Piloting a Medical Respite Service for Homeless Patients at University College London Hospitals

Summary Report

November 2016

pathway
Healthcare for homeless people

Introduction

This report summarise the efforts of homeless health charity Pathway to create a pilot specialist medical respite centre for homeless patients leaving hospital in London. It presents learning from nearly four years work and illustrates the challenges of creating a new, boundary crossing service focussed on the needs of patients with multiple complex needs within the myriad constraints of the National Health Service and local authority housing and social care regulations.

The pilot was commissioned by homeless healthcare charity, Pathway, and operated by its hospital partner, University College London Hospitals NHS Trust (UCLH). Funding for the project came from a one off grant from the Department of Health's Homeless Hospital Discharge Fund (HHDF).

Pathway's vision for medical respite care was described in a service specification, which Pathway produced for the Department of Health in early 2012. We set out the need for step down convalescent, rehabilitation beds, in a unit equipped to manage patients with substance misuse problems and personality issues. Such a unit would provide compassionate, patient-centred care for homeless patients becoming ready for discharge or immediately after a stay in hospital. Medical respite would intentionally blur the hard bureaucratic boundary between hospital care and care provided in community settings. The vision was based on a wide range of research. [1]

In October 2012, Pathway was the recipient of a Department of Health (DH) grant through the Homeless Healthcare Discharge Fund (HHDF) of just over £469k. The application to the HHDF Fund proposed establishing a pilot Medical Respite Centre (MRC) in London, based on successful models already established in the US. The bid described a centre with between 15 and 20 beds, able to take patients from a number of London hospitals, keeping them for an average length of stay of between two and four weeks. The MRC would offer a tranquil, healing, psychologically informed environment that supported convalescence, resilience building, improved nutrition and physical recovery.

Ultimately, the pilot project, Pathway to Home, ran from 9th March 2015 to 31st March 2016. This report summarises the main findings from delivering the pilot. It also provides some insight into the substantial work undertaken to set up the pilot and the challenges encountered along the way.

A more detailed version of this report is available on the Pathway publications page at http://www.pathway.org.uk/publications/

Getting Started

The early phase of project delivery (from October 2013), focused on establishing governance arrangements, finding premises for a medical respite facility, quantifying set-up and operating costs and agreeing the right operating model. Governance was handled through Pathway's Board of Trustees (strategic and spending decisions) and a Medical Respite Project Board to lead the project work on medical respite within UCLH.

From the beginning, finding suitable premises proved a difficult challenge. Discussions had taken place with NHS property managers during the bid stage, noting there was a significant amount of vacant, surplus clinical space within the system in London. On the advice of the Department of Health, Pathway's premises search was therefore initially focused on vacant NHS space. The rationale for pursuing this was to save on rental costs; Pathway received a lower grant than requested on the basis that funds would not be required to cover rent as vacant NHS space is already funded.

Having assessed a number of options, a single operationally feasible location was identified, suitable for the pilot and practically usable for a UCLH operated service. This option was a brand new, unused and self-contained 17 bed ward in central Finchley, north London. The Pathway team felt that, in this ward, it would be possible to provide the type of psychologically informed environment in which medical respite services have been shown to thrive. For medical respite, the ward was too large for patients from a single hospital to fill the beds, so it would only be feasible with multiple referring Trusts.

1 http://www.pathway.org.uk/wp-content/uploads/2013/05/Pathway-medical-respite-for-homeless-people-03.01.pdf

After much negotiation, it was not possible to reach an agreement with the building's private owner and relevant NHS tenant as to who should pay the rental and service charge costs. Their expectation was for Pathway to meet the full rental costs. The reduced grant award made this impossible as rent and services would account for approximately 90% of the total. The complexities of dealing with the various layers of NHS management proved impossible to overcome in relation to the premises issue. There was an inherent tension between local (CCG) and regional (NHS England – London region) bodies, leading to lengthy discussions on where responsibility for rental costs actually lay. Despite fervent lobbying from various parties, Pathway was left with no option but to walk away from the preferred premises option.

At the same time, more detailed modelling of the estimated costs of staffing an 8-16 bed facility proved equally prohibitive, with the minimum safe staffing requirement (including at least two registered nurses on duty at all times) likely to cost at least £650k per annum. A facility of this size would also require 2 or 3 referring Trusts to fill the beds. (UCLH estimated a requirement for 4-6 beds for their own hospital). Discussions were not sufficiently advanced to set up a partnership with other Trusts to guarantee patient flow, even if budgets and clinical governance arrangements allowed. Moreover, the DH grant was not sufficiently large to encourage any party to take an up-front risk on the project. This all led to a radical rethink of how to create a viable pilot project.

Getting started: what did we learn?

