

**Piloting a Medical
Respite Service for
Homeless Patients
at University College
London Hospitals
Evaluation Report
November 2016**

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1 Introduction

- 1.1** This report provides an evaluation of a pilot project to deliver medical respite services for homeless patients in London. The pilot was commissioned by the homeless healthcare charity, Pathway, and operated by its hospital partner, University College London Hospitals (UCLH). Funding for the project was provided by the Department of Health's Homeless Hospital Discharge Fund (HHDF).
- 1.2** The pilot project, Pathway to Home, ran from 9th March 2015 to 31st March 2016. This report documents the main findings from delivering the pilot covering the pre-pilot, set-up and delivery phases of the project.
- 1.3** The report sets out the original objectives of the project and how these had to be modified to get a much smaller scale initiative off the ground. It highlights the systemic and operational challenges faced in getting the pilot established, those encountered throughout its year of operation and details of how solutions were found to make the service available to the widest possible constituency of homeless patients. Headline data is provided on patient numbers, acute hospital bed days saved and other key performance indicators. Staff, patient and provider perspectives are included to help illustrate the positive outcomes for patients using Pathway to Home. Their views have been instrumental in making decisions for the next phase of the service.
- 1.4** In February 2016, the UCLH Medicine Board agreed to continue operating Pathway to Home (P2H) for another year, funded by the hospital. All contractual and funding responsibility was transferred from Pathway to UCLH from 1st April 2016.

2 Background

- 2.1** Pathway is a registered charity focused on improving integrated healthcare for single homeless people and rough sleepers. Established in 2009, Pathway has developed a model of integrated healthcare which puts the patient at the centre of their own care. Specialist homeless healthcare teams, comprising GPs, nurses and care navigators, have been set up in hospitals around the UK and use the Pathway model to transform health outcomes for one of the most vulnerable and deprived groups in our society.
- 2.2** 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.
- 2.3** The application to the HHDF Fund was focused on setting up a pilot Medical Respite Centre (MRC) - or series of smaller MRCs - in London. Based on successful models already established in the US, medical respite services are designed to provide step-down, intermediate care for homeless patients in the final stages of their recovery prior to, or immediately post, hospital discharge. Services are clinically led and can range from 'light touch' medical support to more comprehensive clinical input.
- 2.4** The application included detailed feasibility and demand analysis showing the anticipated level of demand for a London MRC based on data collected by each Pathway hospital team located in London and their knowledge and experience of dealing with the complex medical needs of homeless patients.¹
- 2.5** Based on Pathway's analysis, it was estimated that a London-based MRC service would require in the region of 25 beds to deal with the potential number of cases each year and with referrals coming primarily from hospitals with established Pathway teams. It was envisaged this would be achieved either through one large medical respite facility or 3 or 4 smaller centres located in different parts of the city.
- 2.6** Separate analysis carried out by UCLH estimated a need for between 4-6 beds for UCLH alone. An effective delivery model would therefore likely require a lead hospital operator (e.g. UCLH) with other London NHS Trusts referring into the service. Transfer and operational governance arrangements would be a key component of this delivery model.

¹ In 2013, specialist Pathway teams were located in the following London hospitals: University College Hospital, Royal Free Hospital, The Royal London Hospital, Guy's & St Thomas's Hospital, Kings College Hospital.

- 2.7** In May 2013, Pathway produced a detailed Service Specification outlining the core elements of a medical respite service including facility and staffing requirements. This document benefited from substantive contributions from Pathway's group of Experts by Experience (former users of homeless healthcare services). The report also offered up proposals for how such a service could be commissioned along with options on delivery models. The document was referenced by the Department of Health as part of the bidding process for the HHDF.²

3 Getting Started: Formulating Plan A

- 3.1** In the early phase of project delivery (from October 2013), the focus was on the following main areas:

- Establishing project governance arrangements
- Finding premises
- Quantifying service costs (set up, staffing, running costs etc.)
- Agreeing operating (and governance) model (e.g. single hospital operator or lead operator plus additional referring hospitals)

Project Governance

- 3.2** Strategic decision-making, including the agreed deployment of DH grant funds, was the responsibility of the Pathway Board of Trustees.
- 3.3** UCLH and Pathway joined forces to establish a Medical Respite Project Board to lead the work on medical respite within the hospital. The Board was jointly chaired by the two organisations (through the Pathway Chief Executive and UCLH Medical Director). Membership of the Board comprised senior representation from UCLH Integration & Infection Divisions (clinical, nursing and management leads), the Pathway specialist homeless team and a Pathway Trustee.
- 3.4** Pathway appointed a part-time project manager in October 2013. The charity also secured the services of a property adviser to assist with their premises work.
- 3.5** An additional layer of governance was added on commencement of the pilot project in March 2015. This is discussed in more detail in paragraph 5.21.

Premises

- 3.6** On the advice of the Department of Health, Pathway's premises search was initially focused on vacant NHS space. NHS Property Services provided details of 5 vacant wards/buildings in a range of different locations including Edgware, Chingford, Willesden, Finchley and the St Pancras Hospital.
- 3.7** An assessment was made on each of the property options based on criteria such as convenience of location, layout and size of facility, access to support services (e.g. linen, catering, security) and cost.
- 3.8** Three of the options were considered too large for the pilot phase and/or required too much in the way of refurbishment to be viable given the size of grant available. Four of the five were located some distance from UCLH although this did not necessarily rule them out. One facility was based on a large community hospital site and shared a building with vulnerable young adults; this co-location option was deemed to be unsatisfactory. A couple of the wards had unsuitable layouts which would have needed major reconfiguration. The majority had access to the additional services that would be needed for a medical respite facility.
- 3.9** A preferred option was identified at Finchley Memorial Hospital comprising a new and previously unused 17 bed ward with exceptional facilities both in the ward itself and throughout the hospital. This ward provided a turnkey option for the project and the standard of facilities offered exactly the type of psychologically informed environment in which medical respite services have been shown to thrive. The location was a weak point

² Medical Respite for Homeless People: Outline Service Specification. Pathway Report #03.01, May 2013.

(in terms of distance from hospital and public transport accessibility for staff) but was not prohibitive. Furthermore, the size of the ward was too large for a single hospital to operate (see 2.5 and 2.6), so the Finchley Memorial option would only be feasible if 2 or 3 referring Trusts signed up to the service.

- 3.10** It quickly became apparent that an agreement was needed as to who should cover rental costs for the facility. The annual rent and associated service costs were in the order of 90% of the total project grant.
- 3.11** The rationale for pursuing vacant NHS space was to save on rental costs; in fact, the grant awarded to the Pathway medical respite project was significantly reduced from the £1.5m requested on the basis that funds would not be required to cover rent. Rental costs for the vacant ward at PFI funded Finchley Memorial were being covered by the local CCG (Barnet) as is standard in this scenario. In trying to reach an agreement on terms with the building owners to set up a leasing agreement, it became clear the expectation was for the project commissioner (i.e. Pathway) to cover the costs of both the rent and associated service charges.
- 3.12** The complexities of dealing with the various layers of NHS management proved difficult to navigate 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. Pathway had previously been advised that the rent money was ‘already in the system’ and that efforts could be made to redeploy funds as necessary to cover the rental cost.
- 3.13** Despite fervent lobbying from Pathway to NHS England (London Region) and the Mayor’s office to try and help break the log jam, the issue of responsibility was batted back and forth without any resolution. Pathway was left with no option but to walk away from their preferred premises option and return to the drawing board to find a new location.
- 3.14** Subsequent discussions with housing associations and homeless hostels regarding refurbishment of empty properties or taking an allocation of rooms within a hostel did not prove successful either due to lack of availability or similar issues with refurbishment and staffing costs.

Staffing Costs

- 3.15** In addition to the prohibitive rent and/or refurbishment costs discussed above, Pathway worked with UCLH colleagues to estimate the anticipated staff costs of running a medical respite unit.
- 3.16** UCLH has produced its own guidelines for setting safe nursing staffing levels dependent on the number of beds/patients in a ward and level of care required. The guidelines cover the minimum requirements to provide safe nursing for 24/7 cover and to ensure adherence to strict guidelines on dispensing (and counter checking) medication, for example. A ward of 8 beds and upwards requires 2 nurses, at appropriate grades, to be on duty at any one time. To ensure 24/7, annual leave and holiday cover, the nursing requirement alone would be for 10.5 FTEs.
- 3.17** Additional clinical input would be provided through an allocated number of sessions with a specialist GP. A senior nurse role was considered vital for effective management of the service. The clinical roles would be supported by a Care Navigator – a specialist role within the UCLH Pathway team to provide care co-ordination services for patients.³
- 3.18** Furthermore, the vision for a high quality, psychologically informed environment for medical respite led to consideration of a staffing model to include additional roles such as:

- **Clinical psychologist**
- **Therapies staff**
- **Housing worker**
- **Social worker**
- **Healthcare assistants**

Staff in these roles would provide an agreed number of sessions for patients dependent on demand.

³ Pathway Care Navigators (CNS) work alongside clinical teams to support homeless patients. The majority of CNSs are former ‘service users’ who understand from experience the challenges of dealing with homelessness and complex physical and mental health issues. This insight is invaluable in helping to support patients with access to housing, benefits and health and social care once they are discharged.

