
The Road to Recovery

A Feasibility Study into Homeless Intermediate Care

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On behalf of the Homeless Intermediate Care Steering Group

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Executive Summary

Literature Review

Health problems of homeless people

The health problems faced by homeless men and women have been examined comprehensively in recent years. Those living on the streets or in temporary accommodation have higher rates of infection and disease compared to the general population. For example epilepsy is four times as common among homeless people, asthma is twice as common and infections are twice as likely to be severe enough to warrant hospital admission. Tuberculosis and hepatitis are frequent diseases within the homeless population.

The relationship between homelessness and ill health is created by poor nutrition, long periods outside, drug and alcohol dependencies and mental health needs. The chaotic lifestyle of some homeless people also affects their ability to access health services, or cope with formal processes such as registration forms, appointment systems and waiting rooms.

Experience of health services

Barriers within health services also stop homeless people accessing timely services. Research has shown that GPs are reluctant to register homeless people both for financial reasons and a fear of the high level of needs homeless people have. The level of homeless people registered with GPs is low and consequently they make high use of A&E for primary care purposes. It has also been suggested that homeless people present at A&E with more advanced conditions and therefore are more likely to require inpatient care. Discharge from hospital is also a problematic area for homeless people, with many known to self-discharge, or be discharged to inappropriate accommodation or even back to the street, and often with no support package in place.

Intermediate care

It is thought that intermediate care could potentially fill this gap in health care for homeless people. Intermediate care services provide ongoing care in a non-acute setting. They are designed to:

- Avoid delayed discharges
- Prevent discharge to inappropriate accommodation
- Avoid unnecessary hospital admission
- Offer a period of recuperation and rehabilitation from illness or injury
- Equip someone with the skills to return to independent living.

Currently it is difficult for homeless people to access intermediate care services because of the lack of a discharge address on admission and because of their complex needs. There are currently no intermediate care services for homeless people in the UK. In the United States use of homeless intermediate care services is found to reduce readmission to hospital and reduce presentation to the Emergency Room, as well as having significant benefits to a homeless person's overall health.

Needs Assessment

Multiple needs

A variety of information on the homeless population of Lambeth was gathered which shows the multiplicity of need amongst the client group. The evidence showed that the co-morbidity of substance dependence and mental health issues is very common in the local homeless population.

The report presents new data showing that a higher percentage of homeless attendees at A&E are admitted than from the general population, suggesting that

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homeless people are presenting with more acute illnesses than the general population, matching national research on homeless hospital admissions.

Case studies

Case studies collated show the demographic range of homeless people suffering from complex needs and poor health, with both male and female clients, and ages ranging from late twenties to late sixties. In addition to multiple physical health problems people have mental health issues, drug and alcohol needs, mobility problems and a lack of basic living skills. Homeless clients in Lambeth are discharged from hospital without appropriate support packages in place and also without physical health care needs always being met.

The people discussed in the case studies could have benefited from a homeless intermediate care service in many ways, such as physical rehabilitation and therapeutic nursing, improved wound care, regulated medications, regular blood samples, as well as hydrating and feeding those suffering from malnutrition. Intermediate care could also be used as an opportunity for health promotion and as a way to explain a person's condition to them in greater detail.

Stakeholder and Service User Consultation

Primary care

The feedback from stakeholders builds a corresponding picture of homeless people's access to health services to that of the picture built by the literature review. Although it is felt that homeless people in Lambeth have opportunities to access primary care, with many hostels having close links with local GPs and the Homeless Team running clinics in various hostels and day centres, it is felt there are limitations. Those highlighted were a lack of case management and limited nurse prescribing, and the reliance on the homeless person to follow up onward referrals.

Secondary care

Homeless people's ability to access secondary services is then affected, either by not getting referrals to hospital or by not being able to access follow up care on discharge from hospital.

