cases impossible, to overcome.

6.7 Some interviewees really noticed the impact of the gap left in provision following the closure of projects like Endsleigh Gardens, for instance (hospital discharge beds for Camden homeless patients located in a St Mungo's hostel).

6.8 Some cited restrictive admission criteria (generally related to local connection and lack of recourse) as an issue, which prevented suitable patients from making use of the service. It was also not uncommon for the most challenging cases to be turned down in the absence of a detailed assessment. There are frequent delays around discharging patients to step-down beds due to a small number of beds being available at any one time, and protracted assessment processes.

6.9 Most people agreed one of the biggest challenges has been accessing sustainable funding streams to continue services beyond the pilot phase, to develop services further and adapt to local needs. This has been dispiriting for all concerned. The closure of some pilot projects was not necessarily a reflection of their success but rather a consequence of the difficulties in securing further funding. Getting the admission criteria right is also vital to ensure high bed occupancy rates.

6.10 More details of selected medical respite projects (past and current) can be found in Section 7.

6.11 Stakeholders feel that projects have suffered from being too small scale and too short term which limits the opportunity for services to 'bed in.' There is a strong feeling that, despite the best efforts of funders and service providers, there has been *"too much tinkering around the edges."* The collective view is that it is time to move this agenda forward and commission a homeless medical respite service for a minimum of three years.

6.12 These challenges are compounded by the scarcity of suitable accommodation to move homeless individuals on to. Hostel places, temporary accommodation, supported housing and general housing are in short supply generally. The available options at any given time are not always fit for purpose, especially for those with the most complex mental health, substance misuse and/or behavioural problems. One respondent summed up their feelings of frustration on this issue: *"I know I am sometimes placing people somewhere that in my heart of hearts isn't right for them. But choices are limited and I have to move them on quickly."*

6.13 Respondents had mixed views on some aspects of medical respite. Opinion is divided as to the best location for any service. In an ideal world, homeless patients should be placed in step-down beds in their borough of local connection and/or near the specialist services they need to access on leaving hospital. This would suggest having a few small 'hub' facilities sited near hospitals and support services in each borough. Others acknowledge it makes more financial and logistical sense to have one dedicated facility serving all five boroughs.

6.14 Given the predominance of homelessness in Camden, this seems the most logical choice. Somewhere in the north of Camden borough would also be convenient for Haringey, Barnet and Enfield. Of course, location will be highly dependent on finding a suitable building of the right size, which is fully accessible and can be easily adapted into a medical respite environment.

6.15 The majority of stakeholders favour a mixed model both in terms of focus for the service and how it is funded. Provision should be focused on achieving a combination of positive health, mental health, housing and social care outcomes.

6.16 The balance between these is still up for discussion. For example, are we looking at helping those with low-level health needs who require a small amount of time to find suitable accommodation? Or is it more impactful to focus on the most complex, tri-

morbid cases over a longer timeframe? Should we aim to 'mix' the patient categories? The more individuals we can include in the service, the more chance there is to fill the beds and achieve high occupancy. However, working with more complex cases is likely to mean longer stays which then impacts on the rate of turnover.

6.17 A blended funding model of health and local authority (housing, adult social are and possibly public health) sits comfortably with the combined health and housing focus of the service. Other suggested sources include charity, social impact bonds and the GLA. Given the challenges raised regarding trying to secure sustainable funding in a climate of austerity, it is difficult to envisage a funding model that works for all concerned. That said, colleagues from the Healthy London Partnership continue to work on developing sustainable funding models for homeless health initiatives.

Views on hospital discharge

6.18 There were mixed views amongst interviewees on the effectiveness of the discharge process. While some reported a positive experience, others felt there were some problems that need to be addressed to ensure a smooth handover process both *in* and *out* of any medical respite service.

6.19 Some were critical of the quality of paperwork associated with patient discharge. There were instances where patients had no discharge summary at all or who had presented themselves at services (e.g. GP surgeries, local authority housing teams) with incomplete/no paperwork.

6.20 Although there are many good examples of effective liaison between those agencies involved with hospital discharge (e.g. Pathway teams, hospital discharge teams, housing and social care departments, specialist GPs, hostel providers) this was not always standard procedure.

