Pathway Report # 03.01

Medical Respite for Homeless People

Outline Service Specification

May 2013

pathway
Healthcare for homeless people

inclusion health

Pathway was established as a charity in 2010. Our purpose is to transform health services and health outcomes for homeless people by working in and with the NHS. Pathway does this by developing and supporting new service models, setting standards for good quality healthcare, and giving voice to homeless people as patients. Pathway currently has specialist homeless health teams in four NHS hospital trusts and four new teams are due to launch this year. Pathway also hosts and supports the Faculty for Homeless and Inclusion Health.

For an electronic copy of this publication and for more information about Pathway visit our web site at www.pathway.org.uk

Pathway
5th Floor East,
250 Euston Road
London, NW1 2PG

Charity number: 1138741

Contents

Foreword by Professor Steve Field
Chairman, National Inclusion Health Board

(page) 6 Background
6 Purpose of Medical Respite
8 Core elements
11 Standards
12 Staffing
13 Design and operational considerations
14 Commissioning and provision options
15 Conclusion

16 Sources

Appendices

17 Appx 1: Summary of commissioning responsibilities of particular relevance

FOREWORD

I am delighted to introduce Pathway's high-level service specification for medical respite care for homeless patients. I have been supporting both Pathway and the Faculty for Homeless and Inclusion Health to develop their thinking around potential new models of healthcare for homeless patients, and this specification summarises nearly three years of work developing and costing the concept.

I was fortunate enough to attend the Faculty's conference in February this year. Dr Jim O'Connell from the city of Boston gave an inspiring and moving presentation of the range of services delivered by his Boston Homeless Healthcare organisation. He presented a model of integrated, compassionate patient-centred services for chronically excluded, homeless patients in one of America's leading cities. One of the central components of his model was medical respite, shown to improve health outcomes for his patients, and reduce the number of needless visits to the 'emergency room'. I believe the US healthcare system has much to learn from the NHS, but in the provision of specialist medical services for homeless people it seemed clear there is much that the UK can learn from their experience.

This report specifies a new kind of intermediate healthcare facility for sick homeless people leaving hospital. It describes what should be commissioned and suggests which parts of the new system should take responsibility for bringing these new services into existence. I am committed to supporting partners across the NHS to deliver this new model of care.

My long-term goal for our national health service is to deliver high quality services to the most disadvantaged and excluded, wherever possible using an improvement in a homeless patient's health as a springboard towards improvement in other aspects of their lives. In this way the NHS can begin to deliver on our pledge to improve the health of the poorest fastest, and contribute to transforming lives of hopelessness and despair into lives of 'hope, agency and opportunity.'

Yours. Stevefield

Professor Steve Field

Chairman, National Inclusion Health Board &
Deputy National Medical Director, Health Inequalities, NHS England

1. BACKGROUND

Proposals for medical respite services in the UK have been developed by Pathway, based on our clinicians' experience of providing healthcare to homeless people and drawing on a variety of successful intermediate care models. Models of particular note within the UK are Wytham Hall and the St Mungo's / three boroughs Cedars Road Pilot, and those from overseas are the Medical Respite Facility of the Boston Health Care for the Homeless Program and residential health and social care services in Amsterdam and Rotterdam.

Pathway is a registered charity working with the NHS to improve health services for homeless people. Pathway develops models of integrated healthcare for single homeless people and rough sleepers, with care pathways planned around the individual patient. We share these models with NHS organisations, support, develop and train healthcare practitioners and care navigators with lived experience of homelessness, and work with both commissioners and providers to improve the quality of healthcare delivered to the most excluded. In relation to medical respite, it is important to note that Pathway is committed to making the case for the model and securing resources and expertise to establish and quality assure services, but does not see itself as the only possible provider.

Sharing in this endeavour is the **Faculty for Homeless and Inclusion Health** which was established in 2010 and is the first independent, multi-disciplinary body focused on the healthcare of homeless people. Membership is open to medical professionals and people with personal experience of homelessness and an interest in health issues. All members share a commitment to patients being at the centre of their own of healthcare, and to improving the way health services respond to and meet the complex needs of severely excluded groups.

Pathway's original proposals for medical respite, including a high-level business and clinical case, were set out in a prospectus published in May 2012. This paper builds on the prospectus and summarises our recommended approach to, and core elements of, medical respite service provision. The specification draws on the experience of specialist homelessness GPs, nurses, care navigators and a number of hostel service providers, as well as the advice of architects, development, commissioning and finance experts.