- Navigating the complex layers of NHS management was challenging
- Bringing vacant NHS space back into use was not possible due to:
  - Complexity of administrative boundaries & inability to redeploy budgets across these boundaries
  - Prohibitive cost of refurbishment, rental and 24/7 staffing
- Working with a single operator for pilot phase required a smaller scale solution

Creating Pathway to Home

The decision was taken to pare back the pilot project and keep provision more in-house, with UCLH acting as the single operator for a service of up to 4 beds. Fortuitously, plans were well underway at this time for UCLH to launch an at home nursing service (UCLH@ Home). This new service would be aimed at patients who no longer needed care in an acute hospital ward and could safely finish the last stage of their hospital treatment in their own home environment.

Pathway secured an in principle agreement to extend 'UCLH@Home' to homeless patients and to find premises locally that might provide an environment for the delivery of at-home nursing services to patients without a home. Pathway talked to a number of potential partners in the Camden area and was signposted to local hostel provider, Olallo House (OH) which was already contracted by UCLH and by public health colleagues to provide beds for homeless TB patients in their nearby hostel.

Both Boards (Pathway and the Medical Respite Project Board) received a proposal to:

- **commission two dedicated bed spaces for medical respite use;**
- **rent an additional room to use as a treatment room for clinical visits;**
- **carry out minor refurbishment works to treatment room and provide all necessary medical equipment and supplies;**
- **commission OH hostel to provide all catering, laundry and ancillary services for patients;**
- **provide clinical care to patients via the UCLH@Home contract (via private provider, Healthcare at Home);**
- **commission up to two additional beds as required (under a spot purchase arrangement).**

An initial 6 month pilot project, Pathway to Home, was given the go-ahead in July 2014. Pathway's grant covered the costs of the beds, treatment room, catering and ancillary services. Clinical care costs were covered by the hospital's UCLH@Home contract. It was recognised that, even at high occupancy levels, patients would incur a relatively high day rate compared with patients being treated in their own home. However, the opportunity cost of freeing up capacity in acute beds would offset this to some degree.

A considerable amount of work was needed to get all the building blocks in place prior to service launch, including:

- **Preparing a detailed Service Schedule setting out inclusion/exclusion criteria for patients, processes for transferring patients and managing daily visits and protocols for handling emergency situations;**
- **Completing a Service Level Agreement (SLA) to clarify contractual responsibilities for Pathway (as commissioner) and Olallo House (as provider);**
- **Pathway joining the UCLH@Home Governance Group (the group with clinical oversight of UCLH@Home);**
- **Completing risk assessments covering all aspects of patient and staff safety;**
- **Agreeing a set of key performance indicators (KPIs) covering service, length of stay and bed occupancy rates.**

Creating Pathway to Home: what did we learn?

- Homeless hostels, with the right staff and facilities, can provide a good environment for medical respite care
- Do not underestimate lead times required for preparation and sign off of contracts, policies and other important paperwork
- Importance of clear and effective governance arrangements to guide strategy and policy
- The potential difficulties in making small scale provision cost effective

Pathway to Home: Early Days

Pathway to Home (P2H) was officially launched on 9th March 2015 with a view to running for 6 months. The key elements of service provision were:

- **Eligible patients identified by team of UCLH@Home Case Finders** [2]
- **Potential cases discussed with patients' consultants & the UCLH Pathway homeless team**
- **Decision to transfer made jointly by the patient's consultant and Pathway team**
- **Agree treatment plan including number of daily visits required (up to 3 per day)**
- **Once transferred, Pathway team continue care co-ordination for patients in preparation for discharge**

In the early days of the project, occupancy rates were low, primarily due to clinical reluctance to be responsible for patients being treated remotely. Many of these issues were shared with the wider UCLH@Home service which struggled to meet targets initially. The exclusion of methadone patients was a specific challenge for Pathway to Home. This was rectified through the implementation of a UCLH off-site methadone dispensing policy, designed specifically for Pathway to Home. It took five months to design and achieve all the levels of necessary approval for this policy.

2 Detailed eligibility criteria were included in the homeless pathway Service Specification and included factors such as age, medical specialty and level of clinical input required. Patients requiring IV medication were included; initially, those taking methadone were not. Patients with serious mobility issues also excluded due to stair access to hostel main reception entrance.

Figures 1 and 2 illustrate the process for identifying, transferring and caring for patients under Pathway to Home:

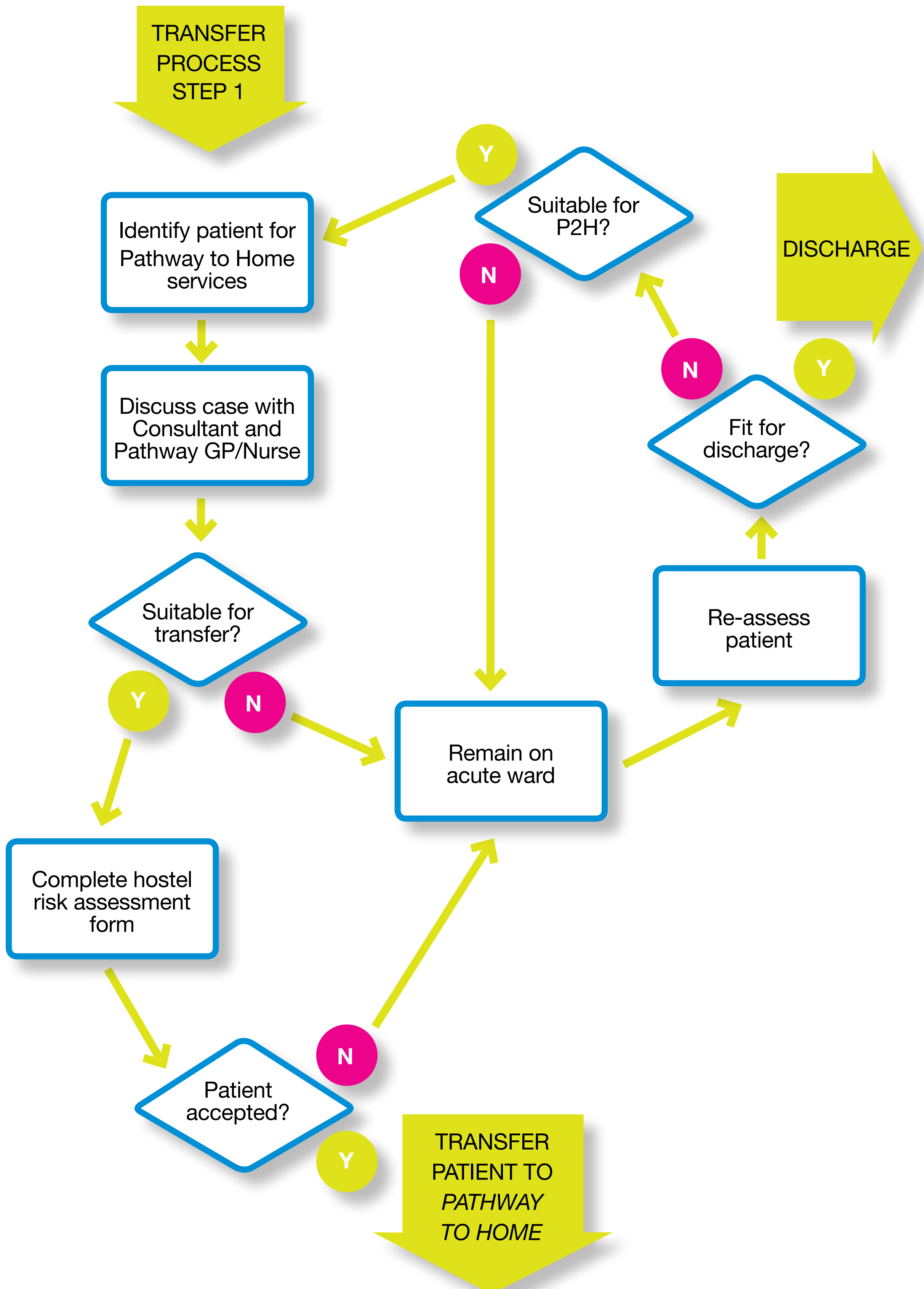

Figure 1: **Pathway to Home – Patient Referral Process**

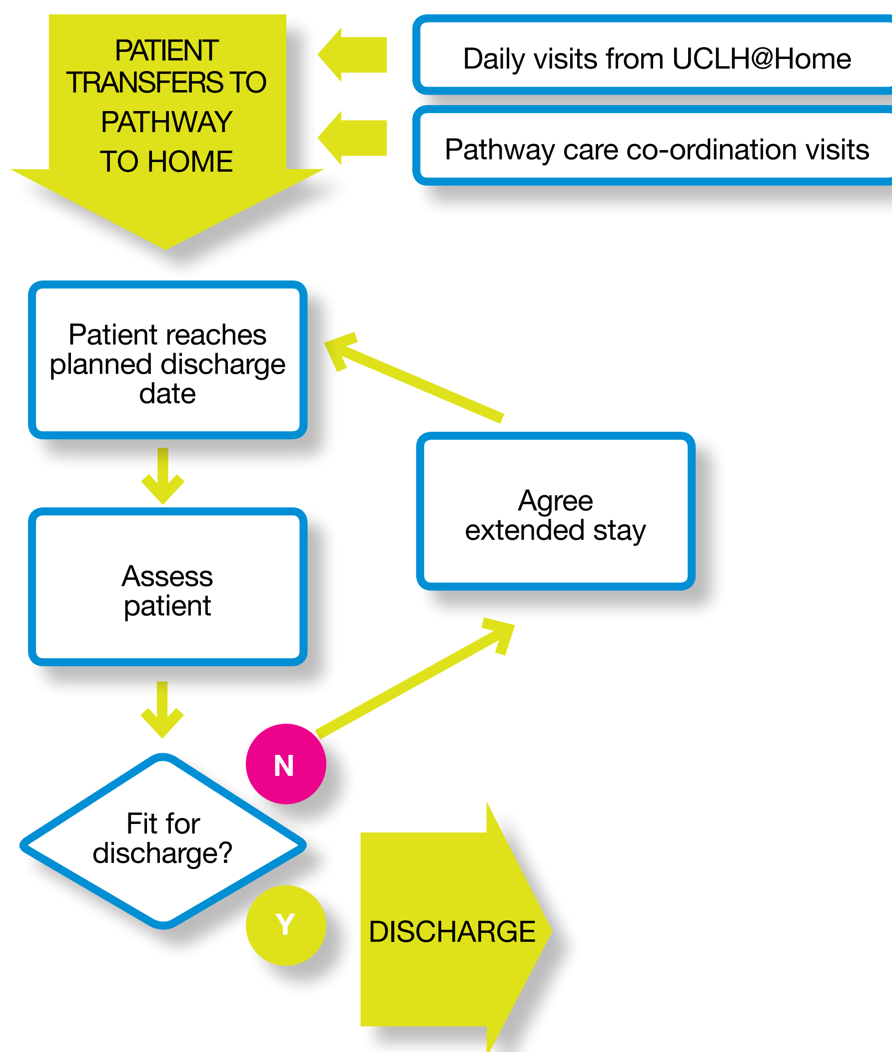

Figure 2: **Pathway to Home – Patient Care & Discharge Procedure**

To maximise use of the grant funding, Pathway also took the decision to make available any unused beds to a new 'B&B' category of client. These would be discharged homeless patients who did not need ongoing hospital care but who would benefit from some extra days respite before moving on. This approach was designed to maximise the use of beds which had already been paid for, as well as getting a bit closer to the Pathway vision of true medical respite provision, softening the boundaries between being in and out of hospital.

The Pathway homeless team selected patients for B&B support for a range of reasons, such as:

- **Respite and recovery (to ensure fully fit for move to hostel/street/temporary accommodation/ home town or country);**
- **Short stay whilst working on housing applications;**
- **Reducing likelihood of condition recurrence or deterioration;**
- **Preventing relapse in drink/drug use;**
- **Providing more suitable recovery environment for the most complex or vulnerable homeless patients.**

Early days: what did we learn?

- Multiple challenges of offering homeless medical respite as a sub set of the UCLH@Home service
- Working with multiple partners within the constraints of UCLH@Home restricted the type and number of patients who could be transferred onto the service
- Under-estimated length of time required to develop and approve off-site methadone dispensing policy