6.21 There is room for improvement in all aspects of documentation and communication. Interviewees quoted examples of good practice to draw on such as the requirement to have a documented discharge plan which can be passed on, standardised templates (with reminders about key things to consider) and regular inter-Agency communication, including discharge planning meetings via Multi-Disciplinary Teams (MDTs).

6.22 Planning for a homeless patient's discharge should happen as early as possible. Trusts with a Pathway team have support to start working on care co-ordination plans as soon as the patient comes to the team's attention. The earlier the discharge

planning process happens, the easier it is to identify patients who could benefit from step-down medical respite. Opportunities to step patients down from the acute setting might be missed if assessments for suitability are not done early enough.

6.23 Similarly, clinical teams should co-ordinate with relevant health, housing and social care teams as early as possible during an inpatient stay. Some respondents believe step-down care offers a good opportunity to do more thorough assessments for health (physical and mental), housing eligibility and social care needs before moving people on.

6.24 A crucial factor in improving the discharge process – and ensuring medical respite services work efficiently - hinges on what happens *after* an individual leaves the step-down service. It is vital to consider and manage their onward pathway or there is a real risk of merely transferring any 'bed blocking' problem from the acute setting to the respite service. This has been one of the problems experienced in some of London's previous medical respite projects that have since closed down. One respondent remarked *"we need to ask ourselves what is the end game for this patient? This means thinking at least 2 or 3 steps ahead to avoid readmission and silting up respite beds."*

Assessing ongoing needs in respite setting

6.25 Stakeholders recognise there are distinct groups of patients and that each group may require a slightly different service response. It may or may not be possible, or desirable, to support every category within one medical respite service.

6.26 What *is* clear is the aim of any service should be to move respite patients through the following pipeline:

STABILISE — TREAT — SUPPORT — CONNECT WITH SERVICES — MOVE ON

6.27 The length of time taken to reach the 'move on' stage will be dependent on the level of physical health and support need required during the patient stay. For some, a rapid assessment of need will be sufficient. If ongoing health and support needs are minimal, and housing eligibility is confirmed, the moving on phase could be reached relatively quickly. For others, the process could take much longer, particularly for individuals requiring ongoing treatment for physical health needs or for people with complex physical or mental health issues and/or addictions.

6.28 Effective assessment of a patient's health and social needs immediately post discharge (and/or during their hospital stay) sits at the core of the respite process.

Again, for some patients, the assessment function will be rapid and they will only require a few days stay in a respite centre. This has been likened to the *No Second Night Out (NSNO)* model for rough sleepers.

6.29 More complex health and social care needs will call for a more rigorous assessment function to cover higher levels of health need as well as mental health and/or substance misuse. Such cases will need longer respite stays.

What are the main challenges?

6.30 The consultation identified a number of challenges associated with getting medical respite services off the ground and making sure they are successful and sustainable. Challenges fall into the three broad categories eligibility, respite environment and funding.

6.31 **Eligibility:** The majority of stakeholder highlighted the importance of having clear eligibility criteria for using medical respite services. It is vital that these criteria do not limit access unnecessarily. Excluding people on the grounds of having no recourse to public funds (NRPF) or a confirmed local connection is a common complaint raised by stakeholders. Some hostels are also not equipped to accept patients with impaired mobility or deal with people with challenging behaviour that can exclude those most in need of help. There is a clear plea to set eligibility criteria to open up the service to the widest possible group of clients.

6.32 **Environment:** There are some clear views on the type of environment needed to support patient recovery post discharge. Any facility must have full disabled access. It is also clear that 'wet' hostels are not the right environment for those who are actively recovering from drug or alcohol addiction. Hostels are not the only potential provider for respite services. Empty NHS space or vacant care homes are another option as is utilising space within operational NHS or intermediate care home space. Housing associations may also have empty properties, which could be refurbished to suit medical respite needs. All these options are likely to require sizeable capital investment for refurbishment.

6.33 **Funding:** The thorny issue of 'who pays' was raised many times during the consultation. Many existing and past projects have grappled with how to secure sustainable funding streams in an austerity environment. It is always challenging trying to develop models of integrated funding. There is no clear view as to whether medical respite is primarily a health or a housing issue. Regardless of the focus, stakeholders agree a blended funding model is needed for a service of this kind. Sources might include:

- CCGs/NHS Trusts
- Local Authorities (Housing & Social Care)
- Greater London Authority
- Charitable Trusts
- Social Impact Bonds

6.34 It should be noted that some medical respite projects have been successful in accessing housing benefit to offset bed day costs for eligible patients. (See Sections 7.20 – 7.24 on Gloria House).