- 3.19** Depending on the location and nature of any chosen site, it might also be necessary to employ support staff to cover services such as security or catering. For the Finchley Memorial Hospital site discussed earlier, these costs would have been covered through a service charge paid on top of the annual rent.
- 3.20** Conducting this in-depth staffing model revealed that even the minimum safe staffing complement for a unit of 8-16 beds would require an annual budget of at least £650k. Adding more ‘nice to have’ roles could push the staffing budget into the realms of £750k-£950k.
- 3.21** The combined assessment of site and staffing requirements revealed that a much larger budget would be needed to deliver the type of medical respite service originally envisaged, prompting a further rethink on what would be viable for a pilot medical respite service within the available grant envelope.

Operator Model

- 3.22** UCLH was a named partner in the original DH grant funding application. The hospital always envisaged being either the sole or lead operator of a pilot project. UCLH was the first hospital to establish a Pathway specialist homeless healthcare team (in 2009). Since that time, the hospital has taken responsibility for funding all clinical posts within the team.
- 3.23** Pathway’s original analysis for medical respite need across London identified a requirement for around 25 beds. Separate analysis focused on UCLH homeless patients estimated a need for 4-6 beds for UCLH alone. The NHS premises search found a number of empty facilities of 15 beds and upwards, so considerably larger than the UCLH requirement. A sole operator model would not work for this scenario.
- 3.24** A mid-sized facility would necessitate 2-3 hospitals referring patients to fill the beds available. This would work under a ‘lead operator’ model i.e. with UCLH leading the clinical care and other hospitals transferring responsibility for care of their referred patients to UCLH. This model would require a significant amount of work to develop a set of governance arrangements that meets the specific needs of each referring Trust whilst providing clarity on the lines of clinical responsibility.
- 3.25** Whilst a couple of Trusts had expressed some interest in participating in a medical respite pilot, discussions were not sufficiently advanced to be in a position to set up a partnership quickly enough to use a 15+ bed facility, even if budgets allowed. The complexity of designing a ‘lead and refer’ governance structure needed more time and thought to resolve. This was another factor which caused a radical rethink in how to create a viable pilot project.

Mr A.

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.

**CASE
STUDY
#1**

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

4 Pre-pilot Testing: Evergreen Ward

4.1 During the first three months of 2014, UCLH made use of the Evergreen Ward, a 17 bed unit based at the nearby St Pancras Hospital. Primarily, this formed part of UCLH's response to 'winter pressures,' but it also allowed the hospital to test out an approach to post-acute care i.e. to provide for patients who do not require the full range of acute hospital services but who are not yet ready to return home. This approach closely matched the Pathway philosophy for homeless medical respite. Working alongside the consultant in charge of Evergreen admissions, it was agreed that suitable homeless patients could also be considered for transfer to Evergreen Ward to complete the last stage of their admission.

4.2 During the 3 month project, over 250 assessments were made of patients considered suitable for Evergreen Ward with 81 patients transferred for ongoing care during this time. Nine of the patients flagged up as potential transfers were homeless or had received attention from the Pathway homeless team based at UCLH. Five of these were deemed suitable by the lead consultant, with four eventually spending time on Evergreen Ward.

Patient Experience

4.3 Table 1 below summarises the varied circumstances, experiences and outcomes for the homeless patients who used Evergreen Ward.

4.4 Of the patients who were not thought to be suitable for transfer, the main reason for this was that patients remained medically unwell and required the input of specialist teams or specialist therapies that could not be delivered on Evergreen Ward. The other consideration was the disruptive behaviour of certain patients that might impact on the wellbeing and experience of the others already resident at Evergreen.

EVERGREEN WARD REQUIREMENT	OUTCOMES
Patient known to both Pathway homeless team and mental health team.	Not deemed to have capacity. Onward care transferred to mental health team.
'Street fit' patient, infected groin abscess, not responding well to antibiotics. Methadone user. Required bed rest and time for wound to heal.	Important learning re safe transportation of methadone supplies to remote site. Highlighted need for step-up/down facility for patients with unstable domestic circumstances.

Patient with no fixed abode and history of epilepsy and alcohol addiction. Recovering from facial fracture and continuing alcohol withdrawal regime. Evergreen stay allowed time for alcohol withdrawal programme and housing support.	Patient left ward and drank excessively – and was therefore discharged. Highlighted need for appropriate environment for patients with substance misuse issues and/or behavioural concerns. Dedicated unit (i.e. not mixed model provision) with appropriately trained staff required to handle complex patients.
Recently homeless patient with fractured hip and history of alcohol abuse. Received physiotherapy.	Evergreen Ward stay enabled patient to receive the necessary physiotherapy (ordinarily available in the community for those who can access it). Successfully referred on to a housing association on discharge.
Patient required convalescence before returning to streets.	Patient self-discharged.

Table 1: Summary of homeless patient experience at Evergreen Ward (Jan-Mar 2014)

Pre-pilot testing: what did we learn?

- Demonstrated some success in effective post-acute, respite and convalescent care for patients with unstable domestic circumstances
- Highlighted challenges of dealing with this complex patient group, including those with behavioural and/or addiction issues
- Showed need for dedicated unit with appropriately trained staff and conducive environment for respite/convalescent care
- Flagged up specific set of challenges around dispensing methadone off-site

5 Closing the Deal: Agreeing Plan B

- 5.1** Returning to the drawing board, (and using the learning from the Evergreen Ward experience), the decision was made to pare back the pilot project as much as possible by keeping provision ‘in house’. UCLH would act as the single operator for the service, providing medical respite care for its own patients and not for other referring Trusts.
- 5.2** The Pathway team revisited its audit of potential patient numbers for medical respite with the focus on UCLH only. (Previous audits had looked at all London Trusts with Pathway teams and/or high instances of homeless patient admissions.)
- 5.3** Audits were conducted on a sample of homeless patients seen by the UCLH Pathway team over the 12 month period from April 2011 – March 2012. The audits focused on opportunities to prevent readmissions or shorten stays in acute beds if individual patients could have benefited from a hypothetical stay in a medical respite facility. This exercise estimated the number of bed days required and therefore the potential number of beds needed for UCLH patients. On the basis of the audit, Pathway recommended a 4 bedded facility to handle expected demand.
- 5.4** Although this was agreed by the Project Board, the conundrum of where to locate a facility was yet to be resolved. Fortunately, plans were well underway at this time for UCLH to launch an ‘at home’ service. This new service would be aimed at patients who no longer required care in an acute ward and could feasibly finish the last stage of their treatment

within their home environment. Patients would remain under the care of their consultant but be treated ‘remotely’ through daily calls from a visiting nursing team until ready for discharge. The ability to move recovering patients to their home would help to reduce length of stay in hospital and cut down on instances of delayed discharge.

A New Opportunity

- 5.5** UCLH@Home was launched in August 2014 as a collaboration between UCLH and Healthcare at Home, a private provider of nursing care. A governance team was set up to oversee implementation and operation of UCLH@Home, chaired by the UCLH Clinical Director for Integrated Care. The service started slowly with only a few medical specialties signed up to the scheme but ramped up gradually over the course of 18 months to widen eligibility and increase the range of care provided in patients’ homes.
- 5.6** The arrival of UCLH@Home prompted discussion by the Medical Respite Project Board who spotted the potential for extending UCLH@Home services to suitable homeless patients if the right premises could be found. Ideally, patients would transfer to a homeless hostel (or similar) and be seen by the UCLH@Home nursing team on the hostel premises for their treatment. In effect, the hostel would become a patient’s ‘home’ for the purposes of receiving UCLH@Home treatment. The specialist Pathway homeless team would also continue care co-ordination support to plan ahead for the patient moving on once discharged.
- 5.7** The beauty of this arrangement was that it dispensed with the need to have 24/7 on-site nursing care which would be a huge saving on the budget. Furthermore, a hostel provider would likely have the right set of skills and experience to deal with the often complex needs of this patient group.
- 5.8** With an in principle agreement to extend UCLH@Home to the homeless patient community, Pathway revisited discussions with hostel providers. Most were still in the position of having access to facilities which required significant refurbishment or did not have any available beds at all. Even with a reduced requirement of up to 4 beds, it was proving difficult to find anywhere with the right space and services.
- 5.9** Undeterred, Pathway continued to explore options and was advised by the hospital’s TB Find & Treat team to consider their hostel provider, Olallo House (OH) who was already contracted to UCLH to provide beds for recovering homeless TB patients. OH is located close to UCLH, making it an ideal location for running a pilot service. Initial discussions with Olallo House were very positive and, after a period of negotiation, a proposal was put forward to both the Project Board and Pathway Board of Trustees for consideration.
- 5.10** The main elements of the proposal were for Pathway to:
- commission 2 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 to provide all catering, laundry and ancillary services for patients;
 - commission up to 2 additional beds as required (under a spot purchase arrangement).
- 5.11** All clinical care would be provided under UCLH@Home as part of the overall contract between UCLH and their private provider, Healthcare at Home. Initially, clinical care costs would be covered under the UCLH@Home contract with the hospital. Provision would be made in the P2H budget to cover nursing costs if and when the Pathway beds became additional to the number allocated in the overall contract. This would be set at an agreed ‘per visit’ rate.
- 5.12** In July 2014, Pathway’s Board of Trustees agreed to go ahead with a 6 month pilot project with Olallo House as the hostel provider and UCLH@Home providing the clinical care for patients.
- 5.13** Preparation work commenced in the summer of 2014 with a view to launching in December 2014. However, a protracted period of negotiation with OH, coupled with long lead times to prepare contracts and UCLH paperwork, meant the service start date was delayed until March 2015.