The chaotic behaviour of clients was seen as a key barrier to accessing treatment in hospital. Challenging behaviour, the need for alcohol and drugs and frequent self-discharge, as well as hospital staff's fear of homeless people, pressure on resources and difficulties in identifying homeless people on admission, all suggest that homeless people do not receive adequate treatment in hospital. Difficulties in determining a person's local connection and a lack of appropriate accommodation to discharge people to, as well as a lack of understanding of the roles of different services in working with homeless people, mean that discharge for homeless people is frequently problematic. Service users stated that they often felt stigmatised when presenting at A&E, and that other patients get prioritised over them, although it was also noted that having someone there to advocate for them in hospital appeared to improve the service they received.

Client engagement

Non-engagement is highlighted as a particular problem, with homeless people not prioritising their health problems, and chaotic lifestyles impacting on their ability to attend appointments and take medications. Drug and alcohol impacts heavily on many people's perception of their health needs and use of health services. Service users felt that hospitals didn't understand their substance use dependencies, and said that drug and alcohol issues are usually their reason for self-discharging. Service users also highlighted transport issues as a major problem in accessing hospital services.

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Response to Intermediate Care Options

Enhance the current intermediate care facilities in Lambeth

Key benefits to this option that stakeholders noted are that it would be mainstreaming the clients; that the staff are experts in delivering nursing in an intermediate care setting; and that links with general practice already exist. Disadvantages are the disparity between the mostly elderly general patients and homeless patients, who would often cross all age groups and may be chaotic; the need for a discharge address on admission; the complex needs of homeless people; and the need to be registered with a GP. Service users felt the current service would not be able to cope with homeless people's substance use problems and this was the main barrier to them accessing this option, although others felt this option would be good as it would give people the chance to have a break from drinking.

Develop a nurse-led floating support service to case manage homeless people for a period of intermediate care

Advantages to this option that people voiced are that as a non-building based service it has the ability to be very flexible; it could work in partnership with a variety of agencies in order to engage clients; and for clients in accommodation it would help them maintain that accommodation. Service users also felt that a key benefit to this option is that they would not have to leave familiar surroundings, and that it would be useful to have someone to support them around attending appointments and taking medications. Disadvantages are the restricted level of care such a service could provide - a concern also voiced by service users; the limited resources and issues created by the physical environment in which the service would be administered; and the difficulties of engaging a client with a visiting service.

Create a nurse-led intermediate care unit within an existing homeless hostel

Benefits to developing such a service are that alongside the nursing staff there would be access to a range of staff familiar with dealing with challenging behaviour, as well as mental health and substance use staff. This option would create opportunities for continuity of care, as clients who moved into the main hostel after completing a period of treatment in the unit would be able to continue to work with specialist staff. The flow of information between the nursing staff in the unit and any primary care staff working with the main hostel clients would be smooth. The hostel would have a well-established resettlement process, which would be beneficial. Disadvantages suggested are that staffing the unit would be expensive, and recruiting and retaining nurses to work in such a service would be problematic; also the practicalities of managing the unit; and the overall expense of running it. This option generated strong feelings from service users both in support of it and against it. They felt that it would be good to get nursing care in a place where the staff understood their substance use issues; the hostel environment would be one they were familiar with, and it might be easier for their friends to visit them there. But some people thought that this type of service would be second class health care, diverting homeless people away from mainstream services to the benefit of hospitals, not homeless people, and that it would be difficult to manage the expectations of residents in the main hostel.

Recommendations

Although the main objective of the study was to assess the need for a homeless intermediate care service, through the process of collecting data and consulting with stakeholders, a number of other issues were highlighted. These have been discussed in the recommendations section of the report. The steering group will be developing an action plan in response to these recommendations.

Background to Study

The Homeless Intermediate Care Steering Group, which consists of people from Lambeth Primary Care Trust (PCT), the voluntary and statutory sectors and others working in homelessness, has been meeting since 2003 to develop the idea of an intermediate care service for homeless people. This report is the outcome of the steering group's successful bid for a feasibility study. The aim of the study was to carry out a literature review, assess the need for a homeless intermediate care service in Lambeth, and to consult stakeholders on three proposed options of providing such a service.