Additional points

6.35 There is a real opportunity to achieve positive impact on health, housing *and* social care outcomes through medical respite.

6.36 Success measures should reflect this, and should be well thought out and meaningful, taking account of not only quantitative and cost saving indicators but also those that can illustrate medical respite as 'doing a good thing' for homeless individuals.

6.37 Any medical respite service must have properly commissioned in-reach services covering physical health, mental health, substance misuse, housing and social care. The exact nature of the requirements for mental health users of medical respite is explored in more detail in the separate mental health analysis referred to earlier.

The patient voice

6.38 As part of the consultation exercise, Pathway advertised in advance and arrived to deliver 2 focus groups – one at the Camden Health Improvement Practice and one at the Arlington House hostel. However, only two people with recent experience of homeless hostel discharge in the NCL area came forward. As such two 1-1 interviews were undertaken instead. Nevertheless, these discussions still provide valuable insight into how the 'system' does or does not work for those needing the help. This report also includes the perspectives of service users who contributed to the South London Needs Assessment. There are many similarities in the views expressed by both groups.

6.39 Contributors were also asked their opinions on the value of having access to medical respite services, whether they had personal experience of this or not.

Patient voice: key points

- Service users give negative reports of the whole hospital experience, including the discharge process
- Supportive of idea of medical respite as a useful transition out of hospital and on to the next step
- Views are split on the most appropriate environment for respite and other support
- Many feel homeless hostel is not the best place for this kind of service, mostly in relation to the rules on drinking alcohol
- Divided opinion on whether individualised drinking regimes can be applied successfully; most feel respite facilities should be 'dry'
- Strong feelings that end of life care can, and should be improved
- Support for mental health must form part of any medical respite support; similarly for support with accessing benefits and employment opportunities
- Providing a programme of meaningful activities for users of medical respite will help the recovery process
- Service users believe medical respite should be available to all, not just those with local connection
- However, they recognise being discharged to the street at the end of their medical respite stay may be the only viable option for some people.

6.40 One in-depth interview with a service user revealed their frustration at being 'batted around' between different organisations (hospital, housing etc) and feeling that no one really wanted to help them. The person concerned had been admitted to two different hospitals on four occasions in the recent past. They were treated for the same condition each time. They also had addiction issues (drugs and alcohol). The following quotes describe their experience.

> **"I was in for 6 weeks. When the time came, they told me to do to Camden Housing…when I got there, they didn't have anything for me."**
>
> **"When you get discharged you shouldn't have to worry about where you are going to go…it made me feel lonely and depressed."**
>
> **"Now they know about my drink and drugs I feel like they are not bothered…now they know me, they turn their nose up."**

6.41 For medical respite to work effectively, the service user experience must be core to the service design. Pathway recommends doing further work with local service users to get a broader perspective on what is needed for homeless patients in North Central London.

7 Review of existing medical respite models

Introduction

7.1 An important part of the discussion regarding medical respite care focuses on learning from previous pilot projects. Although needs assessments, and practitioner 'on the ground' experience strongly suggest a need for these services, in practice pilots have often failed to deliver.

7.2 Interviews with service providers and analyses of project reports reveal multiple challenges that have stopped projects meeting the needs of many step-down clients. These are:

- rejected referrals for clients with NRPF or no local connection as funding for beds has mostly come from the local authority
- bed blocking by clients with high support needs
- a lack of, and potential need for alcohol-free respite beds to support recovery leading to failed interventions
- a need for disability accessible accommodation and/or personal bathroom - essential for the discharge of some patients
- on-site substitute prescribing provision - essential for the discharge of some patients
- a KPI / commissioning focus generally based entirely on targets set for bed occupancy and reducing emergency and unscheduled health care usage
- short-term funding not enabling projects to learn, adapt or embed to meet the needs of as many referrals as possible or develop creative business management models

7.3 Despite the challenges, the projects have all demonstrated reduced emergency care usage and improved health outcomes. However, when projects have failed to deliver required bed occupancy targets, they have often been decommissioned rather than understanding what needs to happen to enable more clients to make use of projects or engaging in project redesign.