- New and innovative projects of this type require a minimum of one year to become established – and require significant resources for promotion and project management
- Maximising occupancy requires a mix of post-acute inpatients and recently discharged patients who need additional recovery time

Headline Findings

Table 1 below provides a summary of admissions to the 12 month Pathway to Home pilot.

PATHWAY TO HOME		BED & BREAKFAST	
Admission numbers	31	Admission numbers	28
Readmissions	2	Readmission	4
Bed days saved	243	Bed days saved	264
Average length of stay (days)	7.6	Average length of stay (days)	9.4
(hospital target)	*(5.1)*	-	-
Occupancy rate	31%	Occupancy rate	34%
(hospital target)	*(80-85%)*	-	-
-	-	Additional bed nights purchased (i.e. over and above 2 dedicated beds)	62
P2H patients transferred to B&B	10	-	-
Methadone patients assisted	5	-	-
Average number of nurse visits per day	1.5	-	-

Table 1: headline results from P2H pilot project

Occupancy levels for each strand of service user fluctuated considerably throughout the pilot phase (see Table 2 on following page). Occupancy rates reflect the slow start and the quieter summer months and a rise in the winter months.

This below expected occupancy demonstrates that predicting anticipated demand is never an exact science and that hypothetical analysis will only take you so far. Analysis of the anticipated demand was not done with a hospital at home model in mind. This placed restrictions on the type of patient who could use the service that did not necessarily cover all possible types of medical respite case as defined in Pathway's original vision.

