

KHP Pathway Homeless Team
Scoping Paper

Options for Delivery of Homeless 'Medical Respite' Services

Executive Summary

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Samantha Dorney-Smith,
Service Development Officer, Pathway

Dr Nigel Hewett,
Medical Director, Pathway

Executive Summary

Introduction

Pathway teams provide individual care coordination supported by multi-disciplinary teams, and use the opportunity of hospital admission to help patients into housing, support and care in the community. However despite this expert support, not all discharges are timely or to ideal destinations.

Medical Respite is an American term for clinically supported intermediate care for homeless people in the community. This includes peripatetic nursing and bed based solutions, and can range from low-level supported housing to comprehensive clinical care. Such services provide a safe, recovery based environment to discharge homeless patients to, and some already exist in the UK.

This paper considers the need for Medical Respite services to support the KHP hospitals: Guy's, St Thomas', King's, and the Lambeth and Maudsley hospitals. The paper summarises the latest evidence, outlines opinions from patients and stakeholders, and presents case studies and an analysis of KHP Pathway team data. The paper identifies 5 groups of homeless patients in secondary care with separate and distinct needs, and presents potential opportunities to improve services.

The paper aims to encourage discussion among stakeholders and enable a consensus to be reached, regarding whether action is currently needed to enhance services locally. If a consensus is achieved through this paper, a further exploratory phase with local leadership is recommended.

Literature review

Homelessness is strongly associated with multi-morbidity, premature mortality and frequent use of urgent secondary care.

There is strong international evidence for Medical Respite services showing benefit to patients and the health economy. Positive outcomes have been demonstrated in pioneering pilot projects in the UK including the Homeless Intermediate Care project based in Lambeth.

Local context

Published statistics suggest a homeless population across Lambeth, Southwark, Lewisham, Croydon and Westminster (the main boroughs that the 5 hospitals serve) of at least 16,491 people. This figure represents rough sleepers, clients living in homeless hostels, clients living in second stage supported accommodation, and Part VII statutory homeless declarations at the local authority, but does not include 'hidden homeless' people.

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

826 patients referred to the Pathway team at GSTT occupied an estimated 5981 bed days during Oct 2014-Sept 2015, with an average length of stay of 7.2 days. Re-attendance and readmission rates were high (21% and 19% respectively). At King's, the number of bed days occupied by 306 homeless patients for the same period was 4109, with an average length of stay of 13.4 days. SLaM data is still being collected, but prior research shows that the average length of stay ranges from 110.1 to 173.6 days for homeless clients who needed re-homing. 132 patients were referred at SLaM in the first 11 months.

Existing service review

Review of the existing UK services revealed some excellent practice, but also many challenges. Interviews with service providers uncovered difficulty maintaining flow when beds were in local authority control, a potential need for alcohol-free step down beds to support recovery, and a frequent need for relationship building with clinically informed social care coordination and delivery, rather than hands-on nursing care per se. A need for disability access and substitute prescribing provision was evident. All projects delivered clinical services via a Mon – Fri 9-5pm model.

Despite the challenges, the projects have all demonstrated reduced emergency care usage and improved outcomes. The project attributes that have been key to success have been identified in the report, along with the operational details of each project. It is hoped that this will provide a resource for all the projects, and a guide for any new project setting up.

Data analysis

Background data analysis was undertaken on three cohorts of patients seen by the Pathway team during 2015. This showed that a significant number of all patients seen by the Pathway team do not have a local connection (GSTT 64.2%, Kings 42.7%, SLam 32.5%), although it appears that long stayers are more likely to have a local connection. About 14% at GSTT and King's have been confirmed to have no right to housing or welfare benefits in the UK, although as such, most patients do potentially have recourse to public funds. Around 12% of admitted patients at GSTT and King's are still being discharged to the streets for a variety of reasons.

Further detailed analysis was then undertaken on 30 randomly selected patients, and on 46 patients identified by the teams as likely to benefit from Medical Respite. Detailed analysis was partially targeted on those likely to benefit, in an attempt to clearly define the types of facilities that might be needed. In the detailed analysis the number of bed days that could be saved was identified first, followed by an estimate of the number of days that might be needed in a respite facility.

Key findings

Across the 3 Trusts an estimated total of 4410.2 bed days could have been saved in year if medical respite options were available.

Analysis of homeless patients across KHP who might benefit from Medical Respite revealed a variety of needs that have been separated into 5 groups, requiring different types of service provision. An estimate of the total number of bed days required to meet the needs of the KHP Pathway team has been made (by extrapolating the sample findings to fit the whole population). Sampling methods and the assumptions are explained in the main document. Within these groupings it has been assumed that clients with primary physical health and primary mental health diagnoses can be managed together. As most existing services allow direct admission from the community to avoid hospital admission (step-up), we also include additional capacity for this purpose where this is relevant, and set a target of 80% bed occupancy to support throughput and rapid admission (as suggested by many stakeholders). Additional figures, considering the needs of the population with a Lambeth and Southwark connection only, are offered at the end.