Pathway acknowledges with gratitude their contributions to shaping plans for medical respite and financial support from 'Knowledge into Action', the Greater London Authority and the National Inclusion Health Board, to develop the model. We are also grateful to Dr Jim O'Connell, President of Boston Healthcare for the Homeless, for his generosity in sharing the detailed specifications and operational guides from Barbara McKinnon House (in Boston, MA).

2. PURPOSE OF MEDICAL RESPITE

Pathway describes medical respite as the provision of specialist convalescent services, offering patients accommodation in a short-term supportive community setting providing both medical care and other specialist services. Core components of medical respite provision are:

- clear medical leadership;
- personalised treatment and care provided by specialist multi-disciplinary teams;
- provision of services and care in a 'psychologically informed environment';
- a parallel focus on convalescence or recovery, and client centred, co-ordinated planning for move-on.

Essentially this is 'care closer to home', for those without a home. The service is intended for single homeless people, including rough sleepers, hostel dwellers and "sofa surfers" for whom discharge would otherwise be delayed because adequate care cannot be provided in their previous environment. Its core purpose is two-fold – i) to deliver better care and health outcomes for homeless patients, and ii) to make more efficient use of available health resources.

Specialist medical respite will aim to meet the needs of **homeless people with tri-morbidity** i.e. physical ill-health or injury complicated by a history of mental illness and problems related to substance misuse. Patients will be sufficiently recovered to no longer need high cost acute medical or surgical hospital care, but still need a further period of convalescence and community care planning before a safe hospital discharge can be achieved. Initially we see medical respite as providing specialist step-down from acute hospital care, but over time we anticipate its further development as a step-up facility providing an alternative to avoidable hospital admissions.

The annual **cost of unscheduled care** for homeless patients is eight times that of the housed population[6]. Demand for hospital-based treatment is high, particularly for people sleeping rough, or staying in hostels or emergency shelters. Homeless people attend A&E five times as often, are admitted more than three times as often, and stay in hospital three times as long as those who are not homeless[6,10], and are found to be two to three times as sick on admission. Despite all this activity the average age of death for homeless patients is just 47 years[4] and quality of life is significantly reduced by multi-morbidity.

Levels of **demand for hospital treatment** for homeless patients are illustrated by the following summary of Pathway needs assessments from six hospitals:

Hospital* (Total beds according to Dr Foster Health)	Number of homeless patients admitted during (year)	Total annual number of homeless admissions	Number (%) of patients admitted more than once	Total number (%) of homeless re-admissions	Number (%) of re-admissions occuring within 28 days
UCH (846)	488 (2010)	680	102 (20%)	294 (43.2%)	153 (51%)
RL (728)	650 (2010)	955	136 (20.6%)	295 (30.9%)	150 (50.8%)
BSUH (496)	237 (2010)	430	81 (34%)	274 (63.7%)	123 (44.9%)
RF (622)	218 (2010)	288	56 (26%)	92 (32%)	27 (29%)
GSTT (858+270)	1044 (2011)	1379	168 (16%)	503 (37%)	181 (36%)
KCH (830)	214 (2011)	240	13 (2%)	26 (11%)	14 (54%)

(* UCH = University College Hospital | RL = Royal London Hospital | BSUH = Brighton and Sussex University Hospital | RF = Royal Free Hospital, London | GSTT = Guy's and St Thomas's Hospital, London | KCH = King's College Healthcare, London)

Length of stay is increased, and likelihood of successful discharge decreased by the limited availability of suitable **step-down or community provision** to meet the healthcare needs of homeless people, once they are deemed 'medically fit' for discharge from hospital. 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 and planning for post discharge care particularly challenging for homeless patients, who often have weak or no ties to

any locality and lack documentary proof of any entitlements. Even when these problems can be overcome, short term convalescent care is often very difficult to obtain for isolated individuals with chaotic lifestyles living in hostels or shelters.

In addition, many specialist services have admission criteria, which exclude those with continuing or unmet needs across the spectrum of mental and physical illness and substance misuse. By way of illustration, for 20 to 25% of UCLH inpatients supported by the Pathway team, the discharge options currently available to them were seen as being unable to cope with their complex needs[9]. Among a sample of hostel clients taken by ambulance to hospital, only 11% of those who attended A&E and 30% of those who were hospitalised came away from the acute trust with a treatment plan[13]. As well as compromising patient care, lack of access to continuing healthcare poses additional financial risks to hospitals, which do not routinely receive payment for patients readmitted within 30 days of discharge[11].

