A Needs Assessment for Homeless Medical Respite Provision in North Central London

SUMMARY

February 2019

Pathway funded this study to support partners across North Central London's NHS to improve health services for homeless patients leaving hospital.

This needs assessment highlights the pressing need for Medical Respite - intermediate step down care for homeless patients - in North Central London. Similar services are already commissioned in other areas of England and make a significant contribution to improved and cost effective care for homeless patients.

A Medical Respite service located in North Central London could support homeless patients with their recovery and help with access to support services. The goal is to assist with next steps in finding more secure housing outcomes for patients and reducing instances of patients ending up back on the street.

The study examines the extent of homelessness in North Central London along with instances of hospital admission and A&E attendance over a one-year timeframe. The assessment presents data supplied by all the acute Trusts together with some limited information from mental health Trusts.

The study describes four distinct categories of patient who would benefit from some form of intermediate care, the types of support needs prevalent in these groups and reasons why some opt to return to rough sleeping.

The study also presents learning points from two existing medical respite services operating in London. One benefits from CCG funded beds and has successfully reclaimed housing benefit for one third of its clients. The other is managing a mixed caseload of hospital inpatients (as part of a ‘hospital at home’ service) and recently discharged clients needing extra recovery time. It is also able to support patients with no recourse to public funds.

Based on the findings of this study, Pathway is actively engaging with partners to establish a medical respite facility in North Central London to serve homeless clients with a range of intermediate care and other support needs.

1. Introduction

Pathway is an independent charity that works to improve the quality healthcare for people experiencing homelessness. Pathway has developed a hospital-based model of care, Pathway teams deliver individual care co-ordination for homeless patients through a multi-disciplinary team approach. Pathway teams work with patients during their hospital admission to help them with housing, support and social care.[1]

However, despite this expert support, not all discharges are timely or to ideal destinations. Pathway regularly conducts needs assessments to support hospitals around the UK in setting up 'in-house' teams. Pathway also carries out assessments to ascertain demand for specific homeless health services, including, for example, intermediate healthcare provision such as medical respite.[2]

Medical respite is an American term for clinically supported intermediate care for homeless people in the community. It includes both peripatetic nursing and bed-based solutions, ranging from low-level supported housing to comprehensive clinical care. Such services provide a safe, recovery-based environment to discharge homeless patients to. There is a growing international evidence base which shows that such services result in more positive outcomes for patients.

Based on Pathway's earlier work to consider demand for medical respite provision in south London hospitals, the charity has conducted this needs assessment for acute Trusts located in North Central London.[3]

This paper summarises some of the key highlights from the full needs assessment based on data collection from NHS Trusts, a more detailed patient audit (from one Trust) and qualitative interviews with a range of stakeholders, including service users.

2. North Central London: homeless facts and figures

There are at least 14,000 single homeless adults across the five boroughs

The North Central London area has an estimated homeless population of approximately 11,500 people. This comprises single homeless adults who are either rough sleepers or living in temporary accommodation, such as homeless hostels.

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[1] The Pathway team approach has been highlighted as good practice in NHS England's Long Term Plan. See p42 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

[2] S. Dorney-Smith & N. Hewett, Options for Delivery of Homeless Medical Respite Services: KHP Pathway Homeless Team Scoping Paper, April 2016.

[3] London Boroughs of Camden, Islington, Haringey, Barnet & Enfield

We estimate that the 'hidden homeless' population may account for an additional 20% of people experiencing chronically insecure housing circumstances, for example 'sofa surfers' or people threatened with eviction. A more accurate estimate of homeless people across the five boroughs is therefore a minimum of 14,000.

The homeless population accounts for over 6000 A&E attendances and over 1000 hospital admissions in one year

Data supplied by all the acute hospital trusts located in the area looked at A&E attendances, hospital admissions, re-admission/attendance rates and average length of stay information. Trusts were asked to search for all patients where either their address was given as: No Fixed Abode (NFA); a recognised homeless hostel or day centre in the local area; or their NHS number showed registration with a specialist homeless GP service. A summary table is shown below.