Cost and Compromise

- 5.14** For the initial pilot phase (6 months), the total cost of block purchasing beds, treatment room rental and all catering, laundry and ancillary services was just under £47,000. An additional £2.2k was spent on minor works and equipment for the treatment room to ensure it met with UCLH standards on infection control. A spot purchase day rate was agreed for any additional beds used.
- 5.15** 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 extent.
- 5.16** Whilst it was a relief to have found a solution to the numerous operational challenges, Pathway was acutely aware of the compromises required to get this pilot project up and running. The proposed new service was a significant departure from the original vision of the Pathway Trustees in that it would be very small scale, with a local focus (not London wide) and a single referring hospital trust.
- 5.17** Furthermore, the ‘locus of control’ was dictated by the service specification of UCLH@ Home. This limited the type of patient that could be referred for medical respite care. Fundamentally, the service was only open to inpatients who met the strict criteria of a limited set of signed up medical specialties. In effect, this excluded other categories of patient that Pathway had identified as potential users of a medical respite service such as recently discharged patients requiring a period of convalescence or recuperation.
- 5.18** That said, the opportunity to finally test the theory of medical respite was extremely welcome; it was a chance to get something done and develop a proof of concept case for potential future funding. UCLH demonstrated strong commitment to include a homeless patient pathway into their ‘at home’ service. This pathway presented an opportunity to try something new, innovative and collaborative, a service which would provide a blend of medical respite, clinical support and care co-ordination services.

Closing the Deal

- 5.19** A considerable amount of work was needed to get all the building blocks in place prior to service launch. A detailed Service Schedule was prepared for the UCLH@Home homeless pathway. This set out the inclusion/exclusion criteria for patients, the process for transferring patients and managing their daily visits and details of what to do in emergency situations. The Schedule gave clear instructions to all those involved in patient care including the hostel, UCLH@Home and Pathway homeless team.
- 5.20** Pathway prepared a Service Level Agreement (SLA) setting out the contractual responsibilities for Pathway (as commissioner) and Olallo House (as provider). The SLA covered financial management details and service review arrangements.
- 5.21** In terms of governance, Pathway team members joined the UCLH@Home Governance Group. This group has clinical oversight for the whole UCLH@Home service and reports to the UCLH@Home Project Board. Risk assessments were completed to cover all aspects of patient and staff safety.
- 5.22** It was agreed the Medical Respite Project Board would continue to manage wider strategic, funding and reporting issues. Given the new operational arrangements, Project Board membership was extended to include representation from Healthcare at Home (provider of UCLH@Home nursing care) and Camden & Islington NHS Foundation Trust.
- 5.23** A set of key performance indicators (KPIs) was agreed for Pathway to Home, based on the reporting format for UCLH@Home. The hospital was keen to follow the average length of stay (LOS) target for the whole service (5.1 days). The target for occupancy rate was set at 80-85%, although it was acknowledged it could take some time to build up to this level.
- 5.24** The new service was named Pathway to Home (P2H).

Closing the deal: what did we learn?

- Homeless hostels, with the right staff and facilities, can provide an ideal 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
- Highlighted early on the potential difficulties in making small scale provision cost effective

6 Advent of ‘Pathway to Home’

- 6.1** Pathway to Home (P2H) was officially launched on 9th March 2015 with a view to running for 6 months. The main objective of the pilot was to provide proof of concept for the service and, if proven, to make a business case for the hospital to continue funding (and possibly expanding) P2H beyond the pilot phase.
- 6.2** Under P2H, eligible patients would be identified by the team of UCLH@Home Case Finders and discussed with the patients' consultants in conjunction with the Pathway homeless team GP and/or senior nurse. The decision on whether to transfer a patient would be taken jointly between the consultant and Pathway team. They would also agree a treatment plan for each patient, including the number of daily visits required from the UCLH@Home nursing team (up to 3 per day).⁴
- 6.3** In addition, hostel risk assessments were completed for patients to ensure any behavioural or addiction issues were flagged up and that hostel staff agreed they had the capacity and capability to deal with such cases.
- 6.4** After a patient was transferred, the Pathway homeless team continued to work on care co-ordination in preparation for discharge. This mostly focused on securing onward accommodation or assisting patients to return to their home town/country of origin. Pathway would also help with general welfare needs such as clean clothes, mobile phones (for emergency contact) and travel cards.
- 6.5** Figures 1 and 2 (right) illustrate the process for identifying and transferring suitable cases to Pathway to Home (Figure 1) and the process for providing care and assessing when to discharge patients (Figure 2).

Early Days

- 6.6** The first patient was transferred onto P2H on 13th March and 7 patients were cared for within the first three months of operation. As can often be the case with pilot projects, there were teething troubles which impacted on the ability to transfer patients and maximise bed occupancy. Patient numbers started to fall during the summer, mirroring the situation with UCLH@Home.
- 6.7** A major factor affecting low occupancy concerned the reluctance of clinicians to treat their patients 'at arm's length'. The UCLH@Home approach required a step change in culture amongst hospital consultants in particular; some were reluctant to maintain responsibility for patients who were based at home or in a hostel rather than on the ward. Staff close to the project say it took at least a year to address this, and only after a concerted education and publicity programme across all areas of the hospital.

⁴ 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.

