Homeless medical respite in the UK: A needs assessment for South London

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ABSTRACT

A needs assessment was undertaken to provide evidence to support a business case for enhanced homeless medical respite provision in South London. A literature review was undertaken, and existing homeless medical respite models were reviewed. Learning is summarised. A summary of the locality inpatient caseload analysis undertaken is presented, offering a new insight into the varied post-discharge needs of homeless patients. Service provider and service user perspectives are presented.

Key Words: Homeless health • Medical respite • Intermediate care • Alcoholism

Pathway teams provide individual care coordination for homeless people in hospital (Dorney-Smith et al, 2016), and use the opportunity of hospital admission to help patients into appropriate housing, support and care in the community. However, despite this expert support, not all discharges are timely or to ideal destinations.

Medical respite is an American term for clinically-supported intermediate care for homeless people in the community. This includes peripatetic nursing and bed-based solutions, and can range from low-level supported housing to comprehensive clinical care. Such services provide a safe, recovery focused environment into which homeless patients may be discharged. Some already exist in the UK, and four are profiled later in this article.

This article summarises the results of a local needs assessment for potential medical respite services that was undertaken to support the King's Health Partners (KHP) Pathway Homeless Team (that works across Guy's and St Thomas' (GSTT), King's and the South London and Maudsley (SLaM) Foundation Trusts). The work was funded by the Guy's and St Thomas' Charity, and included a literature review and review of current homeless medical respite service provision in the UK. The article outlines potential learning from the project, and offers recommendations for the future.

Literature review

Respite provision

Mainstream intermediate care services are provided in the UK to help stop patients entering

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into hospital unnecessarily, and to help them regain as much independence as possible. Homeless patients are often not able to benefit from these services for a variety of reasons.

An evaluation of the Liverpool Care Pathway specifically highlighted the lack of intermediate care and palliative care beds for homeless patients (Whiteford and Simpson, 2015). Intermediate care services are often already over-subscribed, and cater mostly for older patients (NHS Benchmarking Network, 2015). This is unfortunate, as homeless patients have been demonstrated to have an onset of multi-morbidity around 10–15 years earlier than in the general population (Barnett et al, 2012), and are thus much more likely to need intermediate care at an earlier age. These services also rarely admit someone without an onward address, for fear of a patient getting 'stuck'; and are often not well-equipped to deal with the multiple complex needs, including substance misuse issues, found in many homeless patients.

Homeless intermediate care services that do exist in the UK have grown up locally in response to local need. One of the earliest examples was Wytham Hall, founded in 1984 in collaboration with Great Chapel Street Medical Centre (a specialist homeless GP practice in Westminster). However, this project has now evolved into lower level supported housing.

Lane (2005) published *The Road to Recovery: A Feasibility Study into Homeless Intermediate Care* on behalf of a Homeless Intermediate Care Steering Group that had recently been formed within the London borough of Lambeth. The report did not find any replicable models of intermediate care in the UK at that time. It identified a clear need, but no consensus on the ideal model was formulated. However, this article led to a hostel based homeless intermediate care pilot in Lambeth (Dorney-Smith, 2011), which showed a 77% reduction in admissions and 52% reduction in A&E attendances. The project has continued on a small scale, but is unfortunately only available to those already resident in the hostel that hosts the project, which is the current 'multiple complex need' hostel in Lambeth.

A similar case for medical respite was made for Dublin in 2006, as part of a comprehensive health care response (O'Carroll et al, 2006), but this has not yet led to the commissioning of a service, despite continued lobbying.

Most publications come from the USA, where medical respite services for homeless people are common. A monograph from the American Health Care for the Homeless, Respite Care Provider's Network recommends that medical respite should be provided in free-standing units, rather than hostel-based units (Ciambrone and Edgington, 2009). Health Care for the Homeless is a long-standing clinical network of around 10 000 clinicians.