Based on our homeless health needs assessments in just some of London's hospitals, and the clinical experience of Pathways teams to date, we can clearly demonstrate a minimum **level of immediate demand** in London for 47 medical respite beds. This is certainly a significant underestimate, being based only on admission data from some of London's acute trusts and excluding data from mental health trusts, which are likely to be an additional source of referrals. However, we include it here as a very conservative indication of the immediate need for medical respite provision.

3. CORE ELEMENTS OF MEDICAL RESPITE

Medical respite is designed for homeless people with tri-morbidity (i.e. physical ill-health or injury, with a history of mental illness and problems related to substance misuse) who are:

- 'medically fit' to be discharged from acute care, but not well enough to be discharged to the street (in the case of rough sleepers) or unsuitable temporary accommodation;
- not yet stable enough to be adequately supported by community-based health services;
- needing regular medical treatment, care or support beyond that generally available in the hostel system; or
- not currently needing acute admission, but requiring respite for convalescence to prevent further unscheduled admission or frequent A&E attendance.

For the purpose of the first medical respite service, the following additional criteria are proposed, to enable the model to be fully tested and refined, and its value more clearly demonstrated:

- referrals to be accepted from hospital only (step-down) and not the community (step-up);
- decisions about admission to be taken by Pathway hospital teams based on assessment of need, and patient benefit;
- priority to be given to patients with tri-morbidity;
- patients known to have no rights to non-emergency NHS care will only be admitted if the referring hospital agrees to continue funding the placement.

The model is based on provision of close observation, turnaround, and respite beds to meet **different levels of need within one facility**. This offers continuity of care, providing patients with tailored care and support as they progress through each stage of convalescence, recovery and move-on. Treatment and care options will be based on assessed need and active

consideration of each individual patient's views and advice from the referring Pathway hospital team. Care packages are likely to include tailored treatment for physical illness, injury, mental illness, and substance misuse; continued care to facilitate convalescence from surgery or treatment for wounds, illness or infections; and active support for recovering physical health and mental wellbeing.

Medical respite provision will be designed to treat and manage the **range of health problems** affecting homeless people, providing the continuing care required following acute hospital admission. It will include provision of treatment, care, support, and advice to deal with health issues likely to present, including conditions identified as disproportionately affecting homeless people[10,13] such as:

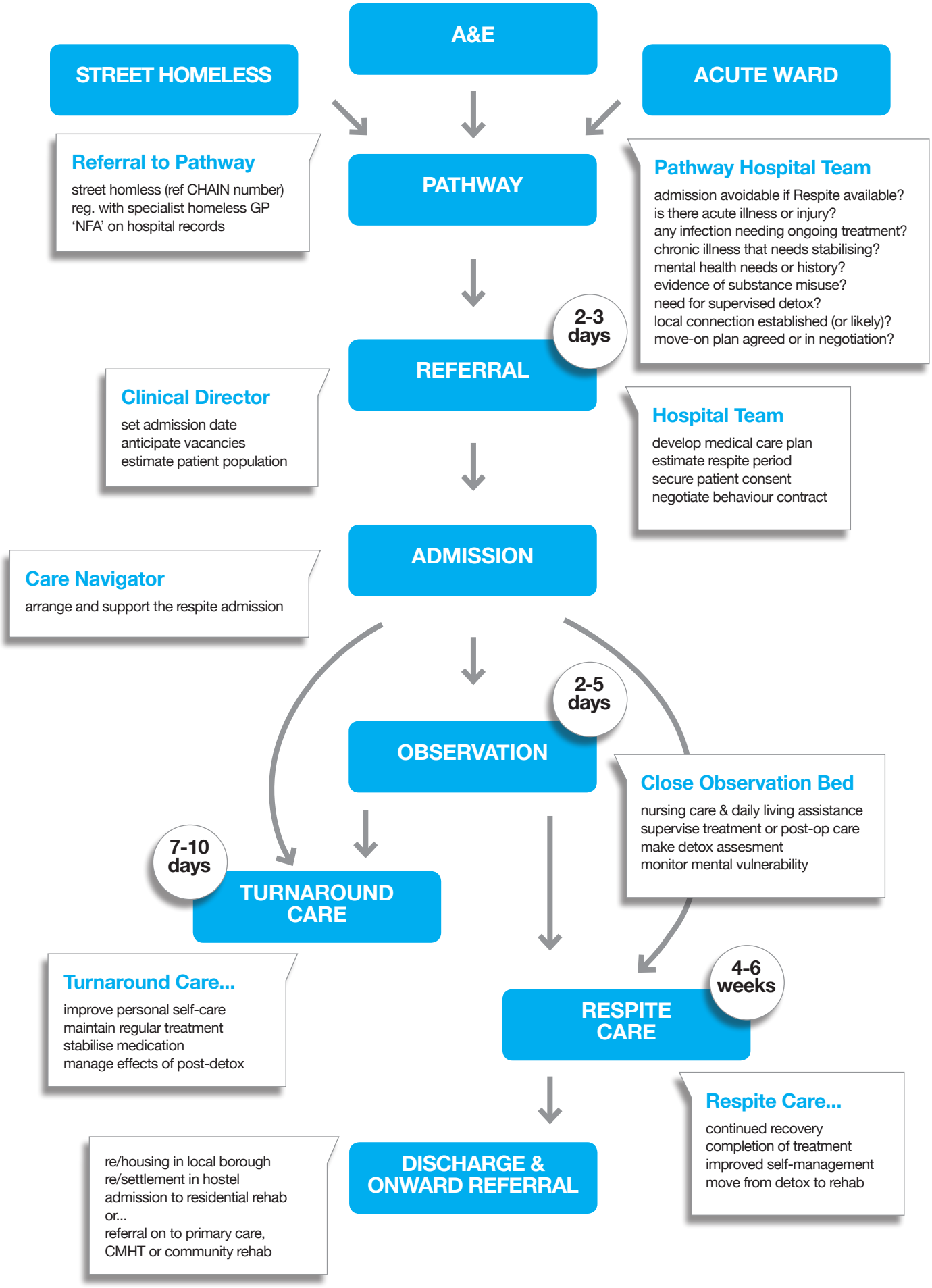
- trench foot, frost-bite, wound infections;
- TB, asthma, bronchitis, pneumonia, TB;
- diabetes;
- gastrointestinal problems;
- dental problems;
- poor nutrition;
- blood borne viruses including HIV and Hep C;
- traumatic injuries (fractures, wounds);
- alcohol and/or drug misuse and its consequences;
- mental illness including suicide risk;
- history of 'complex trauma', often associated with personality disorder.

Pathway estimates medical respite admissions will involve an **average stay of four weeks**, depending on assessed need, ranging from around 14 days for convalescence to several months for palliative care (likely to be required by relatively small numbers of people). The predicted lengths of stay are based on consideration with clinicians and care navigators of the diverse needs of a sample of Pathway patients. We anticipate many, but not all, would require a period of up to seven days in close observation and/or turnaround beds and most will require time in respite beds for further convalescence, rehabilitation, and move-on planning. One 25-bed unit could provide medical respite to around 260 homeless patients each year, based on an average total stay of four weeks.

The flowchart on the following page illustrates the range of **anticipated routes** patients may follow into and through the service, with an indication of criteria and process for decisions at each step.

The service will be alcohol and drug-free, and patients who are not committed to 'aspiring to abstinence' are unlikely to be admitted. Emphasis throughout assessment and treatment will be on actively supporting patients to plan and initiate next steps towards **recovery, rehabilitation and resettlement.**

Assertive and active move-on planning with relevant boroughs and/or primary care providers will commence at (or before) admission. Patients will remain under the care of the NHS and will not acquire 'ordinary residence' or 'local connection' housing rights in the borough where respite is located. However there will be intensive in-reach to the facility from partner community based services including housing, community mental health services, alcohol and drug services, social work and social care, and welfare and benefits advice.