7.4 An additional issue is that most boroughs do not have enough homeless medical respite candidates in their own right to make an economic case for providing an

entirely new specialist service. There is a strong argument that this really needs to be delivered in partnership with other boroughs to make it viable.

7.5 Finally, few people experiencing homelessness actually complain about lack of provision in this area, and the consequences. When homeless people die on the street it might hit the media, but there are few actual complaints.

Examples of current medical respite projects

Lambeth HICP (Graham House & Keyworth Street Hostels, Lambeth)

7.6 This project is an intensive case management project and supports the existing very high need population residing in these two homeless hostels. There is a caseload of 8, and the Local Authority funds beds. The CCG funds health support, and the local hospital charity (Guy's and St Thomas's) funds psychology input.

7.7 The project has been in operation since 2009. Addictions staff in-reach to the service, and there is on-site Methadone / Subutex prescribing. There is a good relationship with addictions social workers. Psychology input is available for 1:1 work and staff support. The project takes step-up and step-down clients.

Key points

7.8 Some key points of note from this project are:

- Reduction in A&E attendance and admissions for clients on the caseload
- Increase in planned and routine health care during intervention (however often drops off after intervention)
- Pre-existing in-reach health services were bolstered to provide higher level of support
- Cannot take anyone not already residing within these two hostels
- Move-on is an issue
- Addictions recovery support is very difficult in this environment

Pathway to Home (Olallo House)

7.9 This step-down service has been operational since 2015. Originally funded as a pilot under the Department of Health's Homesless Hospital Discharge Fund (HHDF), the service is now funded by UCLH. *Pathway to Home (P2H)* is part of UCLH's Hospital@Home service where patients can be sent home (or in this case, to a local hostel) to complete the last few days of their treatment.

7.10 Individuals transferred to this service are still hospital in-patients, but do not require an acute bed for the latter stages of their treatment. The service is open to the majority of clinical specialities with consultants making the decision on suitability for transfer in conjunction with the Pathway team. Nursing teams visit patients daily and planned discharge dates (PDDs) are agreed in advance.

7.11 P2H is delivered in partnership with Olallo House, a homeless hostel located near to UCLH. The hostel has 2-4 beds available for this service, which the hospital funds on a spot purchase basis. The visiting nursing teams are also funded by UCLH.

7.12 The target length of stay for P2H is 5 days. This gives very limited scope for any recovery-based intervention, but patients have given favourable feedback to the service overall.

7.13 In addition to P2H, the UCLH Pathway team occasionally utilises additional beds at Olallo House on a 'Bed & Breakfast' basis. Using funds from the UCLH Hospital Charity, the team can discharge patients to the hostel as a transition step. For example, the team may see a need for some extra recovery time for recently discharged patients and/or a short hostel stay to allow time to finalise an individual's housing application. The Pathway team decides who is suitable for the service. Length of stay can be more flexible for this client group, although the aim is to fit within a 3 to 5-day timescale.

Key points

7.14 Some key points of note from this project are:

- Acceptable to wider cross-section of patients – not a 'high support needs' hostel, with multiple complex needs clients as a background population
- Running at less than 100% bed occupancy - can take clients at very short notice
- Very close to hospital making it possible for hospital to continue medical management, and Pathway team to continue with case management
- Can take patients who are non-local, or do not have current housing eligibility
- Stop-gap only, does not allow for recovery type interventions
- Not suitable for people with significant mobility issues

Westminster Integrated Care Network for Homeless Health

7.15 This service is a peripatetic support service managed by the specialist homeless health services in Westminster. The service supports clients by placing them in spot purchased physical or mental health hostel beds in Westminster, where there is availability. Alternatively, clients can be supported through funding for a B&B placement for up to 6 weeks.

7.16 Originally a 10-bedded service, the number has since been reduced to 4 beds, despite the service having been very well utilised in the first year. The reduction seems to have been related to a perception that that funding of the beds had not conveyed a specifically health related cost benefit. For example, it was felt that the beds were being used to enable immigration casework to be undertaken for clients with no recourse to public funds.

7.17 Other changes include reconfiguring the service to focus on step-up clients to prevent admissions, as this is perceived to confer more financial benefits for the CCG. Step-down from hospital is no longer an option for this service.