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

A reflection on what can happen without appropriate medical respite is also available. Biederman et al (2014) highlight that in the absence of a designated medical respite programme a 'patchwork medical respite service' emerges with staff struggling to cope with clients who are discharged into less ideal environments, after unnecessary and/or prolonged hospital stays. This is both time consuming and frustrating for staff, and results in care of variable quality and benefit for patients.

Finally, a recently published national evaluation of the Department of Health's (DH) Homeless Hospital Discharge Fund, emphasised the importance of step-down provision being available to support hospital discharge, although this was not specifically focused on medically supported provision. The report showed that where homeless hospital discharge teams had access to dedicated accommodation this improved housing outcomes—with 93% of clients discharged to appropriate accommodation compared to 69% overall. Interestingly, the evaluation also found that hospital discharge teams that included nursing staff—rather than isolated housing workers—resulted in improved

health and housing support on discharge (Homeless Link, 2015).

Cost-benefit analysis

The majority of papers come from America, although Lowson and Hex (2015) do provide an economic analysis of the Bradford Pathway team's recent medical respite collaboration with Horton Housing. This 14-bed medical respite unit is projected to have saved £280 000 in secondary care costs during its first year of operation (2014–2015).

A systematic review of American research into intermediate care for homeless people showed that medical respite programmes reduce future hospital admissions, inpatient days, and readmissions—alongside improving housing outcomes (Doran et al, 2013). Results for emergency department usage and costs were mixed, but promising. Key papers included one study of 229 consecutive homeless admissions to a Chicago hospital, where some patients benefited from medical respite and others did not as beds were unavailable. This study demonstrated a 49% reduction in future hospitalisations in the respite group (Buchanan et al, 2006). A subsequent study in Boston (Kertesz at al, 2009) showed a similar 50% reduction in risk of readmission within 90 days for those experiencing respite, compared to a matched group.

A recent *Lancet* evidence review confirmed these benefits (Hwang and Burns, 2014), concluding that medical respite programmes provide homeless patients with a suitable environment for recuperation and follow-up care upon leaving hospital. They are confirmed to reduce the risk of readmission and the number of days spent in hospital.

Current UK service provision

The service review examined seven operational projects, and three decommissioned projects. Four models emerged. *Table 1* gives a working example of each model with an operational description. In the process of undertaking the review the following was noted:

- All the projects have demonstrated that A&E attendance and admissions can be reduced in the client population served (including the projects that have been decommissioned)
- Clients admitted to these projects have tended to suffer with tri-morbidity (the co-concurrence of physical health, mental health and substance misuse problems); have had high support needs; and have often needed opiate substitute prescribing. Physical and cognitive disabilities have been common. Move-on has sometimes been slow as a result, as appropriate onward placements are sometimes lacking
- These projects have been primarily delivering complex case management interventions. Nursing care has not necessarily been required for many clients on a daily basis
- Projects delivered in hostels which are 'wet' (i.e. allowing alcohol consumption on the premises) have not delivered sustained improved health outcomes for many clients, although it is still possible to reduce unnecessary secondary care usage while the client is being supported in such a project
- Projects with a high level of integrated planning with the local authority have been most successful
- Models requiring a local housing connection for access have been unable to support many clients that the hospital teams would have liked to refer, and have sometimes not been able to maximise their potential bed occupancy as a result. This highlights the increasing barriers to emergency housing associated with austerity
- When clinical leadership is provided by a specialist homeless health service, this is beneficial
- Project managers felt strongly that pilot projects needed adequate time to embed before being evaluated (2–3 years minimum), as they may not have time to prove their worth without this.

Who needs medical respite?