A Patients requiring hotel-type low level support - 30% of the 76 cases.

These are relatively independent patients with physical or mental health difficulties (sometimes with mobility issues) who are statutorily homeless, but would not normally be expected to become rough sleepers. They have often been evicted (as unable to cope due to their health problems), or have been sofa surfing with friends or family who can no longer cope. They don't usually have addictions. They can often be demonstrated to be in priority need, but are short term bed blockers while their housing case is argued with the local authority. **6.5 bed spaces per year.**

B Patients with serious health problems who have no recourse to public funds 11% of the 76 cases.

Conditions include cancer, diabetes, renal failure and late stage HIV. These patients often have mental health problems, but not addictions. There are complex debates about whether they meet the care needs threshold, and their support requirement increases over time. They are often severely delayed, so although only a smaller percentage of individuals, they are over represented in excess bed days. These patients have been allocated into group A or C in the report in terms of the respite support required (depending on disease progression).

C Patients with significant care needs requiring a care placement 8% of the 76 cases.

These patients are ex rough sleepers with acquired care needs and/or cognitive deficits with addictions. This makes them difficult to place due to a lack of appropriate social services funded accommodation. They need daily support, including with activities of daily living. They are often severely delayed, and are thus also over-represented in excess bed days. **4.3 bed spaces per year.**

D Chaotic, tri-morbid patients requiring specialist hostel based support 51% of the 76 cases.

These patients have all been rough sleepers at some point, and are chronically physically and/or mentally unwell with addictions problems (most have alcohol issues, many also have drug issues). They have often received or been offered every service available to them. They are usually already in a hostel, or are still rough sleeping despite repeated attempts to get them in. They are often frequent attenders, although they can also be non-engagers. They rarely block beds initially, as they often leave prematurely or self-discharge, but they often block beds later as they become more unwell. They need an intense psychologically informed case management, and may need end-of-life care. Existing provision focuses on this group, and so far has been delivered in 'wet' hostel type environments (i.e. hostels that tolerate on-site drinking). **10 bed spaces a year.**

E Chaotic tri-morbid patients wanting to stay dry

Within the above group there are a significant number of patients who have had an unplanned alcohol detox as part of their acute hospital admission, and are expressing a desire to stay dry, and to not return to their hostel. As many of these patients' have had limited or no prior engagement with alcohol services, there is no possibility for them to have an urgent admission to an addictions rehabilitation bed. **These patients appear to need a rapid-access stand-alone dry unit where they can be stabilised and engaged with abstinence support. 3.8 bed spaces a year.** Note that if this provision were available, it would reduce group D to 6.2 bed spaces a year.

The adjusted figures for Lambeth and Southwark residents combined are: Hotel type low level support 4.6 days; Care environment 1.1 days; Specialist hostel 8.0 days; Dry provision 3.4 days (reducing specialist hostel provision to 4.6 days).

Case Studies

18 case studies of clients needing respite are presented in the report. These were selected by the Pathway and HIT teams. These case studies include clients needing step-up care, and end-of-life care, and one who needed community neuro rehabilitation. Two TB cases are also considered. The importance of adapting to the needs of the client group e.g. by providing support for couples, comes through in the narrative.

Patient and Stakeholder interviews and focus group findings

'I have been discharged and slept in the hospital grounds because I felt safer – I knew I wasn't very well. I went back and hoped I'd see a different Doctor'

service user

Service users and stakeholders all felt that although hospital discharge processes have improved since the KHP Pathway team has been in place, there is more that can be done to improve hospital discharge and stop the revolving door. Most interviewees were generally supportive of the concept of enhancing the local medical respite provision, although some wondered if other ideas should take priority, such as strengthening existing teams to offer post-discharge floating support. Several stakeholders pointed to ongoing funding practicalities around medical respite provision, if the intention is to continue to provide services in Local Authority controlled accommodation (thus requiring housing benefit entitlement).

Alcohol dependence was recognised to be the major health problem for this group. Service users and stakeholders alike talked consistently about the key issue of being able separate those aspiring to abstinence from continuing drinkers, and the near impossibility of providing a 'dry' environment within a 'wet' hostel. This was particularly important to service users, who favoured a bed-based model of medical respite. Service users also offered useful contributions regarding the staffing of potential respite provision.

Overall a number of key debates / dilemmas came through in this engagement work, and these were:

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

Stakeholders repeatedly talked about the need for clarity of purpose, and often proposed piloting services for one or two of the 5 groups identified by the data analysis, rather than focusing on all 5.

Discussion

As outlined above, differing types of service provision will offer different outcomes. 'Hotel' provision is most likely to achieve immediate bed day savings, while concentrating on the 'chaotic tri-morbid' group is likely to foster recovery and provide long term value for investment. Providing an opportunity for alcohol dependent clients to stay dry, stabilise and engage with services seems important. London has higher excess mortality rates secondary to alcohol in homeless persons compared to other regions, and this provides an additional moral driver.