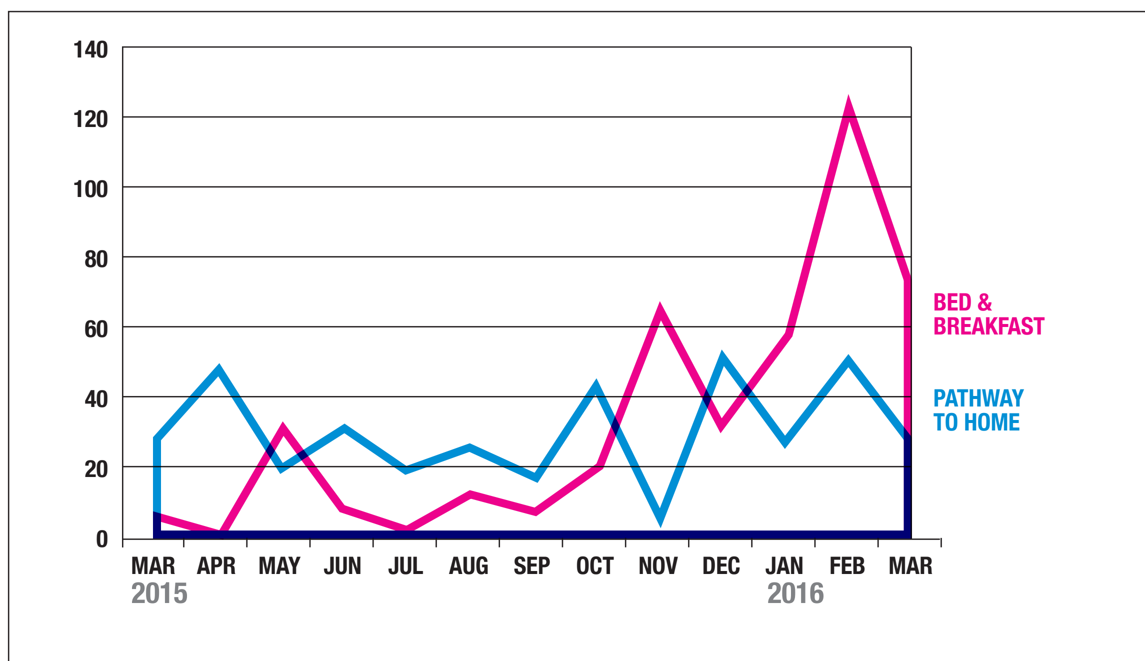

Table 2: Percentage occupancy rates by month (P2H and B&B users)

Just over one third of patients (35%) were treated for wound care (e.g. leg dressings) during their stay. 29% were supported with their medication, including checking compliance with medication regimes (e.g. for methadone users). 19% received daily observation checks for conditions such as skin infections, sepsis and TB. A couple of patients received treatment for diabetes. Blood pressure checks and anti-coagulant injections accounted for two more cases. Care co-ordination was provided by the Pathway team to Pathway to Home patients and B&B cases alike. Support included help with securing housing and accessing benefits.

Pathway estimates that, without access to the B&B beds, at least a quarter of patients involved would have been discharged to the street, leaving the team unable to provide further housing or welfare support. Pathway's clinical staff estimate that providing additional recovery time (for drug/alcohol rehabilitation or prevention of condition deterioration) avoided an estimated 112 readmission days.

As expected, the vast majority of users (85%) accessing the service had some form of local connection in London. 4 users (7%) were from other parts of the UK, with 2 patients from overseas (France and Sweden). One patient's local connection was unknown. In terms of onward destination, just under one third of users (29%) were successfully housed in a London borough or elsewhere in the UK. An additional 20% were found places in hostels,

Mr A.

CASE STUDY #1

Mr A came to the UK from East Africa 5 years ago. When his visa expired he claimed asylum, but was unsuccessful. He stayed with a friend, but eventually the friend became homeless and they were both on the street in London for several months. He was brought to hospital by ambulance breathless and was admitted to ITU with pneumonia and pericarditis. After some weeks, he was found to have pulmonary TB. He was very underweight and weak and so was transferred to Olallo under UCLH@Home so his recovery could be monitored. His observed TB treatment was observed and the Pathway team helped him to make a case for statutory housing. His condition was considered serious enough to warrant this even though he had no recourse to public funds. Whilst at Olallo he had an intermittent fever and nursing staff were eventually concerned enough to readmit him to hospital. He was found to have a pneumothorax and required a chest drain. Following treatment for this, returned to Olallo for a further week by which time the local council had found suitable accommodation where he could stay with his partner.

Had he been discharged to the street, he may well not have survived. Whilst on Pathway to Home, he received excellent care, was swiftly readmitted when he needed to be, and convalesced out of hospital despite being homeless.

night shelters or refuges. 15% (9 cases) were discharged back to the street (a few by choice). Encouragingly, there were 3 instances of patients remaining at Olallo House (TB bed, reconnection bed or work placed bed) which demonstrated the value of having access to onward patient pathways via the hostel provider.

Service Costs

Of the total grant funding received (£469k), one third was used on service set-up, covering costs attributed to staff/management time, purchase of equipment and minor refurbishment works. Just under half of the grant (47%) was attributed to direct running costs of the pilot service. The bulk of this covered rent (£107k) with a further £47k attributed to staff costs comprising UCLH clinical advisory time and Pathway nurse/care navigator input. The UCLH@Home nursing service cost was covered by UCLH via its provider contract (Healthcare at Home). On average Pathway to Home patients received 1.5 nursing visits per day. A small amount of spend was incurred after the pilot to cover evaluation work and transition arrangements.