7.18 Other additional criteria include: (a) preference for clients with a Westminster connection; (b) clients must have recourse to public funds (previously accepted NRPFs). Service can also accept A&E frequent attenders.

Key points

7.19 Some key points of note from this project are:

- Good for patients as there is a choice of setting
- Fully integrated physical / mental health support
- Capitalises on voids in hostel system
- 60% of bed space in first year perceived to be taken up with NRPF with borderline health / housing / social issues, therefore health funding was withdrawn for the spot purchase of the bed spaces

Gloria House

7.20 Launched in January 2018, Gloria House is a partnership between Peabody Housing, the Royal London Hospital Pathway Team and Tower Hamlets CCG. Peabody has renovated one of its properties to provide step-down medical respite care for homeless patients being discharged from the Royal London Hospital. The Pathway team selects suitable patients for transfer. The team also work alongside Peabody colleagues to ensure discharged patients are supported to register with a GP and receive district nursing and other support whilst at Gloria House. Tower Hamlets CCG has commissioned the service.

7.21 During the first 11 weeks of operation, the service accommodated 10 occupants who had an average length of stay of 16 days. Occupancy levels during these first few weeks were at 37%. 6 out of the 10 occupants were eligible for housing benefit, whilst 3 were NRPF. At the time of writing, Peabody has achieved a 58% success rate of reclaiming housing benefit. More recently, average occupancy has risen to 56% and has been as high as 83%.

7.22 Occupants of Gloria House have received support in a variety of ways, including:

- Support with accessing benefits (housing, ESA, PIP)
- Help with GP registration, arranging hospital appointments and district nursing visits
- Medication prompting
- Legal assistance and advocacy (Section 184)
- Reconnection assistance
- Help to register for substance abuse support
- Help with accessing food banks and hardship funds

7.23 Now that the service is finding its feet, Peabody staff feel more confident about accepting more 'challenging' referrals i.e. more complex cases around mental health, substance misuse and behavioural difficulties. Close partnership working between Peabody and the Royal London Pathway team allows for in-depth conversations around discharge planning for each potential client.

Key points

7.24 Some key points from the project are:

- Successful 3-way partnership between housing provider, hospital and CCG
- Exclusive referral rights by the Pathway team
- CCG funded beds with some notable success at reclaiming housing benefit to offset costs
- Strong package of support to help occupants with all aspects of health, housing and social care
- Gradually opening up eligibility to include more challenging and complex cases

Bradford BRICCS

7.25 Bevan Healthcare in Bradford provides a range of services to support homeless healthcare in the city. This includes a Pathway homeless hospital discharge team, a street medicine team and the Bradford Respite and Intermediate Care Support Service (BRICCS).

7.26 BRICCS (Bevan House) is a 14-bedded unit providing respite care for discharged hospital patients. The project was established following a comprehensive needs assessment and was funded through two Department of Health grants. BRICCS is delivered in partnership with a Housing Association and local social care services. Discharged hospital patients usually require an intermediate length of stay at the unit to take sufficient time for recovery and planning for move on accommodation. The relationship with the housing associated and the availability of care packages makes these longer stays manageable. Many patients remain at Bevan House for six months or longer.

7.27 Bevan Healthcare received an Outstanding CQC rating in February 2015, and this included an assessment of the developing outreach and respite services. An independent analysis from the BRICCS identified annual secondary care cost savings

of £280,000 and high levels of client satisfaction with services. The project has won both a Housing and a Community Impact award.

7.28 Bradford has demonstrated the advantages of not being restricted by local connection/ borough boundary issues. It is important to note Bradford has far fewer clients with NRPF.

Key points

7.29 Some key points of note from the project are:

- Fully integrated service
- Improved housing outcomes and assistance with benefits
- Improved access to primary and social care
- Very well evaluated by patients and staff
- Has delivered clear financial benefits, and won awards
- Does not have the London challenges of multiple people with no local connection or no recourse to public funds

8 Opportunities & options What type of medical respite service do we want? Some options.

8.1 As discussed earlier, there are a number of options for determining how patients are prioritised for medical respite and any associated support. The first key question is around patient eligibility.

Key question 1

SHOULD MEDICAL RESPITE SERVICE INCLUDE INDIVIDUALS WITH (a) NO LOCAL CONNECTION AND (b) NO RECOURSE TO PUBLIC FUNDS?