Summary data table: acute NHS Trusts in North Central London

	Number of A&E attendances (1 year)	A&E re-attendance rate (7 days)	Number of hospital admissions (1 year)	Re-admission rate (30 days)	Average length of stay (days)
UCLH	3771	20.4%	602	18.3%	4.1
Royal Free	971	57.8%	234	9.4%	3.1
Barnet	277	48.7%	81	9.9%	2.2
Chase Farm	25	40%	4	0%	0.5
North Middlesex	606	7.4%	133	11.2%	4.2
Whittington	684	Not known	102	Not known	3.1
TOTAL	**6334**	-	**1156**	-	-

Majority of patients seen tend to be chaotic, tri-morbid clients with a history of rough sleeping

Pathway was able to carry out a further, detailed audit of case notes for a sample of patients seen by the Pathway team at University College Hospital (UCLH). Patients audited broadly fell into four categories, matching those developed from Pathway's similar medical respite needs assessment for south London. The following table shows the breakdown of patients for each category.

Category	%
Low level or specific discrete medical needs - has recourse, housing requires resolution, not prior rough sleeper	17.4%
No recourse to public funds with significant medical problems e.g. cancer or HIV / TB. Needs housing and some support, mostly past sofa surfers	14.5%
Care needs resulting from medical problem plus chronic addiction or end stage cancer, mixed background	13.0%
Chaotic, tri-morbid clients – generally a chronic history of rough sleeping	55.1%

All categories could benefit from some form of medical respite assistance as part of their physical recovery as well as supporting recently discharged patients with housing or legal issues. The criteria for referring patients to any intermediate care service will determine the level of service provision required (low level to more complex cases) and the type of assistance offered (help with housing, clinical input, mental health or addiction support).

Intermediate care can meet a range of support needs for recovering homeless patients

The audit showed a wide range of needs that a medical respite facility could consider as part of a service offer. 92% of patient cases analysed identified a need for housing or reconnection support. Complex needs care co-ordination and supervision of medication were common support needs (76%). Helping clients with mental health or addiction issues is another key requirement (60%+). 43% would benefit from nursing or allied professional support (e.g. wound care, IV medication). 45% had a mobility issues at the point of discharge – a key consideration for medical respite to ensure buildings are accessible. The following table lists the various support needs identified in the audit.

Summary of support needs required

Support need	%
Mental health	63.8%
Addiction	60.9%
Intravenous drug use potentially requiring substitute prescribing	24.6%
End of life care issues	18.8%
Medication that would benefit from support / input of health care professional at least once or twice a week	76.8%

Medical issue that would benefit from support from a nurse / allied professional – e.g. wound dressing, condition monitoring, medication requiring injection at least once or twice a week	43.5%
Mobility issues (at point of discharge, includes clients with shortness of breath)	44.9%
Support with housing or reconnection to local area	92.8%
Support with eligibility	30.4%
Complex needs that need care coordination	76.7%
Care coordinator or support worker already involved	43.5%
Care or intensive support needs	13.0%

Some patients are still returning to the street despite support being available to them

Analysis of a sample of discharged patients at UCLH reveals several reasons for individuals returning to the street. 18% of those cases refused any support, with a further 13% self-discharging whilst the Pathway team was working with them. The majority of patients received basic help (e.g. clothing, travel card) before leaving (23%); this was the only support logged in their notes. 18% of patients were sent to other services, including borough housing teams, but failed to achieve a positive outcome (or result is unknown). Reconnection was the only option for another 13%. Violent or difficult behaviour accounted for 5% of discharges.