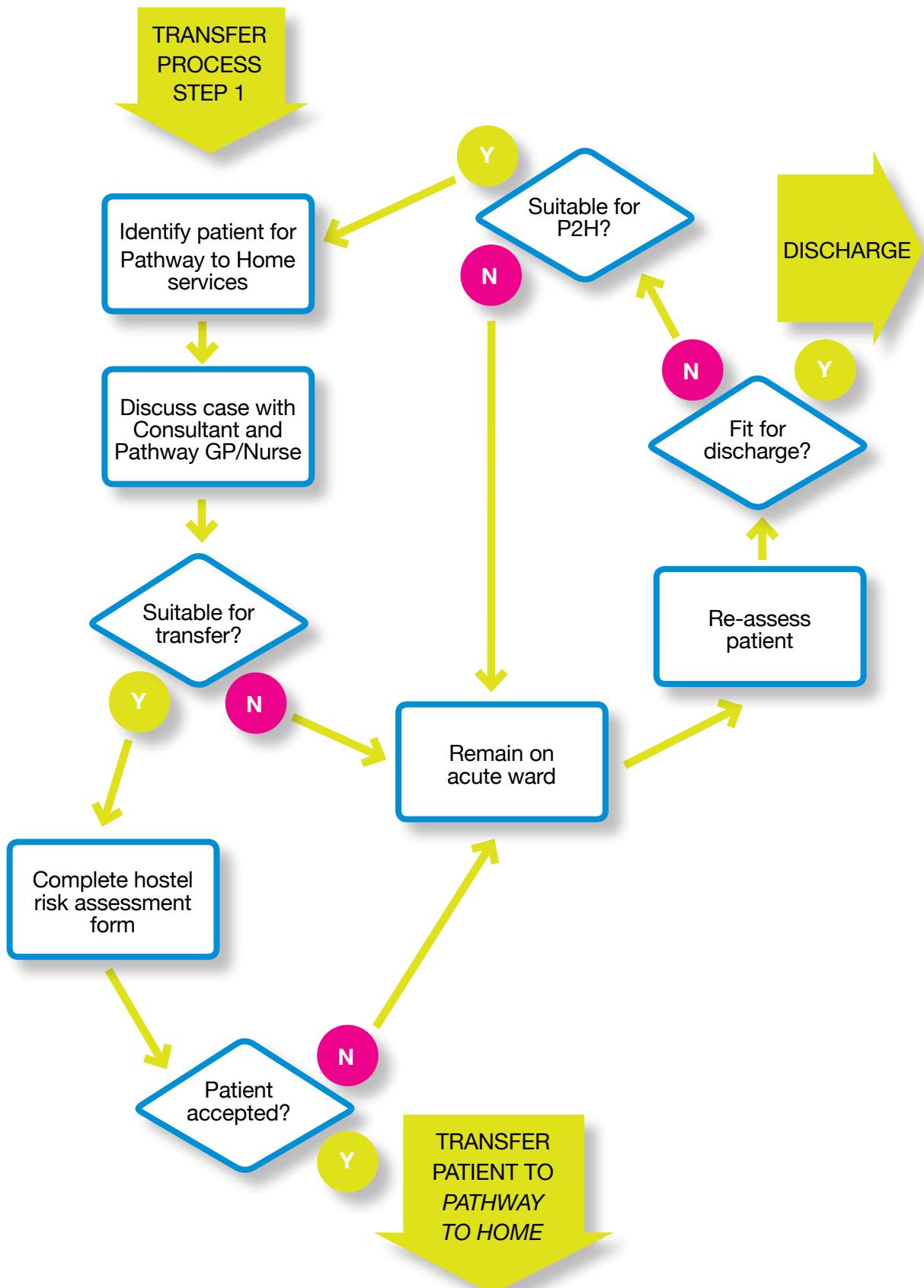


Figure 1: Pathway to Home – Patient Referral Process

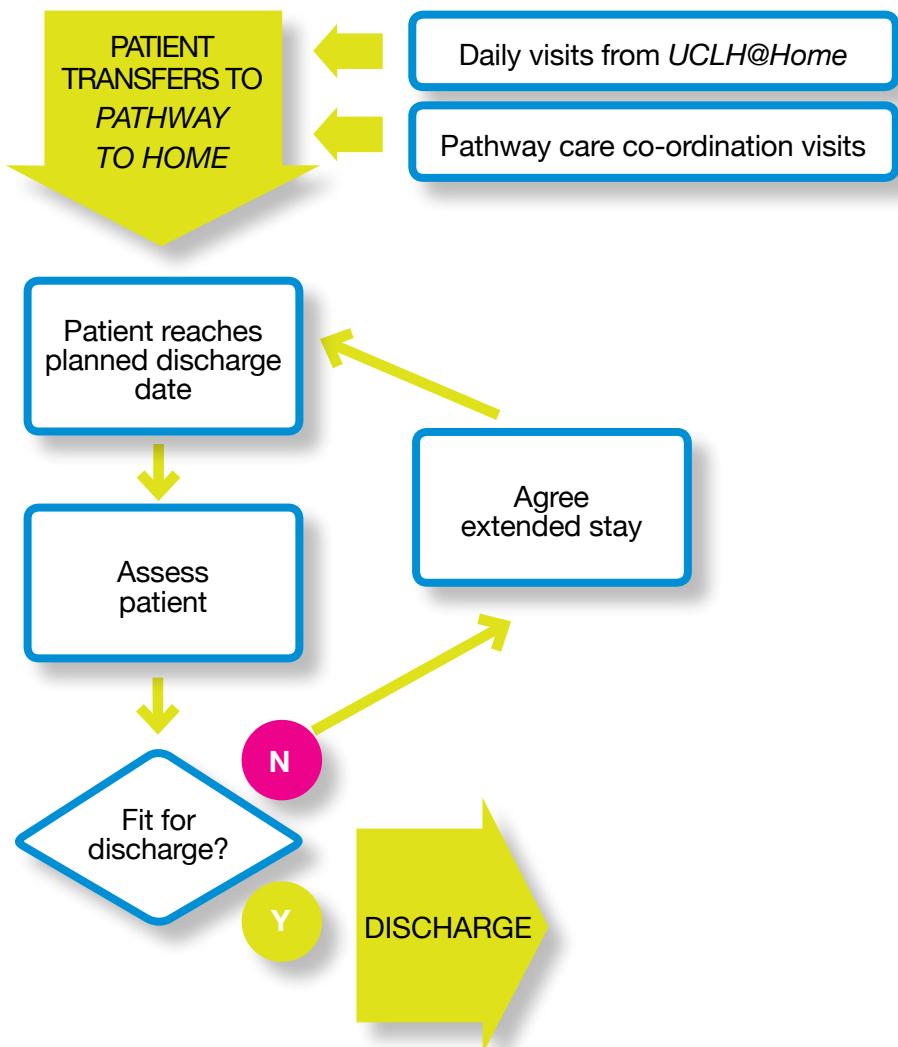


Figure 2: Pathway to Home – Patient Care & Discharge Procedure

- 6.8 Another contributory factor to the slow start was around the number of medical specialties signed up to UCLH@Home. Again, it took several months of intensive negotiation to secure sign-up from all the main specialties that would most likely provide suitable patients.
- 6.9 For Pathway to Home, the exclusion of methadone patients was another limiting factor. Both the Project Board and UCLH@Home Governance Group agreed a solution needed to be found for the latter and initiated a process to design a methadone policy bespoke to the requirements of P2H. Although this decision was taken very early on in the pilot, the process took almost five months to complete; the inclusion of methadone patients did not come into effect until mid-August 2015.
- 6.10 In the early days of Pathway to Home, UCLH@Home nurses were reluctant to attend visits on their own. Staff were not used to dealing with such complex patients, particularly those with addiction, complex mental health or behavioural issues. It was not cost effective (or logistically possibly) to send two nurses per visit, so Pathway staff agreed to ‘double up’ on visits until the UCLH@Home nursing team felt comfortable with lone working. This was an unforeseen problem, but was quickly overcome; after a short period of conducting joint visits, UCLH@Home staff felt sufficiently confident to attend visits on their own.

Extending the Pilot

- 6.11 Given the above factors and their impact on patient numbers, the Pathway Board of Trustees and the Project Board agreed to extend the project by a further 3 months to early December 2015. After 6 full months of operation, patient numbers were still variable, although the introduction of the methadone policy was beginning to take effect. The Pathway Board Of Trustees (as custodians of the Department of Health grant) held further discussions on whether to grant a longer extension to the pilot phase. Despite the low occupancy rates – and consequently, high bed day rates – there were signs that things were about to take a turn for the better.

6.12 This was partly due to a big push from the hospital which deployed additional resources into the management and publicity of UCLH@Home to boost occupancy rates. The hospital was also making good progress signing more specialties up to UCLH@Home. Pathway supplemented these efforts with a new publicity drive for P2H, including articles in the staff magazine and intranet and a series of one-to-one meetings between the Pathway GP and hospital consultants to advise them of P2H benefits to patients.

6.13 Pathway Trustees therefore agreed to one final extension to take the project to 31st March 2016. This would give the project one full year of data and service experience to draw on for evaluation purposes. It would also take account of the new methadone policy and other service modifications.

Introducing ‘Bed & Breakfast’

6.14 Another key development at this time was the creation of a new category of ‘patient’ who could make use of the hostel beds. From a Pathway perspective, it was always the intention for a medical respite facility to offer care to recently discharged patients who were not deemed to be street fit or who had not yet secured onward accommodation, temporary or otherwise. Evidence from medical respite facilities in the US shows that having extra time for convalescence, rehabilitation or simply to process applications for housing is a key factor in reducing hospital readmission rates for homeless patients.⁵

6.15 To help optimise the grant funding, Pathway also took the decision to allocate any unused beds to a new ‘B&B’ category of client. These would be discharged patients who did not need clinical care but who would benefit from a few extra days respite before moving on. Beds were only allocated as B&B if there were no potential patients waiting in the wings suitable for transfer to P2H. This approach was designed to help maximise occupancy in beds which had already been paid for as well as sounding out the practicalities of delivering a true medical respite model.

6.16 This B&B patient category was not included in UCLH’s monitoring statistics, their sole interested being Pathway to Home patients. Any chance of securing funding for the service beyond the pilot phase was likely to be based on a strong business case showing high occupancy rates (and therefore good value for money), reduced readmissions and improved health and social outcomes for patients. The omission of B&B beds from the statistics would clearly impact on the overall results and make it more difficult to produce a compelling case overall. However, as two beds were available (and paid for) at all times, it made sense to use them for homeless cases that could benefit from a hostel stay whether they were inpatients or recently discharged.

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

⁵ 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, 96(7). 1278-1281.

7 Headline Findings

Pathway to Home

- 7.1** During the 12 month pilot project, there were 31 separate admissions to Pathway to Home. Of these admissions, two patients were readmitted on one occasion with another patient accounting for two readmissions.
- 7.2** P2H patients accounted for 243 bed days saved in UCLH acute wards. Length of stay (LOS) ranged from 2 – 22 days with an average LOS of 7.6 days (against a service-wide target of 5.1 days). The most frequent LOS was 3 days.
- 7.3** These figures translated into a P2H occupancy rate of 31%, significantly below the UCLH expectation of 80-85%. The overall UCLH@Home service also struggled to meet targets. In the year to 31 March 2016, the service achieved 18% of the patients referred target and only 15% of bed nights saved. In Pathway to Home's case, such a small number of beds can skew occupancy rates considerably; in effect, the service is either 0%, 50% or 100% occupied at any one time. There were instances of over occupancy recorded during the final 3 months of the pilot (see 7.12).
- 7.4** Similarly, it is difficult to achieve any meaningful economies of scale in terms of cost savings to the hospital by transferring patients from an acute ward to P2H. However, UCLH recognised the opportunity cost presented by freeing up capacity in the hospital. This would offset some of the costs of the service. This has not been quantified for Pathway to Home, but is analysed periodically as part of the overall ULCH@Home contract.
- 7.5** There were 10 instances of Pathway to Home patients transferring to B&B status following their official hospital discharge date. This was considered the best option for selected patients for a variety of reasons (see 7.9 below).

Bed & Breakfast Provision

- 7.6** There were a further 28 admissions to Olallo House for B&B cases of which two clients had one further stay and one returned on two different occasions. B&B beds were used for 264 bed days making an occupancy rate of 34%.
- 7.7** Additional beds were spot purchased for B&B clients on 43 separate days. (Pathway's Service Level Agreement with the hostel stated that, if additional beds were needed over and above the two dedicated spaces, these could be purchased at the going day rate). Spot purchased beds accounted for 62 additional bed nights.
- 7.8** Length of stay for B&B clients ranged from 1-66 days with an average LOS of 9.4 days. Half of B&B stays were for one week or more. The long stay case (66 days) concerned a vulnerable individual who required adequate recovery time off the street. This provided time for blood sugar checks and regulation of insulin intake. The Pathway team was also involved in lengthy discussions with a London housing team who maintained the individual was not eligible for housing. Legal intervention was required and the case was eventually resolved in the patient's favour.
- 7.9** 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 respite 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.**

- 7.10** It could be argued that recently discharged patients could be adequately (and more cheaply) cared for in other environments such as a hostel shared dormitory or regular bed and breakfast accommodation. The Pathway homeless team frequently uses such options as move on accommodation immediately after discharge. However, for some patients, this is not a feasible option. This can be down to simple logistics (e.g. the requirement for ID from many hostels and B&B establishments). Another common scenario is that newly discharged patients are still too ill, vulnerable or have behavioural or dependency issues which are too complex for communal or unsupervised living conditions.
- 7.11** In these more complex situations, the Pathway GP or Nurse would make a judgment call on the best option for each patient, taking into account the likelihood of relapse or deterioration, behavioural and dependency issues and the level of support still required by the Pathway team. For the latter, this usually relates to assistance with housing and/or benefits.