The three options are:

- Enhance the current intermediate care facilities in Lambeth – i.e. focused training and information to better equip them to take homeless patients
- Developing a nurse-led floating support service that would visit clients in their hostel/accommodation or other environment
- Create a nurse-led unit within a hostel environment – i.e. 8-10 beds that would have nurses on shift where clients could receive intensive health care support.

For the purposes of this study, a homeless person is defined as a single person sleeping rough or living in a hostel or other temporary accommodation, usually with complex needs in addition to his or her housing status.

Homeless people often have poor physical health, with conditions reaching a more advanced state before they receive treatment. They have difficulty accessing appropriate primary and acute care because of their transient nature and complex needs, and when they are admitted to hospital their discharge is often problematic because of their housing status. Intermediate care has been recognised as a way of facilitating appropriate discharge for the general older population who need transitional health care after a hospital stay, or as a way of avoiding unnecessary hospital admission, and it has been suggested that the successes here could be replicated for others with complex needs. The Royal College of Physicians issued a definition of intermediate care as 'services that do not require the resources of a general acute hospital, but are beyond the scope of the traditional primary care team. These can include "substitutional care" and "care for people with complex needs"'.¹

Homeless people currently are often unable to access existing intermediate care services because of their complex needs and lack of discharge accommodation, and therefore do not receive adequate after care or support during an illness when rough sleeping or living in a hostel.

An intermediate care service for homeless people would be an opportunity to improve health interventions for this client group. Although intermediate care is not a substitute for appropriate hospital admission or accident and emergency (A&E) care, it is an opportunity to decrease inappropriate A&E attendances and admissions to hospital, and facilitates reduced hospital stays and appropriate discharges. A specialist service would enable homeless people to access health care in an

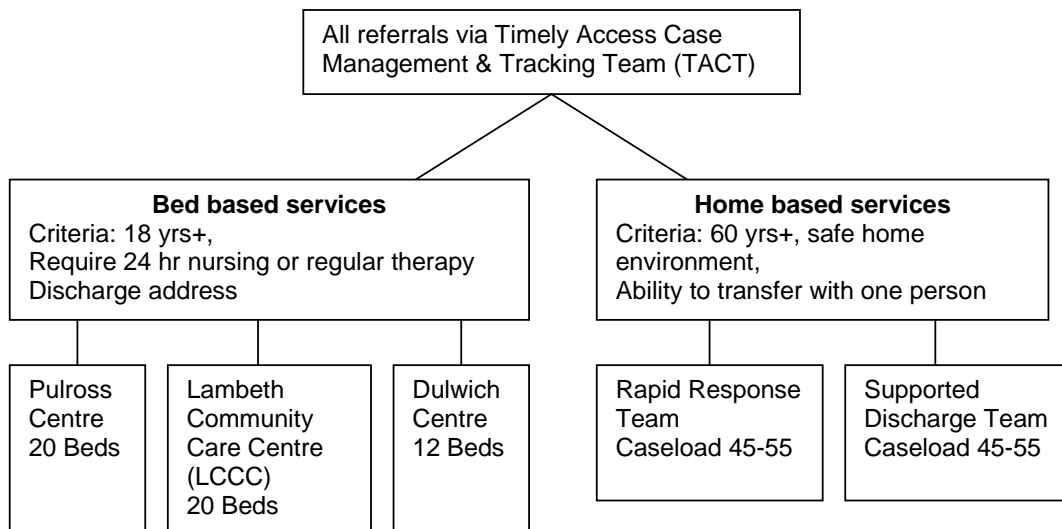
¹ Black, C. Black, D. Alberti, G. Intermediate Care: Statement from the Royal College of Physicians of London: http://www.rcplondon.ac.uk/college/statements/statements_interm_care.htm

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environment designed to foster the highest level of engagement from this complex client group. Partnered with agencies that are experienced in mental health, substance use and challenging behaviour, such a service would be able to offer nursing care, rehabilitation and therapies to homeless people who currently have problems accessing physical health care.