As part of the needs assessment, data analysis was undertaken in the KHP Pathway Homeless Team hospitals. This enabled the predicted number of bed days that could be saved locally—as well as the number of potential days that

Table 1. Case studies

	Model	Operational aspects
1	Hostel-based medium support with specialist clinical staff on-site (e.g. St Mungos Hospital Discharge Network services) Set up with money from Department of Health's Hospital Discharge Fund KPIs: Reduction in clients discharged homeless; reduction in use of A&E admissions; increase in planned and routine healthcare during stay at HDN; clients will be engaged with community/statutory services *Contact: dean.thomson@mungos.org*	• 6 beds within 40-bed hostel • Step down and step up: 12-week stay target • Clients have to have to be eligible for housing in Camden • 1 WTE nurse, 1 WTE health support worker, psychotherapy input, 0.2 WTE from 8a nurse manager. • Medical support provided by local specialist practice, two sessions a week • Project provides: nursing care; engagement with all relevant health services, e.g. GPs, rehab services; addictions, mental health; escorting to appointments; encouragement to engage with hostel groups; move-on planning • Funding provided by Camden Clinical Commissioning Group for 3 years • Hours of operation: Monday–Friday 9–5 pm
2	Peripatetic medium support service managed by specialist teams (supporting both physical health and mental health hostels) e.g. Westminster Integrated Care Network for Homeless Health Set up as local pilot in response to need KPIs: EQ5D improvement; clinically assessed improvement in health: each admission linked a health goal. Achievement measured as: a) full, b) partial or c) not achieved; positive move/on discharge destination *Contact: m.radcliffe@nhs.net*	• 10 beds across Westminster hostels • Step down and step up: 6-week stay target • Clients have to be registered at specialist or mainstream Westminster GP, be a client of the Joint Homeless Team, or be rough sleeping in Westminster • 1 WTE project manager Band 5, 2 WTE housing support workers (Band 4 equivalent). Medical and nursing input from specialist practices. 0.1 WTE support from 8a nurse manager at Great Chapel Street Medical Centre. Partnership with Groundswell for peer advocacy support • Monthly referrals/multidisciplinary team meeting with all partners in attendance • Project provides: comprehensive clinical review; nursing care; engagement with all relevant health services e.g. GPs, rehab services; addictions, mental health; escorting to appointments; encouragement to engage with hostel groups; move-on planning. • Funding provided by Westminster Clinical Commissioning Group • Hours of operation: Monday–Friday 9–5 pm
3	Hostel based: low-level B&B-type support with at home team support if required e.g. University College London Hospital P2H (Pathway 2 Home) Set up with money from DH Hospital Discharge Fund KPIs: Target maximum length of stay 5.1 days; target bed occupancy 80% *Contact: tim.robson@nhs.net*	• 2 beds in 32-bed hostel—spot purchased. • Step down only—target length of stay 5 days • Only open to patients admitted to UCLH (but includes people with NRPF and local connection) • 0.2 WTE support from 8a NHS manager. Housing support/case management provided by Pathway team as part of ongoing role. Clinical care provided by at-home service on daily basis (up to 3 visits). Medical support provided by consultants • Funding provided by University College London Hospitals (from 1 April 2016). • At home team provides care 8am–8pm if needed • Hostel staff provide additional support if required, as well as catering, laundry and cleaning services
4	Stand-alone service, e.g. Bradford Respite and Integrated Care and Support Service Converted with money from Department of Health capital grant (previously student accommodation) KPIs: improved housing outcomes; improved access to benefits; improved access to primary care; improved access to social care; positive move-on *Contact: Gina.rowlands@bradford.nhs.net*	• 14-bed intermediate care facility—based on hospital site • Step down only—target 12 weeks • Pathway Team is essentially an outreach service from the local homeless practice and manages admission and provides clinical support • Project is a collaboration, and has staff in-reaching from health, social care, and housing association on-site during the day • Funding provided by Bradford City and Districts Clinical Commissioning Group (clinical input) and adult social care and public health (social care input) • Warden cover from 5 pm each night through to 9 am the next morning

would be required in medical respite—to be estimated. It also enabled an understanding of the caseload to be developed. Some analysis was undertaken on the whole cohort, and 76 cases were also examined in depth.