Occupancy

- 7.12** As stated above, average occupancy rates for P2H and B&B clients were 31% and 34% respectively. Beds were fully occupied (2 beds used) on 117 nights out of a possible total of 386. In addition, over-occupancy was achieved on 43 individual nights (3 beds used on 28 nights, 4 beds on 11 nights and 5 beds on 4 occasions). This means full or over occupancy was achieved 41% of the time. At least 1 bed was in use for 76% of the time.
- 7.13** The two beds were under occupied on a total of 224 nights (58% of the time). Zero occupancy was a feature of 89 nights, just under a quarter of the time of the project.
- 7.14** Occupancy levels for each strand of service user fluctuated considerably throughout the pilot phase. (See Table 2 below). Rates reflect the expected slow start and the quieter summer months with less pressure on bed spaces in the hospital. The increase in September coincided with the methadone policy coming into play. The winter months saw overall occupancy levels start to increase, as would be expected for homeless patients. That said, P2H occupancy rates continued to fluctuate for the final few months, with a noticeable (and unexplained) dip during November. B&B occupancy rose sharply during February leading to a high level of over-occupancy for this particular month. This reflects the usual winter pressures on hospital beds at this time, including a high number of homeless patients. Pathway's aim of minimising street discharges is another explanation for the surge in B&B bed use in the final couple of months.

Mr B.

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.

CASE
STUDY
#2

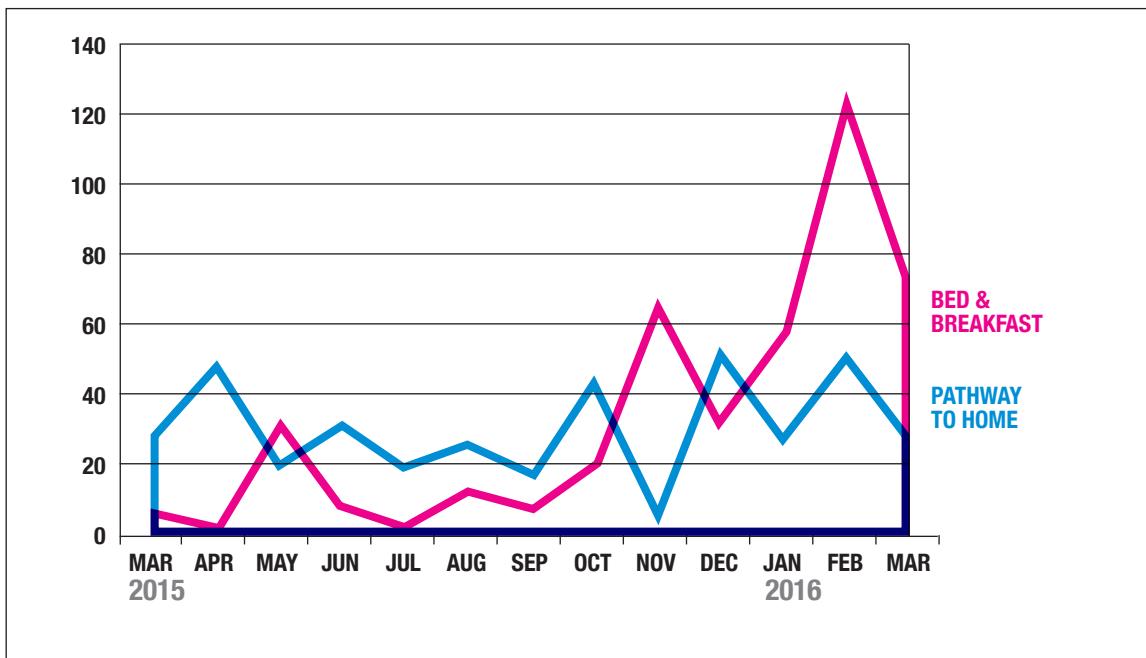


Table 2: Percentage occupancy rates by month (P2H and B&B users)

- 7.15** Occupancy levels were well below the target expectation (for Pathway to Home beds) of 80-85%. Given that Pathway's initial analysis suggested a bed requirement of up to 4 beds (for UCLH as the sole operator), occupancy was indeed well below par.
- 7.16** On reflection, this demonstrates that predicting anticipated demand is never an exact science and that hypothetical analysis will only take you so far. It should also be remembered that the initial demand analysis 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.
- 7.17** After the first six months of the project, Pathway did some analysis of potential patients who might have used the service but did not meet the eligibility criteria (e.g. medical specialty not signed up, mobility issues, methadone user prior to policy taking effect). This analysis estimates occupancy rates could have been boosted by at least 8%. This is likely to be an underestimate as the exercise was only carried out once during the pilot phase and only covered a small sample of potential patients.
- 7.18** All those involved in delivering the pilot project acknowledge the length of time it can take for a new service to become established; an 18 month to 2 year timeframe is not unusual. For Pathway to Home, the challenge of 'hitting the ground running' was complicated by the fact it was a strand of the new UCLH@Home service - 7 months old at the time of the P2H launch. It is fair to say that UCLH@Home has taken a full 18 months to break through many cultural and operational barriers within the hospital concerning the remote treatment of patients in the final stages of their inpatient episode of care. This is evident in the year 1 statistics for UCLH@Home; only 18% of the target number of patient referrals was reached and 15% of bed days saved.
- 7.19** Pathway to Home's performance should therefore be considered in that context; an occupancy rate of 31% for patients and 34% for other respite cases is commendable given the sluggish start to proceedings, the challenges faced along the way and the usual fluctuations in homeless patient numbers across the course of a year.

Medical Conditions and Care Received

- 7.20** The most common type of nursing input required by Pathway to Home patients was wound care (11 cases), primarily leg dressings for patients with cellulitis. There were 9 instances of the UCLH@Home team providing medication support for patients. Table 3 gives a summary of all the clinical support received by P2H patients during the pilot.

NURSING CARE RECEIVED	NUMBER OF PATIENTS
Wound care/leg dressings	11
Medication support/compliance, of which:	9
<i>HIV</i>	2
<i>TB</i>	3
<i>Methadone</i>	1
Observation, including:	6
<i>Skin infection</i>	1
<i>Sepsis</i>	1
<i>TB</i>	1
Diabetes monitoring	2
Blood pressure checks	1
Anti-coagulant injections (for blood clots)	1

Table 3: Pathway to Home – summary of nursing care received

- 7.21** Pathway to Home patients received an average of 1.5 visits per patient per day from the UCLH@Home nursing team. In addition, all patients received care co-ordination support from the Pathway team in the same way as they would if based on a ward.
- 7.22** Pathway staff (nurse or care navigators) always accompanied patients to Olallo House on the day of transfer to help settle them in. During their stay, patients received an average of one visit every 2-3 days from Pathway staff, most commonly to assist them with securing accommodation once discharged. Pathway also visited patients as part of their ward rounds, to carry out general welfare checks and assist with benefits. Mobile phones were supplied to patients who needed them to ensure they could reach the appropriate people in an emergency.
- 7.23** Care co-ordination was also a feature of Pathway support for B&B clients. Although they did not require daily clinical care in the same vein as Pathway to Home patients, Pathway continued to help with securing housing/accommodation or accessing benefits. Pathway is of the firm belief that this category of service user benefited from having extra time both to work on these issues and to aid their overall recovery. There is a strong likelihood that many of these former patients would have lost the opportunity for specialist, targeted Pathway team support if they had been discharged without the option of this additional recuperation time.
- 7.24** 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. In reality, keeping these former patients close to the team through the B&B service led to some notable successes in terms of securing onward accommodation, including 6 cases where individuals were housed.
- 7.25** Furthermore, for B&B clients with a history of, or undergoing rehabilitation for, drug or alcohol addiction, Pathway is convinced that having additional recovery time avoided likely readmissions. The same is true of former patients with a high probability of condition deterioration or relapse. Pathway estimates that having access to the B&B option has helped to prevent around 112 readmission days.

Methadone Policy

- 7.26** A total of 5 patients were successfully transferred to the service under the newly established methadone policy. The majority of these cases passed without incident although there were some teething troubles to contend with.

- 7.27** The prescription for the first methadone case transfer contained an error; this was picked up by the community pharmacy and rectified quickly. Another patient was using heroin on top of their methadone although this was alerted as a possibility during the risk assessment so all parties were aware. The hostel agreed to take the patient.
- 7.28** Overall, the methadone policy was cited by UCLH, Pathway, the hostel and the UCLH@Home team as an excellent addition to Pathway to Home. It opened up the service to a wider cohort of patients and found a safe and effective solution to the off-site dispensing of a controlled drug to hospital inpatients. The methadone policy is still in place and more patients have benefitted from Pathway to Home since the new contract transferred to UCLH control.