Such a service could sit either under the umbrella of current Lambeth intermediate care services, the homeless sector or the Three Boroughs Homeless Team, or across all three. A new intermediate care service needs to be strategically rolled-out with a commitment to long-term planning, long-term leadership and clear evaluation processes. Clear admission and departure criteria will ensure the system runs smoothly, but there also needs to be a level of flexibility to support fluctuating local needs, the needs of referral agencies and the skills and development of the team and service.

Current intermediate care services for Lambeth (and some Southwark) residents are:



Literature Review

Introduction

The health issues of single homeless people have been covered extensively in literature over the last decade, in particular homeless people's use of and ability to access general practice or A&E departments. Literature often focuses on the disparity between the government's agenda on health inequalities and the low life expectancy and poor health quality of homeless people, and barriers to primary care.

There has also been much discussion of intermediate care and the different models in practice. Debates on intermediate care focus heavily on its benefits for older people and as such current models discussed usually have older people as their subject. There appears to be very little on the concept of single homeless intermediate care provision in the UK, primarily because there are no models. In comparison, several other European countries, and also Australia and the United States, currently have homeless intermediate care provision.

Health Needs

There is a variety of evidence to suggest that there is a wide range of health issues in the homeless population. A frequently cited Crisis report states that the life expectancy of a rough sleeper is 42 years. Several studies have compared the health of homeless people to the general population and selected findings from North (1996), Bines (1994) and Acheson (1998) are that:

- Homeless people's injuries are four times more likely to be the result of an assault
- They have twice the rate of infected wounds, and these infections are twice as likely to be severe enough to warrant an admission to hospital for further treatment
- Asthma is twice as common
- Stomach ulcers, gastritis and liver disease are all more common
- Epilepsy is four times as common
- Digestive problems are at least twice as common among rough sleepers
- Mental health issues are eight times as high among hostel and B&B dwellers
- They have a higher prevalence of bronchitis, tuberculosis, arthritis, skin diseases, infections and health problems related to alcohol and substance misuse

Croft-White and Rayner (1999) note that homeless people are particularly vulnerable to several major communicable diseases, such as hepatitis B and C, tuberculosis and sexually transmitted diseases.

Warnes (2003) discusses how the homeless lifestyle has a striking impact on people's health. Rough sleepers are exposed to the cold and damp and are at risk of hypothermia. Skin infestations such as scabies and lice are common. They may spend long hours standing in public places or walking around the streets, which leads to musculo-skeletal and circulatory problems such as arthritis, leg ulcers and oedema and cellulitis.

Bunce (2000) suggests that homeless people might also find it hard to maintain a good diet: approximately 50% may have only one regular meal a day, with the rest eating sporadically. A lack of money and an irregular lifestyle can make it impossible

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to plan the next meal, and drug and alcohol dependencies and mental health issues mean that regular meals are unlikely to be a priority. Poor nutrition also increases the risk of infection.

Drug dependency is a prevalent issue amongst homeless people, and Wright (2004) details the multiple morbidities that occur in intravenous drug users including viral hepatitis (B and C), HIV infection, deep vein thrombosis, pulmonary embolism, septicaemia, encephalitis, endocarditis, cellulitis and abscesses. Users will often be taking multiple drugs, with crack and heroin a familiar combination. The importance of harm reduction work and drug treatments is highlighted.

Wright also highlights the medical problems homeless people with a chronic alcohol dependency may suffer from, such as gastrointestinal, hepatobiliary, neurological, cardiovascular or metabolic complications along with depression and suicide. Other mental health problems range from schizophrenia, drug-induced psychosis, anxiety states, affective disorder, and 'personality disorder'. Dual diagnosis – mental health and substance misuse – is common in homeless people.