Continuing the Service: Financial Viability

The pilot was intended to provide both proof of concept of the delivery model and to demonstrate financial savings (or at least cost neutrality) for the hospital. There is plenty of evidence to support the first, but a 2-bed facility is too small to demonstrate any significant cost savings. That said, analysis of the overall 'at home' contract costs revealed that, if UCLH was to assume responsibility for the Pathway to Home contract costs (in addition to the wider UCLH@Home contract), the number of beds required to break even on the contract would remain the same.

Performance indicators & cost: what did we learn?

- The delivery model works: patients transferred successfully, received good care and incidents arising dealt with quickly and effectively
- Occupancy rates lower than anticipated due to length of time taken for UCLH@Home service to become established in UCLH
- Occupancy rates also impacted by restrictions on eligibility (e.g. methadone users, patients unable to manage hostel stairs) and requirement for joint decision making on patient suitability for transfer
- B&B category a crucial element of effective medical respite (from a Pathway perspective); estimate 112 days of readmission avoided through additional recovery time
- Difficult to draw meaningful conclusions on cost effectiveness, impact on readmissions etc. at such a small scale of operation
- UCLH@Home contract break-even point unaffected by incorporating P2H into the hospital cost base.

Feedback from Staff, Patients and Hostel Provider

Staff acknowledged there were many positives to the P2H service once the initial hurdles of getting a service up and running were overcome. Fundamentally, the pilot project has shown it is possible to deliver good quality, intermediate, medical respite care for

homeless patients in a safe, caring environment that addresses patients clinical, housing and other welfare needs. All staff involved in the project were interviewed as part of this evaluation. The main benefits flagged up in staff interviews are summarised in Table 3 (below).

Strengths of Pathway to Home

- Overall, pilot has clearly demonstrated the process of medical respite care provision and positive outcomes for patients
- Service frees up acute beds and moves homeless patients onto more appropriate pathway to complete their care
- Service has ability to deal with highly complex cases, including methadone patients
- Methadone policy hailed as an innovative development and a notable first for UCLH
- Service is considered safe for patients with no major incidents reported; any issues arising were dealt with swiftly and effectively thanks to effective team working and well-structured governance and project board
- Many excellent examples of effective collaboration and relationship building at different levels, including:
  - Unique and innovative 4-way partnership (2 charities, hospital and private healthcare provider) which always placed patient at centre of all actions
  - Good relationships formed between visiting nursing teams and patients
  - Linked to the above point, recognition of value of having different nursing team dealing with P2H patients helps to form a different relationship for the 'move on' stage of patient care
- Medical Director as project champion and senior clinical staff on Project Board helped achieve sign-off at vital project milestones
- Olallo House singled out for providing excellent care and willingness to respond to requests arising
- Clear benefits to hostel and Healthcare at Home teams and learning achieved through the project:
  - Healthcare at Home team successfully overcame challenges of dealing with complex patient group with staff now more confident and competent;
  - Healthcare at Home provided excellent care, thorough monitoring and successfully picked up on problems which required an emergency readmission;
  - Hostel staff expanded on their homeless care experience to include sick and recovering patients
- Moving forward, staff acknowledge benefits of having additional beds available (under spot purchase arrangement) to support P2H patients, especially during busy winter months

Table 3: **Staff views on service strengths**

Service Weaknesses

The main issues raised here were:

- **Tendency to push patients onto the service to raise occupancy rates (whole service issue, not just P2H);**
- **Difficulties arising in making medical respite fit the UCLH@Home model;**
- **Unrealistic target length of stay (LOS) for Pathway to Home patients (5.1 days) for patients with such complex healthcare needs;**

- **Hospital underestimated the amount of project management resource required to oversee the whole UCLH@Home service;**
- **Tendency for hospital to over-regulate as a way to manage risk;**
- **Some challenges around managing and dispensing medication off-site.**

Staff also put forward suggestions for changes to Pathway to Home and/or medical respite provision more generally.

IDEAS FOR CHANGE	
PROJECT SPECIFIC (PATHWAY TO HOME)	**LONDON WIDE MEDICAL RESPITE**
Explore potential for weekend referrals to P2H, supported by the Integrated Discharge Service (IDS)	Explore feasibility of a locally agreed tariff to facilitate affordable medical respite
Consider taking patients direct to P2H from A&E	Focus on preventing readmissions
Continue communications drive with doctors and sign up of new clinical specialties	Consider feasibility of step up AND step down provision; preventative model could be effective if tackled in collaboration with hostel providers
Need to prioritise service information leaflet: been suggested for some time but yet to materialise [now in production]	Consider scope for having GPs/ dedicated clinical leads for medical respite across multiple London hospitals with patient care transferred from several hospitals

Table 4: Evaluation findings – ideas for change

Consultant Views

Hospital consultants also provided views on their experience of using Pathway to Home as a suitable recovery pathway for some of their most complex and high risk patients, as the following quotes show:

'[Pathway to Home] has been completely invaluable in providing a safe, appropriate environment for complex, potentially high risk patients. The service fulfils the role of the Trust and local health authorities in providing an ethically equitable service for the socially and medically complex, disadvantaged population living around our hospital.'