Local Connection or Country of Origin

- 7.29** As expected, the majority of patients accessing the service had some form of local connection in London. For some, this was through GP registration whilst others had either an existing or historic link with a particular London Borough. Three patients were from other parts of the UK and one from abroad (although they also had local UK connections). Of those, one patient was actively seeking to return to their home country.

LOCAL CONNECTION	NUMBER OF PATIENTS
LONDON BOROUGHS	
Barnet	1
Camden	9
Enfield	1
Haringey	5
Islington	3
Newham	1
Tower Hamlets	3
Westminster	1
OTHER ENGLAND	
Hayes	1
Manchester	1
SCOTLAND (SPECIFIC CONNECTION UNKNOWN)	
FRANCE	1
UNKNOWN	1

Table 4: Pathway to Home patients: local connection

- 7.30** The local connection picture for those using the B&B service is shown in the following table.

LOCAL CONNECTION	NUMBER OF CASES
LONDON BOROUGHS	
Barnet	1
Bexley	1
Camden	6
Enfield	1
Haringey	5
Hillingdon	1
Islington	3

<i>Southwark</i>	1
<i>Tower Hamlets</i>	1
<i>Westminster</i>	6
OTHER UK	
<i>Surrey</i>	1
OVERSEAS	
<i>Sweden</i>	1

Table 5: B&B users: local connection

Patient Outcomes: Destinations

7.31 After completing their stay on Pathway to Home (or as B&B user), patients have moved on:

ONWARD DESTINATIONS	P2H	B&B
HOSTEL/NIGHT SHELTER/REFUGE	7	5
HOUSED		
<i>Bexley</i>	-	1
<i>Camden</i>	1	-
<i>Enfield</i>	1	1
<i>Haringey</i>	2	1
<i>Islington</i>	5	3
<i>Hayes, Middlesex</i>	1	-
<i>Westminster</i>	-	1
STREET	3	6
REMAINED WITH OLALLO HOUSE		
<i>TB bed</i>	1	-
<i>Reconnection bed</i>	1	-
<i>Work based bed</i>	1	-
RETURNED OVERSEAS		
<i>Poland</i>	1	1
<i>Sweden</i>	-	1
<i>France</i>	1	-
HOSPITAL READMISSION	2	1

Table 6: Onward destinations (all users)

7.32 It is encouraging to note the relatively small number of patients being discharged back to the street, although there were more instances of this amongst the B&B caseload. The majority of these cases had no ID which made accessing hostels difficult. Clearly, returning to the street is the option of last resort and reducing instances of this was a key objective of the pilot project.

- 7.33** For those patients/B&B clients who were successfully housed following their stay, the Pathway team can cite many examples of how access to medical respite facilitated such positive outcomes.

Readmissions

- 7.34** As stated in 7.1, there were three readmission cases during the pilot. In each case, patients were admitted to UCLH before being transferred for another stay at the hostel. Two of these readmissions were within 30 days of their initial admission. The third case was the result of deterioration in the patient's condition. This was identified quickly by the UCLH@Home team and the case escalated back to the attending consultant. Following a further spell in hospital, the patient returned to the hostel to complete their treatment. This was an example of good care, preventing a failed discharge.
- 7.35** The robust governance process for UCLH@Home (and Pathway to Home) led to swift action being taken to any issues arising with respect to individual cases. The close team working and strong ethos of communication between all parties helped to address concerns raised and adapt approaches where necessary.
- 7.36** This incident cited in 7.34 demonstrates that every patient case is unique and can involve a myriad of complex issues when considering the best decision for patients who are nearing the end of their hospital stay. It is clear that the pilot provided a much needed proving ground to learn by doing as opposed to attempting to plan medical respite services in the abstract and second guessing what might be required.

Summary of headline findings

- 31 patients were supported through Pathway to Home, saving 243 bed days in acute wards
- A further 28 recently discharged patients were transferred to the hostel for additional recovery time; this accounted for a further 264 bed days
- Additional B&B beds were spot purchased for 62 bed nights (i.e. over and above the two dedicated bed spaces)
- Pathway to Home occupancy averaged 31% with patients staying an average of 7.6 days; this was against respective hospital targets of 80-85% and 5.1 days
- Average length of stay for B&B clients was 9.4 days, with half of B&B cases staying for 1 week or more
- Majority of Pathway to Home patients received clinical support for wound care, supervision of medication and observation for infections
- 24 patients had a local connection to a London borough with Camden, Haringey and Tower Hamlets the most popular locations
- Similarly, 25 B&B cases had London connections with Camden, Westminster and Haringey the most popular
- Two thirds of Pathway to Home patients were either housed or moved into hostel accommodation once discharged; 3 transferred to other beds with Olallo House, 2 returned overseas and 2 were readmitted to hospital
- 3 patients were readmitted to Pathway to Home during the pilot

8 Financial Data

Service Costs

- 8.1** Pathway received total grant funding of just over £459k from the Department of Health's HHDF fund.

- 8.2** One third of the grant was used in the set-up phase. This covered the staff/management/project management input required in the 18 month lead up to launching the pilot and included the purchase of equipment for both the pre-pilot service (Evergreen Ward) and the treatment room at Olallo House.
- 8.3** Just under half of the grant (47%) was attributed to direct running costs of the pilot service. The bulk of this covered rent (£107k for rooms and treatment room) and around £47k attributed to staff costs comprising UCLH clinical advisory time and Pathway nurse/care navigator input.
- 8.4** As the costs of the UCLH@Home nursing service was covered under the UCLH contract with its provider (Healthcare at Home), these are not reflected in this report. Therefore, the true total cost of running the service in relation to clinical staff time has not been calculated.
- 8.5** The rental costs were comprised of an agreed day rate for the hostel service which included all room charges, meals, treatment room hire and ancillary services. Pathway received a small discount for block booking 2 beds in advance. Any spot purchased beds were charged at a slightly higher rate.
- 8.6** A small amount of residual spend was incurred post pilot to cover evaluation work and transition arrangements.

Continuing the Service: Financial Viability

- 8.7** 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 the question of cost is trickier. It was clear to Pathway and UCLH colleagues, even in the very early stages of the project, that a 2-bed facility was too small to achieve any meaningful economies of scale. The effect of the treatment room rental made this even more difficult.
- 8.8** However, the UCLH@Home service model does make economies of scale possible if the P2H beds are included in the overall bed numbers for the hospital-wide UCLH@Home service. For the duration of the pilot, the Pathway to Home beds were considered as a separate entity and therefore not included in the statistics for UCLH@Home as a whole. Towards the end of the pilot phase, analysis of the overall contract costs revealed that, if UCLH also took over responsibility for the costs of delivering the P2H contract (at an agreed level of bed days), this would not impact adversely on the UCLH@Home contract's 'break even' point; in fact, the number of beds required to break even would remain the same. Pathway to Home beds make a direct contribution towards the break even scenario for minimal additional cost.
- 8.9** It was agreed a final decision would be made about service continuation (possibly on different terms with Olallo House) by the UCLH Medicine Strategy Board in late February 2016. Any decision would take account of service performance (including bed days saved) and the quality of patient outcomes, as well as cost.

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.

9 Staff, Patient & Provider Perspectives

Gathering Feedback

9.1 The following groups have provided feedback on their different experiences of Pathway to Home.

- **UCLH staff**
- **UCLH@Home staff (including Healthcare at Home)**
- **Pathway**
- **Hostel staff**
- **Pathway to Home service users**

9.2 Staff perspectives were gathered via a series of informal interviews with the Project Manager. In addition, the Pathway GP sought the views of hospital consultants to get their take on the value of P2H to the treatment of homeless patients in their care. (See 9.19-9.21).

9.3 Olallo House staff responded to a request for written feedback, which supplemented the regular communication received from them throughout the duration of the pilot project. Two review meetings were also held with the hostel provider as stipulated in the Service Level Agreement (see 9.38-9.45).

9.4 Patient views were gathered in a more formal manner via questionnaire. This system was introduced in the second half of the project which meant a valuable opportunity to capture opinions throughout the pilot phase was missed. The response rate was predictably low with only 8 service users completing a questionnaire from a possible total of 28. It is often difficult to encourage homeless patients to participate in feedback exercises, but the responses did provide some useful insight into how the service was perceived (see 9.22-9.37).

9.5 Olallo House also invites residents to complete a short questionnaire on departure. This included our P2H/B&B clients. Hostel staff shared this feedback with us, which was focused on user experience of the hostel. Detailed results are not included here as the information collected was minimal. All clients who completed a questionnaire were satisfied with their stay and did not voice any complaints on the hostel feedback forms.

UCLH, UCLH@Home & Pathway Staff Views

9.6 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 intermediate, medical respite for homeless patients in a safe, caring environment that addresses patients clinical, housing and other welfare needs. The extent of the project's success is neatly summed up in the following staff quote:

'Pathway to Home is a good model for helping patients make the transition out of hospital. I think we achieved a lot in this regard. It's been an effective way of testing out how patients will cope once discharged, particularly for those dealing with drug and alcohol dependency issues. P2H allowed patients to be protected and supervised outside of the acute environment. It helped staff understand more about patient capabilities and level of independence before moving them on.'