A&E
STREET HOMELESS
ACUTE WARD
Referral to Pathway
street homless (ref CHAIN number)
reg. with specialist homeless GP
'NFA' on hospital records
PATHWAY
Pathway Hospital Team
admission avoidable if Respite available?
is there acute illness or injury?
any infection needing ongoing treatment?
chronic illness that needs stabilising?
mental health needs or history?
evidence of substance misuse?
need for supervised detox?
local connection established (or likely)?
move-on plan agreed or in negotiation?
2-3 days
REFERRAL
Clinical Director
set admission date
anticipate vacancies
estimate patient population
Hospital Team
develop medical care plan
estimate respite period
secure patient consent
negotiate behaviour contract
ADMISSION
Care Navigator
arrange and support the respite admission
2-5 days
OBSERVATION
Close Observation Bed
nursing care & daily living assistance
supervise treatment or post-op care
make detox assesment
monitor mental vulnerability
7-10 days
TURNAROUND CARE
Turnaround Care...
improve personal self-care
maintain regular treatment
stabilise medication
manage effects of post-detox
4-6 weeks
RESPITE CARE
Respite Care...
continued recovery
completion of treatment
improved self-management
move from detox to rehab
DISCHARGE & ONWARD REFERRAL
re/housing in local borough
re/settlement in hostel
admission to residential rehab
or...
referral on to primary care,
CMHT or community rehab

4. STANDARDS

Medical Respite provision will be based on the standards for homeless healthcare, set out by the Faculty for Homeless and Inclusion Health. These have informed Pathway's approach to developing the original proposal for medical respite, engaging partners in refining plans, and defining this outline service specification.

In addition to the Faculty standards summarised below, medical respite will need to meet relevant design standards for healthcare facilities, care standards set out by the Care Quality Commission, relevant clinical standards including NICE guidelines, and a range of good practice standards related to governance, employment, and research. These are not detailed in this specification, but continue to inform Pathway's planning and will need to be reflected in future commissioning and provision arrangements.

The Faculty's healthcare standards include the following **principles** which should underpin all provision of homeless health care, and will continue to inform planning for medical respite:

- continuity of care;
- trusting relationships with familiar clinicians;
- multi-disciplinary collaborative care ;
- person centred care with service user involvement in planning and delivery;
- incorporation of the Recovery Approach, summarised by the phrase 'hope, agency and opportunity for all';
- shared decision making as the norm, based on 'no decisions about me without me' approach.

In addition, medical respite services should seek to meet the following Faculty **standards for all homeless health services**:

- 'regular involvement in, and where necessary leadership of, multi-agency planning for rough sleepers;
- visible service user involvement in planning and evaluation of services;
- coordination of the health care of homeless people as they move between different organisations;
- participation in documenting, researching, and publishing on the health hazards of homelessness, evaluations of service delivery models, continuous monitoring of longer term outcomes;
- education and involvement in undergraduate and postgraduate training of medical, nursing, dental, psychological therapy and social work students, and development of links with relevant professional bodies;
- promotion and encouragement of accessible provision of dental and podiatry care;
- promotion of homeless health care as a viable and attractive career choice for staff[5]'.

Finally, medical respite must meet the additional standards recommended by the Faculty for **respite care** which they specify should include:

- person centred case management to include physical health, mental health, and drug or alcohol misuse when relevant;
- a Psychologically Informed Environment, with regular reflective practice integral to daily practice;

- on-site access to a full range of primary care services;
- integrated team working across medical treatment, social care and housing support, ideally from one provider organisation;
- access to education, training, sports, arts activities.

5. CORE ELEMENTS OF STAFFING ARRANGEMENTS

Medical respite services should be staffed by clinically led multi-disciplinary teams with the experience, skills, and commitment required to meet complex needs and provide the best possible treatment and care to homeless people. Staff will be encouraged to see homeless healthcare as a positive career choice and actively supported to develop relevant competencies and confidence.

The service will require 24/7 staffing with a minimum of two staff at night, one of whom will be a waking night staff based in the close observation unit, with support from sleep-in staff and the option of additional waking staff at times of high need.

Pathway has identified the following staff as essential to **creating the core team** for medical respite, with numbers being determined by the size of each respite unit and the patient mix:

- Nurse Practitioner/General Manager to lead the team and be responsible for day-to-day clinical decisions, treatment, and governance issues;
- specialist GP and Clinical Psychologist to provide dedicated sessional input and on-call support and, together with the lead nurse, to form the core team with overall responsibility for all clinical matters (relating both to patient care and staff supervision);
- Care Navigator/s with lived experience of homelessness, based on the Pathway hospital team model and other successful peer support approaches;
- Nurses to staff close observation unit and work with care team staffing turnaround and respite provision;
- Healthcare/Project Workers forming the core team working with patients and supporting their convalescence, recovery, rehabilitation, care planning, and progress towards move-on;
- Housekeeper/Facilities Manager supported by a chef and domestic staff.