8.2 Our discussions with stakeholders and service users plus our detailed audit work suggest that eligibility criteria must be as broad as possible. Individuals should not be automatically excluded from the service on NRPF or local connection grounds. The opportunity to consider respite cases at STP level, as opposed to local, gives more scope to support some of our most vulnerable and complex patients.

8.3 Local connection is a housing, not a health problem. It could be strongly argued that health should be arguing that local connection should not be taken into consideration once a client has become very unwell; the fact that these individuals are accessing care should be the primary consideration.

8.4 The detailed patient audit at UCLH showed almost 15% of those cases were NRPF individuals with serious health issues (e.g. cancer, TB). This group in particular would benefit from access to respite care. There is a precedent for funding TB patients with NRPF in step-down care settings around London. An extension of this model should be considered for NRPF patients on a larger scale. NRPF clients are costing acute Trusts large amounts of money whilst complex decisions are made about whether they can be discharged to the street from a human rights and public health perspective. Even if this uncomfortable decision is taken, they are very likely to return more unwell.

Key question 2 – do we want to be more selective or remain broad in the categories of patients we would support?

WHICH PATIENT CATEGORIES SHOULD BE THE FOCUS FOR MEDICAL RESPITE?

8.5 Our data analysis and detailed patient audit suggested 4 broad categories of patient could feasibly benefit from a stay in medical respite. The categories are:

A – low level or specific medical needs requiring housing resolution (with recourse)
B – NRPF with significant medical needs. Requires housing and some support.
C – Care needs resulting from medical issue. Has chronic addiction or end stage cancer. Mixed background.
D – Chaotic, tri-morbid patients with history of rough sleeping

8.6 Stakeholder discussions show there is a legitimate need to consider all categories as potential beneficiaries of some form of medical respite care. There are mixed views as to whether all categories could be treated together in the same facility. Doing so would require careful management.

8.7 Category D will include some individuals with serious mental health issues. It will also include clients with addictions requesting support to remain dry during their recovery. Careful consideration needs to be given to ensure the needs of this group are adequately accounted for.

8.8 It is recommended that all patient categories should be eligible for medical respite in North Central London. For logistical or financial reasons, it may prove necessary to adopt a phased approach to developing the service. This is a feasible option, provided the ultimate aim remains i.e. including the widest possible constituent of homeless patients who would benefit from respite support.

Key question 3

HOW MANY BEDS WILL BE NEEDED TO SUPPORT MEDICAL RESPITE FOR NORTH CENTRAL LONDON STP?

8.9 The estimated number of beds needed for a medical respite service for NCL is dependent on the approach taken for the service. If the primary aim is to reduce bed blocking, the focus should be on reducing the LOS for acute physical healthcare admissions.

Bed blocking approach

8.10 From our access to secondary care data, the total number of physical health admissions across NCL was 1141. The detailed audit of UCLH patients estimated that 7.2 bed days could be saved per admission. However, these admissions were not randomly selected and represented the longer admission times.

8.11 Taking a conservative estimate that 20% of all admissions could be reduced by 7.2 days through access to medical respite, we can estimate the number of bed spaces required as follows:

Number of admissions	1141 x 20%	228.2
Number of respite bed days	228.2 x 7.2	1643
Bed spaces required	1643/365	**4.5 beds**

8.12 This does not take account of any requirement for mental health patients. It is feasible the total number of beds required could rise to at least 6.

8.13 The calculation also makes the assumption that the medical respite service will accept clients with no local connection or who have NRPF. It also assumes the service will be disability accessible and have the appropriate health support for those requiring it. Essentially it assumes that a commitment has been made for the service to be able to meet all needs.

Recovery approach

8.14 An alternative approach to the service may be to focus on recovery. A recovery approach is likely to result in better, more enduring outcomes for those using such services. In this model, there will be greater focus on in-reach support for physical health and social care requirements. Extra time will be needed for support with, for example, GP registrations, medication compliance, engagement with addictions, benefits and housing services.

8.15 For a recovery approach, we estimate an average length of stay of 30 days leading to bed day requirements of:

Number of admissions	1141 x 20%	228.2
Number of respite bed days	228.2 x 30	6846
Bed spaces required	6846/365	**18.75**

8.16 The same assumptions apply regarding mental health patients and an inclusive acceptance policy around local connection, NRPF etc.