Reasons for return to rough sleeping

Documented reasons	**No.**	**%**
Refused support	11	18.3%
Actively self-discharged whilst team working with patient	8	13.3%
Absconded / away from ward for too long/ bed given up	5	8.3%
Violent / difficult behaviour	3	5.0%
Sent to housing but failed or unknown outcome	7	11.7%
Sent to another service for assistance	4	6.7%
Reconnection only possible option – facilitated as much as possible	8	13.3%
Practical support is only intervention logged (e.g. clothes, Oyster card); 5 were seen on the day of discharge, 4 were frequent attenders, only 2 were from Camden	14	23.3%

3. Mental Health data for Barnet, Enfield & Haringey (BEH)

Barnet, Enfield & Haringey Mental Health Trust sits within the North Central London area. The Trust provided homeless admissions data for the period 1 January 2017 – 31 December 2018 (see Table below). Patients were identified via NFA status, homeless hostel addresses or specialist GP registrations.

BEH 'Homeless admissions' 1 January 2017 – 31 December 2017

	Homeless Patients	**All admissions**
Number of admissions	21	1,937
Number of 28 day readmissions	0	169 (9%)
Average length of stay	56.6 days	66.5 days
Number of outpatient appointments / other appointments	107	228,665
Number of DNAs	17 (16%)	21,369 (9%)

For this cohort of patients, the BEH Mental Health Trust covered the cost of admissions as no address or GP was recorded. It was not possible to separate out costs of individual admissions due to block contract arrangements across the three boroughs.

Camden & Islington Mental Health Trust (C&I) also serves the North Central London area. It was not possible to obtain data from C&I for this needs assessment work.

BEH Mental Health Trust has access to three Recovery Houses for step down provision. These services are used to provide short-term support to people in crisis, including homeless individuals with mental health issues. Patients can be stepped down from acute services (or from Home Treatment team referrals). People using the recovery houses tend to need more support than intensive home visits can offer or where hospital inpatient care is not the right solution.

The person-centred, therapeutic approach to recovery helps prepare individuals for the transition back to independent living – or to secure housing if this is required. Housing professionals are on hand to help clients with this.

During the year of 1 August 2017 to 31 July 2018, 571 patients were stepped down to the Recovery Houses. Of these admissions:

- 228 were recorded as NFA
- 311 had housing issues
- 118 were re-housed

- 193 patients went to variety of destinations, including sofa surfing
- average length of stay in recovery houses is 20 days (all clients)

It is interesting to note the difference between the NFA /housing issue numbers at the recovery houses and the homeless acute admission figures supplied by the Trust. 228 patients arriving at a Recovery House after an acute admission were recorded as No Fixed Abode at that point while only 21 acute primary admissions were recorded as having NFA over one year.

4. Examples of current medical respite projects in London

Gloria House

Launched in January 2018, Gloria House is a partnership between Peabody Housing, the Royal London Hospital Pathway Team and Tower Hamlets CCG. Peabody has renovated one of its properties to provide six step-down medical respite beds for homeless patients being discharged from the Royal London Hospital. The hospital's Pathway team selects suitable patients for transfer. The team also work alongside Peabody colleagues to ensure discharged patients are supported to register with a GP and receive district nursing and other support whilst at Gloria House. Tower Hamlets CCG has commissioned the service.

Occupants of Gloria House receive support with: accessing benefits; GP registration and hospital appointments; medication prompting; legal assistance; and help with accessing food banks and hardship funds.

During the pilot year, Gloria House supported 36 homeless clients and achieved an occupancy rate of 62%. The average length of stay is 27 days. They have assisted 5 patients with No Recourse to Public Funds (NRPF) and have successfully claimed housing benefit for one third of clients.

Staff have flagged up their ability to accept more 'challenging' referrals over time, although the aim is for the service to support those with less complex needs as far as possible. Close partnership working between Peabody and the Royal London Pathway team allows for in-depth conversations around discharge planning for each potential client.