Medical Respite core staff would work with a range of health and social care staff providing sessional in-reach provision to individual care packages, including physiotherapists, occupational therapists, dieticians, counsellors, drug and alcohol workers, podiatrists, and dentists. In addition, the staff team could be enhanced and supported by offering opportunities for health and social care training placements, apprenticeships across care and facilities roles, and adult education in-reach from local providers.

Pathway has developed a staff model for medical respite provision, working with a range of health and homeless service providers. This work suggests each unit's manager should be a senior nurse, supported by a half-time specialist homeless GP and half time clinical psychologist. They would lead a team of around 12 care staff who would ideally be dual qualified, as both healthcare assistants and the equivalent of homeless hostel key worker skills. Based on this structure, staffing costs for a 25 to 30-bed unit would be in the region of

£680,000 (including on-costs at 25%). At 80% occupancy, this is equivalent to £77,62 per bed-night for a 30-bed unit or £ 93,15 per bed-night for a 25-bed unit.

As well as core medical, nursing, healthcare, rehabilitation, and project skills, the following **specific skills and competencies** have been identified as necessary:

- skills and experience to work with and meet needs related to physical illness, mental health problems especially personality disorders, and substance misuse (all staff);
- key worker/case management skills including motivational interviewing or similar (Healthcare/Project staff);
- confidence working with and across the NHS, social care, housing providers (Healthcare/Project staff);
- knowledge of legal issues, welfare rights, and other issues relevant to move-on planning and resettlement (Healthcare/Project staff).

6. DESIGN AND OPERATIONAL PRINCIPLES

Medical respite could be provided in a number of settings, including adapted and refitted units no longer in use for NHS or residential care. Core elements of the **care environment** identified as essential, whatever the size and location, include ensuring medical respite units:

- offer a tranquil, healing, psychologically informed environment;
- are fully accessible and meet good quality inclusive design guidelines;
- meet NHS healthcare design standards;
- cater to the different space and layout requirements for close observation, turnaround, and respite beds.

Based on discussions with clinicians, hostel providers, and architects Pathway has identified that units must provide appropriate **space and facilities** to meet the range of physical and psychological needs of patients including:

- en suite bathroom provision for close observation and turnaround beds (and, where practical, for respite beds);
- catered meals suitable to meet diverse dietary and cultural needs, and to support improved nutrition and recovery, and 24/7 access to hot and cold drinks and snacks;
- shared dining area, with capacity to serve meals in patients' rooms when they are too unwell to go to shared dining area;
- access to quiet and private space for patients to attend meetings with support workers, care managers, legal/housing/welfare advisors etc;
- provision of space and facilities for activity, group support/meetings, IT access etc.

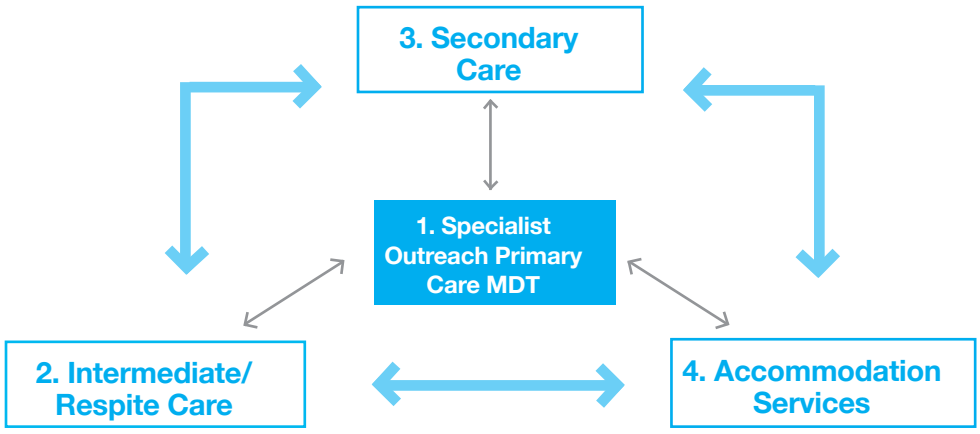
In addition, units need to enable staff to provide the best possible care to patients and to support their workplace wellbeing, including ensuring that the unit:

- is secure, with provision for a staffed reception area, with space for staff to work while on duty;
- offers adequate space for staff meetings, training, support, supervision;
- includes comfortable provision for staff sleep-ins to support waking night staff.