In terms of the wider cohort, 826 patients referred to the Pathway team at GSTT occupied an estimated 5981 bed days between October 2014 and September 2015, with an average length of stay of 7.2 days. Re-attendance and readmission rates were high (22% and 21% respectively). At King's, the number of bed days occupied by 306 homeless patients for the same period was 4109, with an average length of stay of 13.4 days. Historical SLaM data evidenced an average length of stay ranging from 110.1 to 173.6 days for homeless clients. One hundred and thirty-two patients were referred to the SLaM team in the first 11 months of the project.

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

For the 76 clients studied in detail, 30 of these were randomly selected patients, and 46 were patients identified by the KHP Pathway teams as those likely to benefit from medical respite. In this group, 54 clients from GSTT and Kings accrued 472 A&E attendances and 181 admissions from October 2014 to September 2015, with total bed days of 2561.

The 22 SLaM clients accrued 12 136-suite attendances (police power to remove a person to a place of safety under the *Mental Health Act 1984*), 28 admissions and 1634 bed days, and a further 91 bed and breakfast days during the same period. The 14 'frequent attenders' in this sample accrued an average of 23.4 A&E attendances, and 9 admissions per person during the year. A summary of the needs presented by these 76 clients can be found in *Table 2*.

Across the three trusts, it was concluded that 4410.2 bed days could be saved in year if medical respite was provided, with a potential to fill 12.7 medical respite bed spaces annually. The full report can be found online (www.pathway.org.uk). However, an important finding from the data analysis was that patients broadly in the category of 'homeless people requiring medical respite' did not have homogenous needs, and thus did not all need the same level of support outside hospital. This was an interesting finding, as current service provision has tended to focus only on the traditionally homeless, ex-rough sleeping, chaotic, tri-morbid group with broadly similar needs.

The analysis identified five categories of patients from the KHP Pathway Homeless Team caseload, who may benefit from medical respite:

- **Patients requiring hotel-type low level support (30% of cases):** These are relatively independent patients with physical or mental health difficulties (sometimes with mobility issues) who are statutorily homeless, but would not normally be expected to become rough sleepers. They have often been evicted (as they are unable to cope due to their health problems), or have been previously sofa surfing and gaining support from friends or family. They do not usually have addictions. They can usually be demonstrated to be in priority need from a housing perspective, but are often short term 'bed blockers' while their housing case is argued with the local authority. They have some low-level support needs
- Patients with serious health problems who have no recourse to public funds (NRPF) - 11% of cases. Those with 'no recourse' status include undocumented migrants, visa over-stayers, failed asylum seekers and European migrants who have acquired this status by not exercising their treaty rights. Conditions included: cancer, diabetes, renal failure and late-stage HIV. These patients often have mental health problems, but not addictions. There are complex debates about whether they meet the care needs threshold, and their support requirement increases over time. They are often severely delayed, so although they represent a smaller percentage of individuals,

they are over represented in excess bed days.

- **Patients with significant care needs requiring a care placement (8% of cases):** These patients are ex-rough sleepers with acquired care needs and/or cognitive deficits with addictions. This makes them difficult to place due to a lack of appropriate social services funded accommodation. They need daily support, including with personal care. They are often are severely delayed, and are also over-represented in excess bed days
- **Chaotic, tri-morbid patients requiring specialist hostel-based support (51% of cases):** These patients have all been rough sleepers at some point, and are chronically, physically and/or mentally unwell with addiction problems (most have alcohol issues, many also have drug issues). They have often received or been offered every service available to them. They are usually already in a hostel, or are still rough sleeping despite repeated attempts to engage them with support services. They are often frequent attenders, although they can also be non-engagers. They often leave prematurely or self-discharge and only 'block beds' later as they become more unwell. They need intense informed case management and may need end-of-life care. Existing provision focuses on this group, and so far has been delivered in 'wet' hostel type environments (i.e. hostels that tolerate on-site drinking)

Table 2. Needs assessment: 76 candidates for medical respite

- 81.6% had a physical health problem
- 76.3% had a mental health problem
- 60.5% had a substance misuse problem
- 32.9% had a mobility problem
- 77.6% had experienced a delayed discharge
- 81.6% could have benefited from step-down care
- 32.9% would have needed ongoing daily nursing care
- 89.5% would have benefited from ongoing key work support
- 76.3% had a housing issue
- 34.2% had a welfare/benefits/eligibility issue
- 25% were on some form of substitute prescribing
- 25% had a complex needs worker/care coordinator