Key learning points from Gloria House

- Successful 3-way partnership between housing provider, hospital and CCG
- Exclusive referral rights by the Pathway team
- CCG funded beds with some notable success at reclaiming housing benefit to offset costs
- Strong package of support to help occupants with all aspects of health, housing and social care
- Ability to deal with more complex cases if required

Pathway to Home (Olallo House)

Created by Pathway, this step-down service has been operational since 2015. Originally funded by Pathway with a grant from Department of Health's Homesless Hospital Discharge Fund (HHDF), the service is now funded by UCLH. *Pathway to Home (P2H)* is part of UCLH's wider Hospital@Home service where patients can be sent home (or in this case, to a local hostel) to complete the last few days of their treatment.

P2H is delivered in partnership with Olallo House, a homeless hostel located near to UCLH. The hostel has 2-4 beds available for P2H, which the hospital funds on a spot purchase basis.

Individuals transferred to this service are still hospital in-patients, but do not require an acute bed for the latter stages of their treatment. Ward consultants and the Pathway team make joint decisions on referrals. Nursing teams visit patients at the hostel as required and planned discharge dates (PDDs) are agreed in advance. The nursing element is funded by UCLH.

The target length of stay for P2H is 5 days. This gives very limited scope for any recovery based intervention, but patients have given favourable feedback to the service overall.

In addition to P2H, the UCLH Pathway team can purchase additional beds at Olallo House on a 'Bed & Breakfast' basis. Using funds from the UCLH Hospital Charity, the team can discharge patients to the hostel as a transition step. Length of stay can be more flexible for this client group.

Key learning points from Pathway to Home

- Acceptable to wider cross-section of patients including those with multiple complex needs
- Can take in-patients or recently discharged clients needing extra recovery time; can accept clients at short notice
- Close proximity to hospital makes it possible to continue medical and non-medical case management
- Can accept patients who are non-local, or do not have current housing eligibility
- Stop-gap only, does not allow for recovery type interventions

5. What this study adds to the medical respite dialogue – and next steps

The findings from this work make a useful addition to the 'story' of medical respite in London. Taken together, the data analysis and conversations with stakeholders support the view that there is demand for intermediate care beds to support homeless patients either during or immediately after their hospital stay. The work confirms the difficulty of gathering accurate data to inform needs assessments. We are reasonably certain that the patient numbers revealed by the data collection exercise are an underestimate of the true size of the cohort.

It also confirms the broad categories of medical respite patients identified in a similar study for South London. This suggests services can be designed around a limited range of scenarios depending on what is viewed as the main priority for particular areas i.e. rapid assessment/short term recovery or support for long-term recovery patients with complex needs.

There are multiple reasons for patients being discharged to the street on leaving hospital, for individuals not engaging in support services or for clients not securing positive outcomes. These issues require further analysis to inform future detailed design and delivery of intermediate care services.

There are good examples of step down provision already in place to support both physical and mental health needs and the transition from hospital to onward accommodation, reconnection etc. Provision is funded and delivered in different ways and is mostly operating on a short-term basis. The temporary nature of provision makes it difficult to plan ahead in any meaningful way.

Existing London projects demonstrate it is possible to support individuals with complex needs and also those with NRPF. Funding has been forthcoming from a CCG and individual NHS Trusts. Both models work – and both have secured follow-on funding beyond the initial pilot stage. In once case, it has been possible to reclaim housing benefit to offset some of the overall service cost.

Following this study Pathway will continue to push partners across the NHS in North Central London to invest in more provision for homeless patients leaving hospital. Based on these findings, Pathway is actively engaging with partners to establish a bespoke medical respite facility to serve homeless clients with a range of intermediate care and other support needs across North Central London.

Acknowledgements

Pathway would like to thank all those individuals and organisations who contributed to this needs assessment. Over 60 people have shared their views during the course of the study representing the opinions of CCGS, local authorities, acute and mental health trusts, patients, hostel providers, specialist homeless services and end of life care. Their contributions have been invaluable and will continue to shape our thinking as we move closer to establishing the intermediate care and support homeless patients so desperately need.

If anyone is interested in collaborating with us on this important work please get in touch at info@pathway.org.uk or on 0203 447 2420.