It is not possible to accurately estimate the capital costs of building or adapting units to meet these standards until sites are identified, but Pathway is engaged in some exploratory design and planning work on two potential London sites. **Revenue requirements** include the relevant staffing budgets set out above, plus overhead and operational costs estimated to be in the region of £350,000 per unit, plus direct catering costs and medical supplies, based on individual need. Pathway estimates the non-staff costs of provision will be in the region of £45 per bed-night in a 30 bed unit or £55 per bed-night in a 25-bed unit.

7. COMMISSIONING AND PROVISION

The Faculty recommends a model for commissioning comprehensive homeless healthcare provision, based on the best available evidence, the collective experience of Faculty members, and the lived experience of homeless people. This is summarised below[5], and demonstrates the importance of intermediate and respite care as part of a comprehensive, integrated response to meeting homeless people's health needs.



There are several **commissioning options** for medical respite, provision of which could support delivery of relevant duties held by the NHS Commissioning Board, Clinical Commissioning Groups, and Local Authorities from April 2013. This offers opportunities for securing resource, but also poses the significant risk that medical respite is seen as someone else's responsibility and/or is seen as too complex an issue to tackle amongst the range of priorities competing for commissioners' attention. Further, the low numbers of homeless people at CCG or local authority levels increases the risk of their needs remaining hidden in local needs assessments and investment decisions. Finally, the complexities of establishing 'local connections' or 'ordinary residence' impact on access to community provision, and providing timely access to medical respite will only be possible if this reality is reflected in commissioning approaches.

A high-level meeting in London, co-hosted by the Deputy Mayor of London and Pathway, considered a range of commissioning roles and options, and concluded that collaborative commissioning across CCGs will be required to address their concerns that:

- charging back to individual CCGs will be time-consuming and bureaucratic, running the risk that too much resource goes into finance staff rather than care staff;
- Health and Wellbeing Boards have the right range of funders around the table, but individually are responsible for too small a homeless population to commission medical respite.

It is important to recognise and respond to CCGs' potential concerns about their capacity to respond to needs of 'imported patients' (which is likely to be mirrored by local authorities' concerns about acquiring responsibility for new residents).

In developing the medical respite model and this specification, Pathway is seeking to recognise commissioners' concerns and make it easier for them to respond efficiently and effectively to the need for step-down care for their populations. Under the new commissioning arrangements for health it is not clear who should lead the commissioning of medical respite care. Following a period of consultation and discussions with many of the key players we recommend the commissioning of medical respite is led by the National Commissioning Board (probably through its sub-national structures) but includes negotiations across CCGs and local authorities. Appendix I summarises information to support further discussions.

Similarly, there are a number of potential **delivery options** for medical respite. Pathway believes it would be possible to establish a 'franchised model' of medical respite provision, where Pathway will work alongside NHS, charity or other providers to:

- further define and support delivery of core elements of medical respite;
- establish quality assurance measures to ensure commissioned medical respite provision meets these standards;
- work with providers and service users to evaluate services and deliver continuous improvement;
- lead on the establishment and provision of training for Care Navigators with lived experience of homelessness;
- provide on-going professional development to medical respite staff;
- develop and provide opportunities for shared learning across medical respite providers;
- continue to promote and advocate for medical respite, supporting establishment of additional services to meet the homeless populations' health needs.

Potential delivery leads and partners have been involved in developing thinking about medical respite and defining elements of the specification. Delivery could be led by specialist homeless providers, NHS providers, or a combination of both. Likewise, potential sites are being explored and could be developed from existing homelessness and/or NHS provision which is no longer being used for its original purpose.

8. CONCLUSION

Medical respite convalescent stays should be funded from the NHS tariff, as a continuation of the original acute admission. This will both free up acute beds and, by improved convalescence and rehabilitation, offer the prospect of reducing subsequent admissions and A&E attendances. Medical respite provides a model for improved provision of person-centred care to homeless people, while costing in the region of £120 to £150 per bed night; no more than the amount hospitals are paid for in-patient stays for those patients who are over the tariff trim point.