The main barrier to all provision is the siloed and depleted budgets that exist across the voluntary sector, housing and social care. Resolving this can be achieved by better integrated care within each Borough, but this does not provide help for the high number of hospital patients who do not have a local connection. A Locally Agreed Tariff may present a solution, and developing this could an aim for future work.

Recommendations/ opportunities

At the time of writing the London Homeless Health programme is developing pan-London priorities for homeless health care. This paper identifies local opportunities for change, and also opportunities to improve care by regional initiatives.

London wide commissioning

Provision for rough sleepers with significant care needs who need registered care home provision (group C) is a regional challenge, and is beyond the remit of this paper. However this was a consistent stakeholder concern, and probably justifies a separate project.

A Locally Agreed Tariff for Medical Respite Care would facilitate health care funding for most of the other groups, and overcome current problems regarding the need for dual housing benefit when hostel beds are in Local Authority control. This tariff would be paid by the patients' CCG, which in almost every case is already paying for the higher cost of repeated acute medical admissions, and could be tailored to reflect the different levels of care identified. Developing such a tariff would be a very useful contribution from London wide commissioners, and could lead to medical respite unit(s) that could meet pan London needs.

Local commissioning in Lambeth and Southwark

A number of possible options are outlined in the paper. It is important to note that full feasibility / operational details have not been worked out for all these options, and some relevant stakeholders have not yet been contacted. Interested parties will most likely wish to view all the options described to form their own opinions, however the projects felt to be most realistic for development by the authors are profiled here.

Stakeholder suggestions for strengthening discharge arrangements and improving existing community support warrant further consideration.

Discharge 'Hotel' with low level support. Piloting this might be eminently achievable using hospital or charitable funds. Such a project could be delivered in partnership with acute Trusts, working alongside any other projects in development aimed at bed-blocking in the wider hospital population.

Specialist hostel based support already exists for Lambeth residents at Graham House, supported by the Health Inclusion Team (HIT), but there is no rapid access to the beds, because they are in a Local Authority hostel which has very high bed occupancy. Additionally the hostel is due to move soon. Southwark has the recently renovated the Great Guilford Street hostel, and it now has 8 beds on the ground floor alongside two high specification medical rooms. This could be used as a medical unit within a hostel, and was designed as such. The beds are currently used as standard beds, because additional health input has not been commissioned. Extending existing HIT team medical support to this unit, and allowing access by both Lambeth and Southwark residents with a funding package that doesn't require housing benefit (so patients retain their original hostel bed), would make this possible. The HIT team obviously has existing expertise in this area, and would be ideally placed to staff, guide and lead this process if funding were made available. This might be achieved as a charitable pilot, whilst a Locally Agreed Tariff was developed.

Rapid access dry provision. Reorganisation of the Equinox community alcohol detoxification unit in Brooke Drive (or similar), might allow for direct admission from hospital to provide support to maintain abstinence, and move patients on towards recovery. This appears 'just' to need a change of protocols to allow the admission of carefully selected patients who have not previously fully engaged with addictions, and lack a clear discharge destination, but who have a definite desire and will to stay dry. A pilot project could be small, with patients receiving additional clinical and move-on support from extended Pathway / HIT teams. The Pathway and HIT teams could advise on the additional capacity required. A larger unit could be developed in the future if successful, again based on a Locally Agreed Tariff.

Proposed Next Steps

Further development work. Funding could be sought for a further 3 month exploratory phase. This phase would seek to work up a specific bid or Business Plan for a specific chosen option or options. This would involve liaison between health, housing and the voluntary sector to work out the potential operational details of a project, and develop specific staffing models. It would also in all likelihood require significant local cross borough liaison in housing and health. It might also involve examining property options in more detail, and starting work on the tariff concept. A potential partnership with the GSTT charity funded Assertive Outreach Alcohol project could be developed.

Facilitation funding from GSTT charity and/or other sources would be needed in order to develop these opportunities.

Samantha Dorney-Smith

Service Development Officer, Pathway

Nigel Hewett

Medical Director, Pathway.

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Feedback and dialogue on this report is very much welcomed.

- samantha.dorney-smith@gstt.nhs.uk
- nigelhewett@nhs.net

Postscript:

One of the service user contributors to this project died in January 2016 aged 29 years old. This person articulated the difficulties they had experienced with the hospital discharge process extremely well, and offered some extremely useful insights and suggestions regarding medical respite. She is respectfully remembered as this report is published.

Thanks

Production of this scoping paper has only been possible thanks to the many contributors who have shared data and perspectives. Most collaborators are acknowledged at the end of the paper, with apologies to anyone omitted. However the key opinions and perspectives voiced in this paper are those of the authors.

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

Charity number: 1138741