The Royal College of General Practitioners issued a statement on homelessness and primary care which says that homeless people may experience difficulty in accessing health care and health may be a secondary priority, meaning health problems only get addressed when they become acute. It suggests several reasons for homeless people not registering or visiting a GP such as depression, low self-esteem, low health priorities, or that they may find it hard to locate a GP who will register them. It highlights the complex needs of homeless people, who may have mental health or literacy problems, chaotic lifestyles or a lack of social skills, that impinge heavily on their ability to cope with the registration forms, appointment systems, busy waiting rooms and long waits. Others do not recognise the severity or seriousness of their ill health, or mistrust doctors. Some report being embarrassed about seeking help because they are dirty or unkempt, and fear being stigmatised by staff or other patients.

Government Agenda and Health Inequalities

The Homelessness and Housing Support Directorate in the ODPM aims reduce the number of rough sleepers and to ensure there are high quality support services available to enable people to overcome homelessness, or to prevent it. The government has also developed a Hostels Capital Improvement Programme to fund remodelling and improvements into service delivery so that hostels can provide better opportunities for homeless people to move on to independent living.

In recent years the government has placed a strong focus on health inequalities, and although the NHS Plan does not specifically mention homeless people its core principles include:

- The NHS will provide a universal service for all based on clinical need, not ability to pay
- The NHS will respond to different needs of different populations
- The NHS will help keep people healthy and work to reduce health inequalities.

It also points out that health equality can only be met by a partnership between health and local services. The NHS makes health inequalities a key priority in the Priorities and Planning Framework 2003-06.

The Cross Cutting Review on Tackling Health Inequalities identifies homeless people and rough sleepers as one of the vulnerable groups with poor health outcomes who

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would benefit from targeted interventions, such as designing services that can meet their complex needs and taking a holistic approach and joining up services at the point of delivery. In order to encourage joint working the Homelessness and Housing Support Directorate has also developed shared outcomes on health and homelessness for local authorities, PCTs and other agencies involved in homelessness to collaborate on (ODPM & Department of Health 2004).

The Department of Health (2003) has also stated that acute hospitals should have formal admission and discharge policies to identify homeless people on admission, and their pending discharge notified to relevant primary health care services and to homeless services providers. Homeless Link are in the process of finalising guidelines for hospitals on developing protocols around the admission and discharge of homeless people.

Inequities in health services have been comprehensively discussed. It is generally considered that for a service to be equitable it should depend only on the individuals need for treatment, and not on factors that are irrelevant to that need. But research by Dixon et al (2003) highlights different understandings of 'need' – it can be defined as health status – the worse the status, the greater the need. But it can also mean someone's 'capacity to benefit' from the treatment, i.e. those that present at an earlier stage have a greater capacity to benefit, and therefore better outcomes, than those that present with more advanced disease, and therefore worse health status, which would include homeless people. It is noted that capacity to benefit is *very hard* to measure.

Dixon details several sources of disadvantage in health equity, and homeless people can experience all of these:

- Distance and transport
- Employment and personal commitments such as caring responsibilities, loss of earnings, pets
- Voice i.e. lack of ability to demand better services, articulation, confidence and persistence. Also level of patient – doctor communication and ability to elicit correct info / or interpret conveyed info. Poor health literacy, misinterpretation of symptoms, confused diagnoses, vague description of symptoms
- Health beliefs and health seeking behaviour – lack of knowledge of family health history; fear of hospitals/operations/medical tests; fatalistic view of health – view selves as 'old' much younger than richer people; normalising of pains; negative experiences of health care; lower expectations of health services.

Those from lower socio-economic groups often don't go to the doctor, or present at a later stage, or go to A&E rather than a GP and when well, do not access prevention services as often as the better off. When they have made contact they often experience lower rates of referral to secondary tertiary care, lower rates of intervention relative to need, and lower and irregular attendance at chronic disease management clinics.