- **Chaotic tri-morbid patients wanting to stay dry:** Within the above group there are a significant number of patients who have had an unplanned alcohol detox as part of their acute hospital admission and are expressing a desire to stay dry (i.e. off alcohol), and not to return to their hostel. In fact, most clients in the above group had expressed a desire to stop drinking at some point (77.5%). However as many of these patients' have had limited or no prior engagement with alcohol services, it is practically impossible to arrange urgent admission to an addictions rehabilitation bed. These patients appear to need a rapid-access stand-alone dry unit where they can be stabilised and engaged with abstinence support.

Examining cases

In-depth case studies of medical respite candidates (see *Table 3*) revealed further interesting information. Most clients suffered from alcoholism, although they had a variety of differing support needs. Several clients would have benefited from a dry environment after hospitalisation. Many clients with mental health problems were discharged into mainstream homeless hostels—indicating there is clear potential to manage some mental health and physical health discharges together. Sadly, a number of the clients in the case studies had subsequently died—often professionals felt that these were potentially avoidable deaths. End-of-life care, TB management and neuro rehabilitation were also particular respite needs highlighted by these case studies.

Service provider perspectives

A variety of service providers were interviewed to support the needs assessment. Within service providers, there was a general recognition that mainstream intermediate care services were not meeting the needs of this client group. There was also a recognition of the groups of patients identified above. However, stakeholders pointed to ongoing funding practicalities around medical respite provision when services are provided within local authority controlled accommodation. The main challenges were cited

Table 3. Case studies

Male 38: Alcohol-dependent, ex-IV drug user, HIV, bowel resection, stoma, leg ulcers, clots (DVT's), endocarditis. Personality disorder, previous psychosis, suicide attempts

Chaotic client with history of multiple moves and abandonment. Twenty A&E attendances, 13 admissions and 110 bed days in 2 years. Moved into a hostel-based respite from hospital at one point. At this point wanted to stop drinking, and it was thought that 'there was a glimmer of serious hope', however, this respite was in a hostel that was not dry. Client was anxious about contact with other drinkers in the hostels, even asking for an escort when going out to get methadone. Eventually he started drinking and disengaged from staff. However, before he abandoned some progress was made with his medication concordance, and with harm reduction demonstrating some benefit from hostel based respite. A dry respite environment might stop the revolving door.

Male 63: Alcohol-dependent, hyponatraemia, upper GI bleed

Homeless after an eviction—was not coping with depression and long-term alcoholism. Admitted three times in quick succession, 18 bed days. Was given emergency place in homeless hostel after discussion with local authority on third admission. Respite could have avoided subsequent admissions, but also given space to examine possible options. Potential saving of 13 hospital bed days.

Male 43: Drug resistant TB, initially smear positive. Hepatitis B

Client with low educational attainment, lack of understanding contributing to compliance issues. Complicated immigration issues, no recourse to public funds. Essentially self-caring. 135 bed days in 2014–15. Eventually went to a specialist project for NRPF patients with TB, but would have benefited from intensive work in medical respite to work on compliance issues. Potential saving of 93 hospital bed days.

Female 28: Alcohol-dependent, IV drug user, hepatitis C, DVTs, renal failure, asthma, anaemia

Chaotic client history of frequent abandonment, who did not like hospital environments. Avoided hospital for a long time while health deteriorated, and self-discharged several times when unwell. Nine A&E attendances, 6 admissions and 99 bed days in previous year. If the early stages of this health deterioration had been managed better, the acute renal failure might have been avoided.

Male 25: Psychosis, history of cannabis use.

