Medical Respite in the UK - A Needs Assessment for South London

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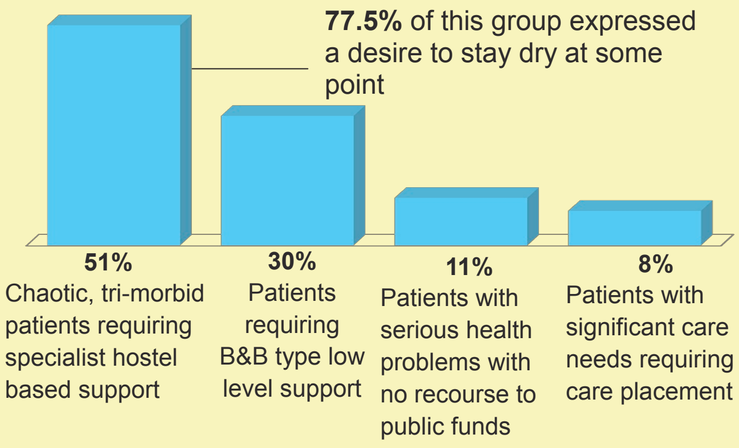
All patients leaving hospital need somewhere safe to recover

Homeless people in hospital often have no appropriate accommodation to return to, leading to delayed discharge, inappropriate discharge onto the street, and high readmission rates. Medical respite is an American term for clinically supported intermediate care for homeless people in the community, including peripatetic nursing and bed-based solutions, and ranging from low-level supported housing to comprehensive clinical care. Such services provide a safe, recovery focused environment into which homeless patients may be discharged. Two recent systematic reviews provide evidence for the provision of medical respite services (Doran et al, 2013; Hwang and Burns, 2014).

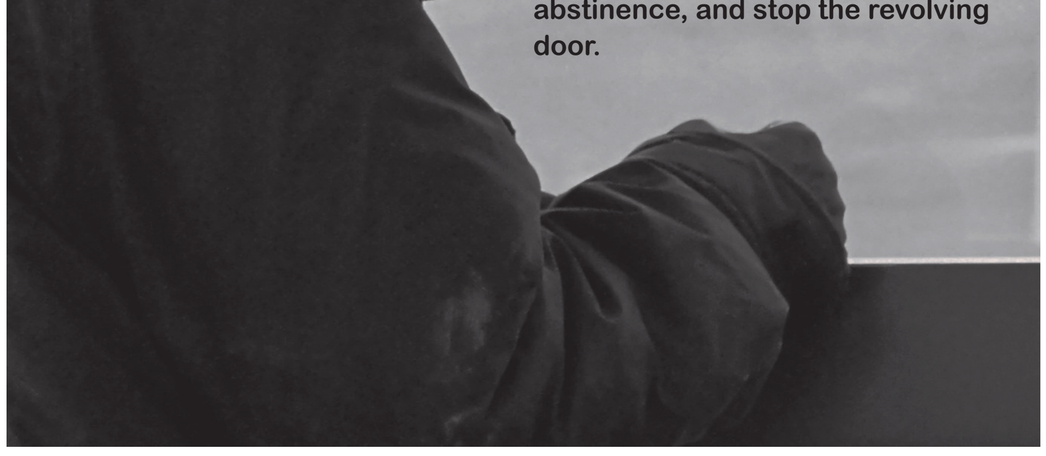
In May 2013 Pathway produced it's first **'Medical Respite for Homeless People: Outline Specification'**. Following this, options for provision in south London have been identified in the report: KHP Pathway Homeless Team Scoping Paper: **Options for Delivery of Homeless 'Medical Respite' Services (April 2016)**, which can be downloaded at **www.pathway.org.uk/publications**

76 potential candidates for medical respite were studied in depth. The following cohorts of patients were identified:



Medical needs:
82% had a physical health problem
76% had a mental health problem
60% had an addictions problem
33% had mobility problems
33% needed ongoing daily nursing care
25% were on some form of substitute prescribing

Social care needs:
25% already had a complex needs worker / care coordinator
34% had a welfare / benefits / eligibility issue
76% had a housing issue that needed resolving
89% would have benefited from ongoing key work support
78% had experienced delayed discharge
82% would have benefited from step down care