This funding model will require active participation of the referring hospitals to ensure that the service is properly funded as part of an acute admission, charged to the relevant CCG's. Because there are many disparate mainstream NHS funding sources for this new model of service delivery, Pathway believes a period of guaranteed revenue funding of three to five years will be needed to set up the service, prove financial viability and demonstrate the benefits to patients.

SOURCES

1. Broadway (2011) Voices of Experience

2. Broadway / GLA (2012) CHAIN Street to Home Bulletin 2011/12

3. Buchanan D, Doblin B, Sai T, Garcia P (2006) The effects of respite care for homeless patients: a cohort study, American Journal of Public Health 90 (7), 1278-1281

4. Crisis (2011) Homelessness: A silent killer

5. Faculty for Homeless Health / College of Medicine (2011) Standards for commissioners and service providers

6. Hewett N, Halligan A, Boyce T (2012) A general practitioner and nurse led approach to improving hospital care for homeless people, BMJ 345:e5999

7. Homeless Link, (2011) Survey of Needs and Provision, November 2012

8. Homeless Link, Crisis and St Mungo's (2010) Homelessness – trends and projections

9. Journal of Prevention and Intervention in the Community (2008)

10. London Pathway (2012) Pathway Medical Respite Centre: Prospectus

11. Porter M and Shand J (2011) University College London Hospital Trust: Homeless Care, Harvard Business School / UCL Partners

12. St Mungo's (2009) Happiness Matters

13. St Mungo's and PHAST (2008) Homelessness: it makes you sick

Appendix I

Summary of this appendix:

The NHS Commissioning Board has a legal duty to promote a comprehensive health service and to pursue the objectives in the NHS Mandate which includes specified priorities to support people with multiple long-term physical and mental health conditions, deliver services that value mental and physical health equally, and prevent premature deaths from the biggest killers.

The NHSCB is responsible for commissioning the following services of (potential) relevance to medical respite:

- primary care services (including dental)
- highly specialised and specialised services (the current advice on which does not include services to this client group, but is based on specific rare medical and psychiatric conditions)
- some services for members of the armed forces and their families.

Clinical Commissioning Groups are responsible for commissioning:

- emergency and urgent care 'for anyone present in their geographic area';
- 'healthcare services to meet the reasonable needs of the persons for whom they are responsible (i.e. principally for patients registered with their member practices, together with any unregistered patients living in their area) except for those services that the NHS CB or local authorities are responsible for commissioning.' This includes, of relevance to medical respite:
    - community health services;
    - elective hospital care;
    - rehabilitation services;
    - healthcare services for people with mental health conditions;
    - continuing healthcare;
    - treatment of infectious diseases.

Local Authorities are responsible for commissioning the following of relevance to medical respite:

- drug misuse and alcohol misuse services;
- public mental health services;
- sexual health services;
- tobacco control and stop-smoking services;
- local programmes to improve diet / nutrition.

Each will be working to support delivery of Outcomes Frameworks which 'set out the main areas where government would like to see improvement' and are intended to 'help track progress without overshadowing locally agreed priorities'. The Frameworks a number of domains or objectives to which provision of medical respite are likely to contribute, including :

- preventing people from dying prematurely (NHSOF – 1 and PHOF – 4)
- enhancing quality of life for people with long-term conditions (NHSOF -2, PHOF – 2, ASCOF – 1)

- helping people recover from illness or injury (including reducing avoidable hospital re/admission NHSOF – 3 and avoiding delayed discharge ASCOF – 3)
- ensuring people have a positive experience of care (NHSOF – 4 and ASCOF – 3)
- preventing avoidable harm / safeguarding vulnerable adults (NHSOF – 5 and ASCOF – 4)

Sources (all published by Department of Health)

- Adult Social Care Outcomes Framework 2013/14
- Functions of Clinical Commissioning Groups (June 2012)
- National Framework for NHS Continuing Healthcare (November 2012)
- NHS Mandate (November 2012)
- NHS Outcomes Framework 2013/14
- Public Health Outcomes Framework for England 2013-16
- Specialised Commissioning – recommendations of the Clinical Advisory Group (September 2012)

Healthcare for homeless people

Pathway
5th Floor East
250 Euston Road
London NW1 2PG

tel: 0203 447 2420
email: info@pathway.org.uk
web: http://www.pathway.org.uk

Design: Chloe Roach and John Wallett at idz.info