Admitted for psychosis. Went into local authority temporary accommodation after first admission, but abandoned this as did not feel safe, and was then readmitted. After second admission went into mainstream homeless hostel. Admission to respite might have provided appropriate support during transition, and would probably have avoided readmission. 28 bed days could potentially have been saved.

as local connection issues, the requirement for the person to obtain immediate housing benefit entitlement for that environment to be admitted, as well as the need for the local suthority to be able to maintain a flow of beds in order to support the project (which is challenging in current times).

Bed blocking of a unit that does not have a clear strategy or protocols was repeatedly raised as a potential risk to any project, and it was frequently mentioned that pilots should try not to be based on 100% bed occupancy models (as this was more likely to reduce 'flow'). Most people also felt that there are a group of

clients needing ongoing 'care' needs who need continuing high support for whom limited options exist, and that this needed to be looked at separately.

Alcohol dependence was recognised to be the major health problem for this group. Service providers talked consistently about the key issue of being able separate those aspiring to abstinence from continuing drinkers, and the near impossibility of providing a 'dry' environment within a 'wet' hostel.

Overall a number of key debates and dilemmas came through in this engagement work:

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

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

Service user perspectives

'I have been discharged and slept in the hospital grounds because I felt safer—I knew I wasn't very well. I went back and hoped I'd see a different doctor' (service user).

Service user perspectives were also obtained, led by Pathway's Expert by Experience project Lead. Service users felt that the presence of KHP Pathway specialist homeless team had improved hospital discharges in the area, but there was still more that could be done. The following points summarise a review of previously published work (Lane, 2005; Hendry, 2009; Burridge, 2012), and the work of focus groups undertaken for this needs assessment.

- Service users are still having negative experiences during all phases of the hospital experience including discharge
- Service users think respite facilities should be 'dry'
- Service users are split on whether controlled drinking for some can be applied successfully in a unit where other clients are trying to stay dry—but more feel this is not possible
- In general, service users do not think existing homeless hostels are a good environment for respite. Although able to understand practical delivery issues and funding constraints, service users feel that higher support, dry, stand-alone units are the most needed type of provision (because they feel that those service users most need intensive, good quality support)
- Service users think medical respite (where it is most needed) should be available for all, not just those with a local connection or recourse to public funds. However, service users recognise that some people might need to be discharged to the streets after time limited interventions (as they would from hospital)
- Service users think that mental health support, and specialist housing/benefits/employment support are a necessary part of respite provision
- Service users were spilt on whether patients discharged from physical health and mental health care hospitals can be managed together (there were concerns in the cases of very unwell mental health clients)
- Service users think end-of-life care needs to improve for homeless people, and this should be a consideration when designing intermediate care type services.

Options for provision

Within the needs assessment document, various potential options for the delivery of medical respite in South London are outlined, and recommendations are made.

Discussion

Current evidence suggests that medical respite can improve care for homeless people leaving hospital and reduce secondary care costs. There are also some tested models available for developing such services. However, as we have demonstrated, this area is complex. A variety of needs present, and differing types of service provision will offer different outcomes.

'Hotel' provision is most likely to achieve immediate bed day savings, while concentrating on the 'chaotic tri-morbid' group is likely to foster recovery and provide long-term value for investment. Providing an opportunity for alcohol-dependent clients to stay dry, stabilise and engage with services seems important, as this is key issue expressed by all. In fact, London has higher excess mortality rates secondary to alcohol in homeless persons compared to other regions (Thomas, 2012), and this provides an additional moral driver.

The main barrier to all provision is the siloed and depleted budgets that exist across the voluntary sector, housing and social care. Improving this can be achieved by better integrated care within each borough, but this does not provide help for the high number of hospital patients who do not have a local connection. A locally agreed NHS tariff for medical respite care may present a solution, and Pathway is currently working to develop this concept. BJHCM

If you would like further discussion about developing a Pathway team or a medical respite servicein your hospital, please contact Pathway Medical Director Dr Nigel Hewett. nigelhewett@nhs.net. If you would like to join the Faculty of Homeless and Inclusion Health, a free clinical network of inclusion health practitioners hosted by Pathway, please visit: www.pathway.org.uk/faculty/join/

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