Conclusion on bed numbers

8.17 Taking account of the above, it is reasonable to recommend ***a minimum requirement of 6-8 beds for medical respite provision in the NCL area***. Obviously the final number will be dependent on the preferred target for length of stay in response and the focus on either rapid or longer term recovery.

Service design options

8.18 The different client categories above will require distinct responses in service design. These responses will take account of the associated requirements for in-reach support to cover health, mental health (to be determined in separate study), addiction, housing and social care.

8.19 Taking these together, the options are:

Option 1 – Respite Short Stay

Who for?
Individuals with low-level/no ongoing health needs
Local connection/eligibility/recourse – various, including unknown

Focus?
Rapid assessment to resolve/confirm eligibility
Rapid resolution of housing issues for those with known housing eligibility
Similar to *No Second Night Out* model
Moving people on to appropriate accommodation and/or referring on to support services
Low level health support (GP registration, medication compliance, attending outpatient appointments, addiction and mental health support)

Length of stay?
5-10 days

In-reach support?
Housing worker
Benefits advice
Nurse/local GP practice
Legal assistance

Pathway, 4th Floor East, 250 Euston Road, London, NW1 2PG www.pathway.org.uk

Option 2 – Stay & Treat

Who for?

Individuals with multiple complex needs requiring more significant time for recovery and assessment for ongoing support
Individuals requiring support for end of life care
Local connection/eligibility – various, including unknown
Medium to high levels of ongoing health support needed

Focus?

Medium to long stay to undergo further assessment, commence/continue treatment
More proactive health support (e.g. linking into health advocacy services, escorting client for GP registration and first appointments, daily work on medication concordance, support with ongoing health needs e.g. dressings, exercises, nutrition, and escorting to outpatient appointments, addiction and mental health support)
Planning next steps for housing, social care, ongoing treatment (e.g. for mental health, substance misuse)
Providing access to end of life care

Length of stay?

4-6 weeks

In-reach support?

Specialist GP/nursing
Housing worker
Benefits advice
Legal assistance
Mental health and/or substance misuse support
Adult social care

8.20 As mentioned above, it is possible to have both options operating within a single service. Doing both is the preferred option as it (a) ensures bed spaces are maximised, (b) meets the aim of being an inclusive service, and (c) has lots of cross over with respect to in-reach support.

Service Delivery Options

8.21 Given the above recommendations on eligibility and service design, a key question remains around who should deliver a medical respite service for NCL. Pathway has conducted innumerable conversations with potential providers over the years. Various premises have been visited with a view to assessing their suitability as a medical respite facility.

8.22 The only location and partnership that has come to fruition to date is the service level agreement with Olallo House (OH). This arrangement is still current, with UCLH spot purchasing beds for homeless patients under the Trust's UCLH@Home service. The UCLH Pathway team also utilises beds to support extra recovery time for recently discharged patients.

8.23 Given the success of this arrangement so far, Pathway is exploring the option of extending this relationship to cover patients being referred from other Trusts in the North Central London area. This will require a programme of refurbishment works to upgrade the hostel facilities, make at least part of the building fully wheelchair accessible and improve communal areas. Pathway is in conversations with the provider about expanding the partnership in this way. Those conversations have been very positive and the provider is committed to exploring this - and working together to bring investment to the table to support this. The following table summarises the key principles of such a partnership arrangement.

Partnership arrangement with existing provider (e.g. Olallo House)

Build on existing UCLH *Pathway to Home* service at Olallo House.

Provide capital investment for wholesale refurbishment of Olallo House (to make fully accessible, to upgrade all general facilities, to provide dedicated rooms, treatment rooms and meeting areas for medical respite).

Offer 3-year contract for Olallo House to provide homeless medical respite service for North Central London.

Service to be delivered in accordance with the chosen service design option(s) and for the agreed priority groups.

Number of beds may grow over time (e.g. start at 6-8 with flexibility to increase over the 3-year timeframe).

Services to be delivered within agreed budget envelope (which may increase as bed numbers rise) and using existing staff.

Details of additional or in-kind contributions.