'I'm sure [Pathway to Home] has saved on many hospital bed days for our patients. I have also found it a relatively safe way of discharging people for whom there is uncertainty about how they will cope in the outside world, when they have little or no other social support available.'

Pathway designed a questionnaire to capture information on the patient experience. Seven Pathway to Home patients completed a questionnaire, giving a 25% response rate. Patients mostly gave scores of 5 (excellent) or 4 (very good) for all aspects of the service such as decision-making, transfer to hostel, support from Pathway team, support from hostel team and discharge from hostel. A couple of lower scores (3) were allocated to the standard of hostel facilities and food. [3]

Some patients gave glowing reports for the staff involved in their care:

'Group of superb staff who not only do their job excellently but are also friendly people. Well done!'

3 UCLH@Home collects separate patient feedback regarding clinical care; it is not known if any P2H patients contributed to this as all feedback via this channel is anonymous.

'Management and staff work very hard to look after people all over the world. I am surprised this type of organisation still exists in London. I thought I was in a five-star hotel rather than a hostel for homeless people. God bless all at Olallo House. Thanks, thanks, thanks.'

One patient also commented on the wider systemic problem of finding housing solutions for those people with no documentation/ID. The B&B provision offered by Olallo House under Pathway to Home did not require client ID, making it a viable stop-gap option on several occasions for individuals who might otherwise have been forced to return to the street.

The hostel management team at Olallo House was asked to provide feedback on their experience of being the hostel operator for Pathway to Home*.* From their standpoint, the main success factors were:

- **positive outcomes achieved for patients who used the service and were *'able to recover medically while taking advantage of the social care model provided by the hostel'***
- **talents and tenacity of team members, effective communication and trusting relationships***;*
- **strong focus on needs of individual patients by all partners;**
- **constant re-evaluation of service and communicating ideas between teams;**
- **management learned about dealing with homeless inpatients (different set of clients to usual caseload.**

Feedback from hostel management reinforced the plight of individuals with no recourse to public funds and/or non-EU residents that invariably have no or few move on options. The hostel supports the premise of effective medical respite which focuses on longer periods of recuperation as a means of facilitating more sustainable patient outcomes and avoiding relapses and/or hospital readmissions.

As one respondent puts it:

'Personally, I feel that the service could have had a higher occupancy with a blended model of health and respite care which meets a wide array of needs at the same time.'

Mr B.

CASE STUDY #2

Mr B was in his early 50s with a long history of a psycho-affective disorder and living in supported accommodation in the north of England. There was concern there about an ex resident who regularly exploited him for money. On impulse, Mr B decided to get on a train and come to London where he slept on the streets for a few weeks. He suffered a fractured hip after being knocked over by a slow moving vehicle.

He was admitted for surgery and was medically ready for discharge a few days later, but had nowhere to go. He was transferred to Pathway to Home, with UCLH@Home staff supervising dressings and injections. His local housing department looked for alternative housing provision to address the safeguarding issue raised. After a week, satisfactory arrangements were made and he returned. His possessions and wallet had originally been lost on admission to the hospital and these were traced and returned to him after his discharge.

To be safely discharged from hospital, he needed both shelter and clinical support. Without Pathway to Home, he would have had neither. The time at the hostel also provided some breathing space for a satisfactory solution to be found to the safeguarding issue in his hometown.

Staff, patient & hostel provider feedback: what do people think?

- Pathway to Home is an effective model for helping patients make transition out of hospital
- Possible to deal with highly complex cases, including those on methadone
- Excellent demonstration of effective, collaborative and innovative working between charity sector, NHS and private healthcare provider – a first for UCLH
- Importance of allocating dedicated staff resources to the planning, policy development and day-to-day operations of the service
- Low occupancy rates an issue, but reasons for slow start are understood; expect next phase of project to see higher numbers coming through
- Consultants who regularly use P2H view it as an invaluable service in managing the safe discharge of some of their most vulnerable and medically complex patients
- All patients (who responded to questionnaires) were either satisfied or highly satisfied with the level of support received from the Pathway homeless team, UCLH@Home nursing team and hostel staff
- Patients received extra support (in addition to nursing care) during their medical respite stay, including help with housing benefit, financial help (e.g. travel tickets), assistance with securing housing/hostel place and general welfare checks
- Olallo House staff echoed the views of others around effective collaboration and communication – and that all parties remained fully focused on needs of individual patients at all times
- Interestingly, hostel staff felt that effective medical respite should allow for a more blended model of care encompassing both clinical care and/or long periods of recuperation to meet a wide range of needs at the same time

What Next for Medical Respite?