Study Cohort Attendances October 2014 - September 2015

Guy's, St. Thomas' & King's	SLaM
56 Patients	22 Patients
472 A&E attendances	12 s136 attendances*
181 Admissions	28 Admissions
2561 Bed days	1634 Bed days 91 B&B days

14 'frequent attenders' accrued an average of 23.4 A&E attendances, and 9 admissions per person during the year

Study Conclusion:

Medical respite could save 4410.2 bed days per year across the 3 Trusts, with a potential to fill 12.7 medical respite bed spaces annually

The service review examined 7 operational projects and 3 decommissioned projects in the UK. 4 main models of support were identified:

- **Hostel based medium support with specialist clinical staff on-site**
- **A peripatetic medium-support service within hostels**
- **A stand-alone service**
- **Low level hostel / B&B support with nursing**

⇒ **All projects demonstrated that A&E attendance and admissions can be reduced in the client population served**

⇒ **Move-on has often been slow, as most clients admitted were tri-morbid, with high support needs, and substitute prescribing. Physical and cognitive disabilities have been common.**

⇒ **These projects have been primarily delivering complex case management interventions. Nursing care has not been required for many clients on a daily basis.**

⇒ **Projects delivered in 'wet' hostels have delivered sustained improved health outcomes for many clients (although unnecessary secondary care usage is often still reduced during the respite admission)**

⇒ **Projects with a high level of integrated planning with the Local Authority have been most successful**

⇒ **Models requiring a local housing connection for access have been unable to support many clients in need, reducing their potential bed occupancy**

⇒ **Pilot projects need adequate time to embed and prove their worth before being evaluated (2-3 years minimum)**

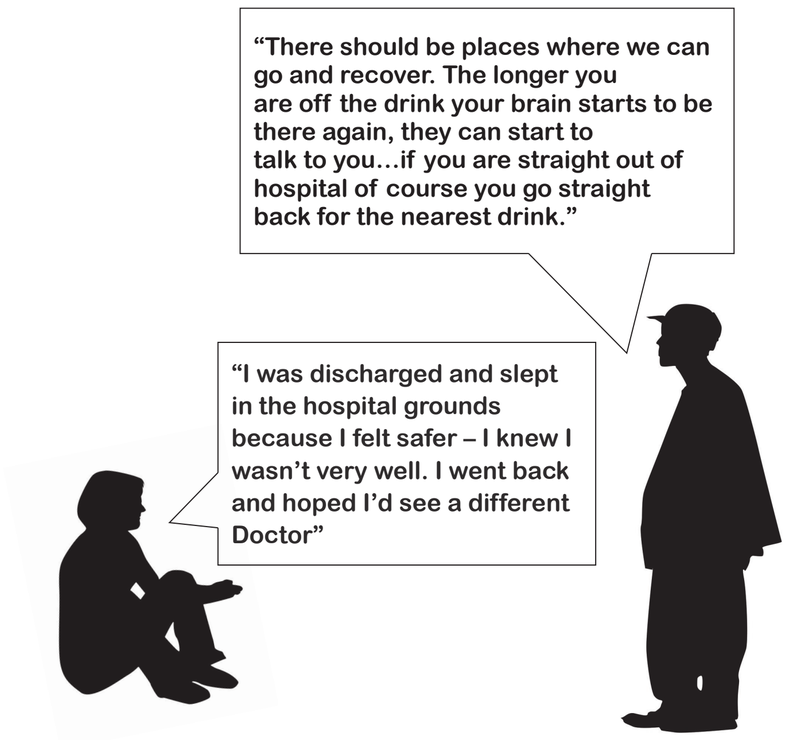
⇒ **Clinical leadership from a specialist homeless health service is beneficial**

Dilemmas

A number of dilemmas were identified and discussed in the review.

Should a project...

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



Doran K M, Ragins K T, Gross C P, Zerger S (2013) Medical respite programs for homeless patients: a systematic review. J Health Care Poor Underserved; 2013;24(2):499-524)

Hwang S, Burns T (2014). Health Interventions for People who are Homeless. Lancet 2014; 384: 1541–47

* Police Power to Remove a Person to a Place of Safety under the Mental Health Act 1984

What Do Patients Think?

Two focus groups, lead by a specialist nurse and a person with lived experience of homelessness were undertaken to support this work, and previous work in this area was reviewed. In summary:

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

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Contact us for more information about the report and Pathway homeless health care models:

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