Experiences of health services

Much has been written about homeless people's access to general practice. The 2003 Lambeth Homelessness Review states that 'a high proportion of homeless people do not have a GP when presenting at hospital.' Bunce (2000) details a survey of London rough sleepers by the Simon Community that found that 28% were registered with a GP, with half of these inappropriately registered with a GP outside

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London. Bunce also suggests that many GPs are less inclined to register homeless people as permanent patients as they fear an 'avalanche of need', and that because GPs are paid for certain items of service on a target basis, they may be reluctant to register homeless people as they may then not be able to meet these targets and will therefore receive no payment. This is backed up by Griffiths (2002) who states that there are strong financial disincentives for GPs to register rough sleepers, especially if the person is believed to be transient. Bines (1994) suggests that although the majority of single homeless people are registered with a doctor, many more single homeless people are not receiving treatment for their health problems than are receiving treatment. Wright (2004) notes that because of personal medical services developments numerous specialist services for homeless people have been set up in the last decade, and that the recent nationally enhanced GP contract may offer incentives for the care of homeless people.

Past studies have shown that homeless people are frequent visitors to A&E units. Bunce suggests that single homeless people are five times more likely to use A&E units than the housed population, although he also found alternative suggestions that homeless people are probably less likely to use A&E as they fear being looked at by other patients, but that this would lead to more advanced untreated conditions and therefore they would be more likely to require inpatient care. North et al (1996) examined homeless people's use of one A&E unit in comparison to the general population. They found that 57% of all visits to the department by homeless people could be classed as inappropriate to that acute clinical setting. The study states that although these clients were expensive in terms of staff time and overheads, the treatments were relatively cheap. Many of these treatments could have been dealt with by a GP for a third of the cost.

North has discussed the importance of the provision of health and social care in hostels, suggesting that it has direct beneficial effects in giving homeless people better access to health care within the primary health care setting, while protecting the role of A&E as a specialist emergency centre. Hewett (1999) asked homeless people how they felt about specialist health services or facilitated access to mainstream services, and 84% preferred a specialist service. Generally, literature suggests that repeated inappropriate use of A&E means that continuity of care and health promotion opportunities are missed.

Scheuer et al (1991) states that homeless people are relatively more likely than local resident populations to make unplanned use of hospital services, and that unplanned admissions and problematic discharges result in a significant cost factor and a reduction in capacity to admit other patients. Stern et al (1989) finds that 9% of the general population have a stay in hospital in over twelve months, in comparison to 25% of homeless people. Waters (2000) finds that 78% of Shelter projects have seen clients who were discharged from hospital to inappropriate housing, and even on occasion to no accommodation at all. This evidence also suggests that support packages are often not put in place for homeless patients. Riley (2003) finds that rough sleepers are discharged into potentially unhealthy living conditions, and claims a reduction in hospital social workers has a part in this. In addition, lack of support in the community means that homeless mentally ill patients experience delayed discharges because of the difficulties in finding adequate supported accommodation.

Discharge for homeless people is further complicated by the issue of reimbursement. Department of Health (2003a) guidance on delayed discharges states that Social Services are liable for reimbursement if a person's discharge is delayed because of a failure to assess the person or to provide adequate services to facilitate their return

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home. If the patient is waiting only for accommodation, reimbursement does not apply.

Masson and Lester (2003) carried out a study into the attitudes of medical students towards homeless patients, finding that there was a significant negative change in their attitude over the course of their training. Most of the students surveyed thought that some doctors viewed homeless people as less worthy of medical care than other patients. Bunce also notes that health care staff can have a negative perception of homeless men and focus on them as 'problem patients'.

Intermediate Care – what it is and what functions it can cover

Stephenson and Spencer (2002) provide an in-depth discussion of intermediate care, and have detailed the Department of Health perspective. There are several definitions of intermediate care but the Department of Health has set a standard definition in order to 'ensure a consistent approach to developing, monitoring and benchmarking services'. An intermediate care service should meet the following criteria:

- Targets people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care, or continuing NHS in-patient care
- Is provided on the basis of comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- Has a planned outcome of maximising independence and typically enabling patients/users to resume living at home
- Is time limited to normally no longer than six weeks, and frequently as little as one to two weeks or less
- Involves cross professional working, with a single assessment framework, single professional records and shared protocols.