In April 2016, UCLH decided to take on responsibility for the Pathway to Home contract on the basis that the additional cost for P2H beds would not impact adversely on the UCLH@ Home contract break-even point. The terms of the contract with Olallo House have changed from a block to a more flexible spot-purchase arrangement, with a guaranteed minimum number of beds days for the hostel. In this way, the DH grant has leveraged mainstream NHS resource to continue the project, at least for one year. This includes a minimum of £26.5k in direct rental costs plus the cost of at-home nursing and other (Pathway) clinical staff time.

B&B provision was halted for six months while an alternative funding source was found to support this element of the service. The hospital focus is on providing at home care for patients, not B&B provision for discharged patients. In October 2016, Pathway successfully secured a pot of funding from the UCLH Charity for this purpose and has reinstated the B&B service with Olallo House – a vital element of medical respite provision for this vulnerable group.

All signs point towards a need to tackle homeless medical respite at a higher level than Trust by Trust. Pathway believes city-wide commissioning is one obvious way to achieve provision of services at sufficient scale to be cost effective. This approach could help overcome the myriad issues associated with housing benefit requirements and/or attributing homeless healthcare costs to the right CCG where borough or CCG judgments about funding responsibilities stand in the way of the right care for a homeless patient.

Pathway is exploring the idea of a Locally Agreed Tariff (LAT) for medical respite care as a potential way of overcoming some of these issues. This is being discussed with the Healthy London Partnership Homeless Health Programme Board, a collaboration between London CCGs and NHS England London region.

Key Findings & Final Recommendation

The main finding from the pilot project is that ***it has successfully put the theory into practice.*** A small scale, medical respite service was established which met the health and social care needs of both current and recently discharged patients, providing a range of appropriate care interventions. It was some way off from Pathway's initial vision but it has shown that such services are possible.

Some supplementary learning points are:

- **Be mindful of the long lead times required for setting up a facility;**
- **Do not underestimate the level of staff resource needed to plan, implement and manage day-to-day operations;**
- **Maximising occupancy rates is dependent on having a mix of service users from inpatients to discharged patients requiring additional recovery time;**
- **Varying levels of intervention are needed to support both clinical needs and assistance with housing needs, social care, welfare etc;**
- **Access to medical respite services should not be unduly restricted by the chosen delivery model;**
- **However, using the at-home model provided an affordable staffing option to help get the project off the ground;**
- **Successful projects require close, collaborative working between all parties (in this case the hospital, the UCLH@Home team, Pathway and the hostel provider);**
- **High degree of skill, experience and flexibility vital to address multitude of complex health and social care needs associated with homeless patients in hospital.**

Based on the Pathway to Home experience and recent research into the need for medical respite services in south London, it is clear that a more strategic, possibly London-wide approach to provision has a much better chance to aggregate demand at a sufficient scale to deliver better outcomes for homeless patients, and significant cost savings from avoided future healthcare consumption. London needs strategic leadership to make this kind of provision happen, leadership which can negotiate the complex interface between health, housing and social care provision for the city's homeless population.

Mr C.

CASE STUDY #3

Mr C in his mid-40s was admitted for assessment for surgery for complicated bowel adhesions. Born in Spain, he had been in the UK over 20 years. For several years, he had been allowed to sleep in a small area in his workplace, using public facilities elsewhere for washing. He was doing low-paid work and was effectively part of the long-term 'hidden homeless' population.

During his admission, he became very ill and was found to have developed pulmonary TB. The surgical team were not willing to operate unless he had a home to return to that at least had a bed and bathroom. His local council wanted documentary evidence to back up his account including payslips. They questioned his eligibility for support and wanted clear evidence to confirm that he was exercising his EU treaty rights.

Finding adequate documentation and negotiating with the council took many weeks. After over two months in hospital, he was deemed well enough to be discharged so was placed in Olallo House as a B&B client. Here, Mr C received the necessary support and supervision until the council finally provided him with accommodation.

Working together, NHS England (London Region), the London CCGs (through the Healthy London Partnership) and the Greater London Authority (GLA) could create a strategic approach and address the challenge of working across boundaries in a way which projects located in one institution (like Pathway to Home) are unable to do.

The core recommendation from this report is:

‘Pathway calls for London-wide provision of specialist homeless medical respite services’

London’s health leaders can expedite this work via the Healthy London Partnership as part of its Health Services for Homeless People priority programme. The learning from recent research, this pilot and other similar projects can contribute to the development of a solution which delivers a step change in the provision of intermediate, homeless medical respite care.[4]

4 Dorney-Smith, S. & Hewett, N Dr. (April 2016) Options for Delivery of Homeless ‘Medical Respite’ Services (Executive Summary): Pathway & Guy’s & St Thomas’ Charity

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