9.7 The main benefits flagged up in staff interviews are summarised in Table 8 following.

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 8: Staff views on service strengths

Service Weaknesses

- 9.8** Staff were also asked for their views on any weaknesses encountered during the pilot and, having reflected on their experience, to suggest any areas for improvement.
- 9.9** The biggest issue raised was around the low occupancy rates experience during the pilot phase. Although staff recognised the value of the service to individual patients, there were concerns that there was no clear financial basis for the hospital continuing the service once the grant funding ceased. As stated in 8.8 and 8.9 above, an analysis of the service costs at the end of the project revealed the service was indeed viable if taken in the context of the overall UCLH@Home contract costs. (See Section 10 for more details on next steps for P2H).
- 9.10** One respondent observed a tendency to push patients out onto the service to maximise the numbers early on in project. This was actually an observation of the overall UCLH@Home service, although it is possible it applied to some specific P2H cases. This was partly a result of ‘cobbling a model together’ that worked to fit with the UCLH@Home service – in an effort to get anything off the ground at all. Transferred patients did not always fit in terms of having easily identifiable clinical needs. Some patients did not need nursing input at all yet the model required this to be the case.
- 9.11** This requirement to fit an existing model had other ramifications for medical respite. There was a clear mismatch between the target set for length of stay for UCLH@Home patients overall (5.1 days) and the basic philosophy of medical respite. The desire to minimise length of stay was a conflict which Pathway had to accept. That said, there were individual cases where all teams agreed patients would benefit from a longer stay and extensions were granted. Pathway’s tighter control over B&B cases also allowed greater flexibility on length of stay for this category of medical respite provision.
- 9.12** The keenness to get something going had other ramifications. It led to a great deal of firefighting in the early days. The amount of resource needed with regard to project management within the hospital was seriously underestimated. The length of time and level of staffing needed to produce the methadone policy is a good example of this. Initially, the hospital managed to negotiate this by using bits of time from already busy individuals. This was not ideal and, after careful consideration, the hospital agreed to provide a dedicated project manager to oversee day-to-day UCLH@Home operations. This appointment has made a measurable difference to the success of UCLH@Home, including P2H.
- 9.13** Another respondent felt there was a tendency for the hospital to over-regulate as an approach to managing risk. Whilst there are clearly good reasons for ensuring effective risk management, especially for a new service where patients are being treated off-site, it is possible to over complicate matters. There comes a point where ‘you just need to get on with it’ and learn by doing. The UCLH@Home governance arrangements are very robust, so any issues arising are picked up and dealt with quickly.
- 9.14** A couple of points were raised in relation to the logistics of managing medication in off-site locations. Visiting UCLH@Home team members were required to collect medicine cabinet keys from the hospital before going on to the hostel. This added to the travel time taken to appointments which caused some issues initially but was resolved by UCLH@ Home staff quite promptly. The other point concerned the requirement to provide the right level of prompting, supervision or dispensing of medication in a hostel environment, ensuring adherence to the complex legislation governing this area. UCLH@Home worked in close collaboration with hostel staff to ensure responsibilities were clear. Hostel staff were comfortable providing prompting for patients where necessary.

⁶ 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, 96(7). 1278-1281.

Suggestions for Change or Follow-up

- 9.15** Staff involved in delivering the project had many ideas for how the service could be improved or areas for potential new development. Respondents also suggested where some follow up work could provide useful additional data to support the wider development of medical respite services in London.
- 9.16** In respect of the latter, London-wide commissioning is considered to be the holy grail of medical respite. Offering small, local services undoubtedly helps individuals, but the real prize is to provide medical respite at scale. This will not only be more cost effective, but will also support more homeless patients through scaled up provision. Furthermore, a concerted London-wide approach could potentially have a measurable impact on readmissions for this patient cohort, mirroring results in the US.⁶
- 9.17** Pathway continues to pursue London-wide commissioning through various channels. Pathway recently conducted research for Guy's & St Thomas's Hospital Charity to look into the demand for medical respite services in the south London boroughs of Southwark, Lambeth and Lewisham. The findings support many of the assertions made in this report, including the need for a more co-ordinated response to medical respite for homeless patients as a means of providing the most suitable care, preventing readmissions and securing better housing outcomes. It also recommends the introduction of a locally agreed tariff for intermediate, medical respite care.⁷
- 9.18** The following tables summarise the range of suggestions discussed.

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 9(a): Evaluation findings – ideas for change

SUGGESTED FOLLOW UP WORK
UCLH to undertake thorough analysis of readmission rates comparing homeless population with whole patient cohort
Conduct further analysis of B&B users to assess impact on discharge, safeguarding & readmissions
Do further work with clinicians to explore their 'level of comfort' with patients being moved offsite (general and specific to homeless patients)

Table 9(b): Evaluation findings – possible follow up work

⁷ Dorney-Smith, S. & Hewett, N. (April 2016) Options for Delivery of Homeless 'Medical Respite' Services (Executive Summary): Pathway & Guy's & St Thomas' Charity

Consultant Views

- 9.19** Hospital consultants have also provided views on their experience of using Pathway to Home as a suitable recovery pathway for their patients. Some consultants have used the service more than others, mirroring the experience of the overall UCLH@Home provision. Those who have recognised the value to their patients have shared their views, illustrating how P2H supports the right kind of care for some of the hospital's most complex and high risk patients:

[Pathway to Home] has been completely invaluable in providing a safe, appropriate environment for complex, potentially high risk patients. Olallo House supports the patients, the Trust and the local health economy in allowing hospital discharge, preventing readmission, supporting directly observed TB [NB through another specialist service separate to P2H] and, through UCLH@Home, IV therapy. 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.'

- 9.20** The same consultant goes on to say:

'It would seem the least the Trust can do [to continue the service], given its huge financial investment in providing expensive, tertiary healthcare for patients from well beyond our borders.'

- 9.21** Similarly supportive comments were received from consultants illustrating how the service has helped to manage complex discharges safely and in a way which helps bring about a more successful transition for patients.

'It was a very useful resource for a difficult discharge of a vulnerable adult we looked after recently. It facilitated an earlier discharge and allowed a useful step down from acute care and eventually into sheltered housing.'

'[I am] very happy to endorse Pathway to Home – we have found it a very useful interim placement for some of our complex discharges. Often it has been the only option available to patients who have no fixed abode and ongoing, stable medical issues.'

'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.'

Patient Perspectives

- 9.22** Pathway received eight completed questionnaires from patients using Pathway to Home. The questionnaire was designed by the Pathway team in an attempt to capture additional information on the patient experience. It was introduced half way through the pilot phase. It was felt this was needed as it was proving difficult to get patients to fill in the UCLH@Home version as they were expected to complete it on their own and post back in a pre-pay envelope (something most homeless patients would find difficult to do for a variety of reasons). Furthermore, the UCLH@Home version is a national, standardised document which only asks a limited set of questions on the patient experience, focused on the clinical care received.

- 9.23** The Pathway feedback form covers a wider range of questions on pre-transfer, transfer to the hostel, support received from Pathway and hostel staff and an assessment of patient satisfaction with facilities. This allowed Pathway to assess views on all aspects of the process which would supplement any feedback received via UCLH@Home and Olallo House. Patients

were encouraged to complete forms while Pathway team members were preparing to discharge the patient on the final day of their stay. Although this more personalised approach undoubtedly helped to get more responses than might otherwise have been received, the response rate was still low (around 25%).

- 9.24** Of the eight questionnaires returned, one did not answer any of the main questions and was discounted from the list. This represents a 25% response rate from the 28 individual patients who used the service during the pilot. The main findings are summarised below.

Key Findings from Patient Questionnaires

Decision making & transfer to hostel

- 9.25** In terms of decision-making, six of the seven patients felt either fully or partly involved in the decision to complete their care outside the hospital environment. The same six patients felt they were given all or most of the information they needed to help make their decision to move to the hostel. Only one respondent said they did not receive enough information and commented there needed to be more paperwork to help patients.
- 9.26** All seven patients were transferred to Olallo House by taxi. Six said they were accompanied by a member of the Pathway team (one did not reply). It is a stipulation of the Service Schedule that patients are accompanied on transfer, so it is likely all patients were taken to the hostel.
- 9.27** With regard to the hostel check-in process, six of the seven rated this as excellent (top score of five) with one respondent giving a rating of four.

Support from Pathway Homeless Healthcare Team

- 9.28** The Pathway team received a glowing report from patients who rated their satisfaction with the team with a score of four or five on the rating scale (top score being five), with six patients giving the top score.
- 9.29** A range of support services were provided to patients during their stay, with the majority stating they received help with their general welfare (four patients responded), financial assistance (in the form of travel tickets, for example – four patients) and also guidance on access to housing benefit (two patients). Housing assistance was another key feature of Pathway team support with two patients stating they received help with accessing housing services (e.g. accompanying them to housing appointments, advocacy) and one patient receiving help to secure a hostel place.
- 9.30** Similar positive views came through in the additional comments received from patients as follows:

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

'I would like to thank all people involved in my care.'

'Nothing is too much [trouble] for them.'

Support from Hostel Team at Olallo House

- 9.31** The overall level of care and service provided at the hostel also received high praise from P2H patients. Again, satisfaction levels were high with ratings of four and five given by all respondents (five giving the top score, and two giving a score of four).
- 9.32** Staff helpfulness was also rated highly by patients, with respondents giving this element of feedback scores of four and five (mostly five). All other aspects of the hostel service received scores of three, four or five (mostly fours and fives), namely standard of bedrooms and bathrooms, communal facilities and standard of food provided.

- 9.33** Additional comments received from patients support these positive ratings for hostel services, most saying the service was ‘excellent’ and that staff were always ‘very helpful and polite.’ One patient in particular was vociferous in his praise:

‘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.’