Sustainable revenue funding

8.24 The amount of revenue funding required to support any medical respite service will be dependent on (a) the 'categories' of patients supported and (b) the average length of stay. As stated earlier, much will depend on the approach to bed allocation i.e. as a means of alleviating bed blocking or focusing on patient recovery.

8.25 Based on previous experience of setting up medical respite projects – and analysis of other services - it should be feasible to operate a service at a bed day rate of £180.

8.26 This day rate is purely for the revenue funding element of the service. The level of any capital expenditure required will be dependent on the level of refurbishment required.

8.27 Given the variables on numbers of beds, patient focus etc. ***it is estimated the level of annual revenue funding required is in the range of £500,000 to £1.25m***.

9 Next Steps

9.1 Pathway continues to devote resource to progress this work and will engage with partners to establish a medical respite facility to serve homeless patients in North Central London.

9.2 Pathway also continues to discuss the various service delivery options described in this report with colleagues representing all facets of homeless healthcare in the North Central London area.

9.3 As plans become clearer and more tangible progress is made (i.e. hostel refurbishment commences), it may be fitting to set up a partner Working Group with representation from colleagues across the NCL area. Pathway will advise of this in due course.

10 Appendices

Appendix 1: List of interviews undertaken

Name & Position/Organisation

Emily Rainbow Commissioning Manager, LB Camden

Brian Matthews Housing Commissioning & Partnership Manager, LB Camden

Minaxi Patel Housing Commissioning, Supporting People, LB Camden

Daisy Akinlade Homelessness Prevention Team, LB Camden

Sophie Konradsen Rough Sleeping Strategy & Monitoring Co-ordinator, LB Haringey

Charlotte Pomery Assistant Director, Commissioning & Public Health, LB Haringey

Helena Stephenson Homelessness Strategy & Commissioning Manager, LB Haringey

Donovan Carpenter Housing Worker (Social Services Team), LB Haringey

Georgina Earthy Supported Accommodation Referrals Manager, Housing Aid Team

Jacqueline Brissett Islington Home from Hospital Support, SHP

Jane Wilson Senior Commissioning Manager, Royal Free & Barnet Hospitals

Sue Coath Head of Complex Discharge Team, Royal Free Hospital

Helen Joyce Discharge Matron, North Middlesex Hospital

Malcolm Hogg Discharge Co-ordinator, Whittington Health

Sara Tiplady FOCUS

Kate O'Brien Senior Specialist Nurse, Substance Misuse, C&I

Adele MacKay Divisional Director, Acute Division, C&I

Suzanne Joels Clinical Director, Ageing & Mental Health, C&I

Jasmin Malik Camden Health Improvement Practice

Paul Daly Camden Health Improvement Practice

Gary Colman Camden Health Improvement Practice

Joe Malone Psychiatric Liaison Lead, C&I

Karl Gill Social Work Team, LB Camden

Kate Tebbet St Mungo's Broadway

David Devoy St Mungo's Broadway

Scarlett Nash Community Nurse, Marie Curie Hospice, Hampstead

Denise O'Malley Clinical Lead Nurse, Marie Curie Hospice

Appendix 2: Interim findings meeting - attendees

Erin Beer Admissions & Discharge Co-ordinator, Marie Curie Hospice

Leigh Rusling Hub Manager, Barnet Recovery Service (WDP)

Team meetings attended:

UCLH Pathway MDT

Fulfilling Lives in Camden (FLIC)

Camden Health Improvement Practice (FLIC)

Enable - Enfield Alcohol & Drugs Service

Appendix 2: Interim findings meeting – attendees

Name	***Position/Organisation***
Will Huxter (Co-chair)	North Central London STP
Alex Bax (Co-chair)	Pathway
Sam Dorney-Smith	Nursing Fellow, Pathway
Emma Thomson	Project Manager, Pathway
Debra Holt	Assistant Director, Integrated Commissioning, Camden CCG
Louise Restrick	Consultant, Respiratory Medicine, Whittington Health
Camilla Wiley	Hospital Director, Royal Free NHS Trust
Jasmin Malik	Camden Health Improvement Practice
Kate O'Brien	Senior Specialist Nurse, C&I
Alex Reeve	Peabody Housing
Miguel Neves	Olallo House (Homeless Hostel)
Susan Harrison	Healthy London Partnership
Cameron Hill	Healthy London Partnership
Minaxi Patel	Housing Commissioning Team, LB Camden