Post-discharge from Hostel

- 9.34** Returned questionnaires did not reveal much information regarding onward destinations. Only 4 patients completed this question, with 2 being referred to London borough housing teams, 1 moving on to a B&B and 1 returning to the street.
- 9.35** The final question invited general comments on whether/how the service could be improved. Some patients reiterated their satisfaction with the service, saying:

‘You lot are above excellent so keep it up.’

‘Not a lot more you can do.’

‘Just continue if you can, because I have been in this country for more than 35 years and this is the first time I have seen such a good organisation.’

‘Thank you for your due care and attention.’

- 9.36** With regard to potential improvements, a few comments highlighted length of stay, move on accommodation and standard of food offer as an important factor:

‘Increase the length of time of stay to recuperate.’

‘Try to find people somewhere to stay for when they are better.’

‘The cooking was excellent but sandwiches could be improved.’

- 9.37** One patient also commented on the wider systemic problem of finding housing solutions for those people with no documentation/ID. This is an all too familiar problem for those involved in the care and support of homeless patients. 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 status of patients in terms of recourse to public funds and/or proof of identity is a recurring problem when trying to find move on accommodation, even in the most basic of hostels and B&B establishments.

Views of Olallo House Staff Team

- 9.38** The hostel management team was asked to provide feedback on their experience of being the hostel operator for Pathway to Home. Opinions were sought on the successes of the first year and also where improvements need to be made for the future.
- 9.39** From the hostel standpoint, the biggest success is the positive outcome 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.**” Olallo House staff were heartened by the fact patients expressed their satisfaction at being out of a hospital environment but still being well cared for.
- 9.40** Again, the talents and tenacity of all the teams involved in the partnership were singled out as a crucial success factor. Effective communication and excellent team spirit led to all parties forging strong, trusting relationships which “**helped to overcome the many challenges of working with the more disadvantaged members of our community.**”

- 9.41** Hostel staff believe all parties were always focused on what was best for the individual patient and were constantly re-evaluating the service and communicating between the various teams. Management felt they learned a great deal during the pilot about dealing with homeless inpatient cases (a different set of clients from their usual case load) and felt assured that they were meeting the needs of individuals as well as the service commissioner (Pathway).
- 9.42** 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. For many of these people, a lack of networks or even social skills is often a barrier to moving on. In terms of Pathway to Home, the hostel believes stronger links could have been made between P2H and the core Olallo House service to provide even more assistance to these individuals. If they were able to stay longer (i.e. beyond the timeframe of their clinical care), it is possible more could have been done to assist them with their move on needs.
- 9.43** In essence, the hostel is supporting 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."***
- 9.44** Hostel management has also suggested improvements for consideration in the next delivery phase. The lack of a service brochure was highlighted. This has been started on many occasions, but come to a halt for a variety of reasons. Pathway, UCLH@Home and Olallo House have now revisited this as a priority action.
- 9.45** Staff feel that more regular operational meetings would be of benefit (e.g. one per quarter) to review service performance and as a check on all aspects of the service from the different partner perspectives. Similarly, there could be mileage in hostel staff becoming more involved with the Pathway team by, for instance, attending parts of meetings when patients are being considered for transfer onto Pathway to Home, particularly those who are expected to stay for more than one week and may require more in-depth support.

Mr C.

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.

CASE
STUDY
#3

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

10 What Next for Medical Respite?

Pathway to Home Extended for 2016/7

- 10.1** As stated earlier in this report, the UCLH Medicine Strategy Board agreed to continue Pathway to Home provision for another year. The hospital took over responsibility for the contract on 1st April 2016. This decision was on the basis that the additional cost for P2H beds would not impact adversely on the hospital's 'break even' point for the wider UCLH@ Home contract.
- 10.2** The terms of the contract with Olallo House have changed from a 'block' to a more flexible 'spot' purchase arrangement to ensure the hospital is only paying for beds which are actually used. To provide some comfort to the hostel provider, the hospital has guaranteed a minimum number of bed days over the course of the year.
- 10.3** This new arrangement is solely focused on P2H patients i.e. those who are still under the care of the hospital and freeing up acute beds on hospital wards.
- 10.4** The DH grant has therefore leveraged additional resource to continue the project 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.
- 10.5** Having been halted for six months while an alternative funding source was found, B&B provision was reinstated in October 2016. With financial support from the UCLH Charity, the continuation of this vital element of medical respite care is welcomed by the Pathway team as a more complete approach to providing the right kind of care and support to this vulnerable group.

Wider London Scene

- 10.6** Since the inception of Pathway to Home, Pathway has conducted further research into the demand for medical respite provision. Funded by Guy's & St Thomas's Hospital Charity (GSTT), the study analyses the need for medical respite provision for the King's Health Partner (KHP) hospitals.⁸ The research identifies five categories of homeless patients in secondary care that could benefit from some form of medical respite care. The experience of Pathway to Home supports the view that patient need for services of this kind range from 'low level hotel-type users' to 'chaotic, tri-morbid patients requiring specialist hostel based support.'⁹
- 10.7** All signs point towards a need to tackle homeless medical respite at the London level. Pathway believes city-wide commissioning is vital to the successful provision and funding of services at sufficient scale to be cost effective and to overcome the myriad issues associated with housing benefit requirements and/or attributing homeless healthcare costs to the right CCG.
- 10.8** The aforementioned report has recommended the introduction of a Locally Agreed Tariff (LAT) for medical respite care as a potential way of overcoming some of these issues. Pathway is pursuing further work on this recommendation as a useful contribution to London wide commissioners.
- 10.9** The Healthy London Partnership (HLP) is a collaboration between all London CCGs and NHS England London region. HLP is tasked with 'supporting the delivery of better health in London.' The Health Services for Homeless People Programme is one of their 13 priority programmes. This programme is focused on implementing a pan-London lead commissioner model that improves homeless health services and access to such provision. The arrival of this programme presents a timely opportunity to build on the 'on the ground' learning from Pathway to Home and other similar projects in deciding how best to take forward medical respite priorities.
- 10.10** Whilst it is positive news that these commissioning issues are being tackled, Pathway is of the view that further strategic leadership is needed from the Greater London Authority (GLA) to help move this priority forward. The GLA provided funding for some of Pathway's early development work on medical respite, so have recognised the value of this type of work. The new Mayor's taskforce on homelessness adds weight to the agenda; Pathway hopes the new administration prioritises this commitment to push for action on commissioning of intermediate healthcare for homeless individuals.

11 Evaluation Findings & Recommendation

Key Findings

- 11.1** 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 intermediate care interventions. A clear governance process, supported by detailed policies and procedures for patient transfer and care, resulted in 59 successful 'admissions' to the service (comprising a combination of Pathway to Home patients and B&B clients).
- 11.2** A key learning point for any organisation looking to establish a similar service is to be mindful of the long lead times required for setting up a facility. Similarly, service commissioners should not underestimate the level of staff resource needed to manage the planning, implementation and day-to-day operations of facilities, even those with a small number of beds like Pathway to Home.

⁸ Guy's, St Thomas's, King's, Lambeth and Maudsley hospitals

⁹ Dorney-Smith, S. & Hewett, N Dr. (April 2016) Options for Delivery of Homeless 'Medical Respite' Services (Executive Summary): Pathway & Guy's & St Thomas' Charity

- 11.3** Maximising occupancy rates is dependent on having a mix of service users ranging from inpatients still under the care of their medical consultant (i.e. Pathway to Home patients in this case) through to discharged patients requiring some additional recovery time (B&B type cases). The level of clinical intervention will vary according to individual needs as will the amount of time spent on additional support needs e.g. access to housing/accommodation assistance, help with benefits, registering with GP etc.
- 11.4** In an ideal world, access to medical respite services should not be unduly restricted by the chosen delivery model. Whilst the ‘at home’ approach was successful in terms of quality of care given to Pathway to Home patients, it did present limitations around service eligibility and agreed length of stay. On the flip side, using an existing hospital service presented an affordable staffing model; without this, the pilot project would have been a non-starter.
- 11.5** Whichever delivery model is applied, successful projects require close, collaborative working between all parties (in this case the hospital, the UCLH@Home team, Pathway and the hostel provider). A high degree of skill, experience and flexibility is vital to address the multitude of issues that can arise when dealing with the complex health and social care needs of homeless patients. Pathway to Home undoubtedly benefitted from the talents of the various teams involved in providing the best possible care for service users and in finding ways to deal with problems as they occurred.

Recommendation

- 11.6** Based on the Pathway to Home experience and recent research into the need for medical respite services in south London, it is clear that all signs point towards finding a London-wide approach to provision.
- 11.7** Whilst Pathway to Home and similar projects are demonstrating successful innovation at the margins, it is not at anything like the scale required to deliver meaningful economies of scale or deal with the level of demand across the capital.
- 11.8** London needs strategic leadership on this matter, leadership which can negotiate the complex interface between health, housing and social care provision for the city’s homeless population. Working together, NHS England (London Region), the London CCGs and the Greater London Authority (GLA) can formulate this strategic approach and address the challenge of working across boundaries in a way which local projects (like Pathway to Home) are unable to do.
- 11.9** The core recommendation from this report, therefore, is:

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

- 11.10** London’s health leaders can expedite this work via the Healthy London Partnership as part of its Health Services for Homeless People priority programme (see 10.9). 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.¹⁰

¹⁰ 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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