The Department of Health suggests that intermediate care should form part of a seamless set of services linking health promotion, preventative services, primary care, community health services, social care support for carers and acute hospital care. Regardless of the Department of Health definition, much has been written about the lack of an agreed definition or concept of intermediate care, stating that it makes it difficult to identify gaps or benchmark services. Melis (2004) suggests this lack of agreed definition is attributed to the fact that the concept of intermediate care arose out of a policy imperative - to reduce the number of inappropriate admissions or to reduce delayed discharges - rather than out of any scientific evidence about effective models of care.

Stephenson and Spencer define what intermediate care is not: it is not transitional care pending longer-term placement, and it is not the same as rehabilitation as part of acute hospital care. It is not about marginalising people from mainstream services, and it should not be the sole responsibility of one professional group. Intermediate care is often nurse led and in terms of homeless people this has many benefits. In a non-acute setting nursing has the opportunity to be more patient focused, can encourage self-care, offer a balanced diet, and recovery time from a stabilised condition, all of which is particularly important for homeless patients who, as already discussed, have very complex individual needs, poor self-care, are malnourished and do not have a quiet environment where they can concentrate on recuperation through intensive occupational therapy and physiotherapy. In acute care services concentrate on disease management whereas in intermediate care the

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focus is person centred, and this difference in focus is one of the reasons why intermediate care would benefit homeless people, who are often familiar with and respond well to individually tailored care, as shown in supported housing.

One of the criteria for intermediate care is partnership working and this is of great importance to homeless people because of their complex needs. As previously discussed, homeless people are discharged to inappropriate housing or even no housing, and often without any sort of support package. This can lead to a break down in the resettlement process and the withdrawal of any mental health or substance dependency work being carried out with the client. The very nature of intermediate care is to ensure a whole systems approach to recovery, and therefore it would be a familiar process in intermediate care to not only re-establish or maintain links between homeless patients and services specific to their needs, but to ensure a jointly developed approach to care and support during and beyond an individual's period in intermediate care.

Wytham Hall in Westminster is currently the closest model for homeless intermediate care in the UK. Wytham Hall is a 14 bed registered care home that aims to provide short-term accommodation and medical and social care to sick homeless people. It has doctors on site. Admission into Wytham Hall entails a community care assessment and an agreement to fund the placement. It is not a replicable model as it uses volunteer medical students.

Intermediate care – good practice

Most literature on good practice in intermediate care focuses on older people's services, but the objectives of care are general and therefore transferable across all services. Stephenson and Spencer suggest that quality services will be patient centred, developing individual care plans; will foster active rehabilitation; be part of a multidisciplinary approach to improved health and social care with all partners recognising they are interdependent; and be time limited with clear entry and exit points into the service with well managed transitions.

Vaughan and Lathlean (1999) discuss several factors that are of particular importance when setting up an intermediate care service. Recruitment of staff needs to be well planned with strong management, good staff development programmes and challenging and fulfilling work. Intermediate care offers the opportunity for nurses and therapy staff to have greater authority or involvement in the assessment and admittance of patients and this could be explored. They suggest cross-skilling as good practice in intermediate care, with different occupational groups and specialities sharing skills, care assistants supporting nurses and therapists, and where schemes can be run jointly by nursing and therapy staff. This can be applied to intermediate care within the homeless sector, where hostel staff and specialist substance use and mental health workers could share skills with nurses and therapists.

The Health and Social Care Change Agent Team provide details of a number of good practice models of intermediate care on their website. Although there are no intermediate care services targeted at homeless people, some are available to older homeless clients. For example, in South Gloucestershire, three units within sheltered housing are available to people in need of active rehabilitation after acute care, including homeless clients who need extra care and support. Southampton ran a four-bed project for people who were bed-blocking for housing related reasons and over the course of four years seven homeless people were admitted. In Merseyside,

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there is a scheme to provide transitional tenancies in extra care and sheltered housing which are used to prevent older homeless people ending up in residential care unnecessarily. The transitional tenancy is an opportunity to assess the client's needs and find more appropriate housing.

Summary of similar units abroad

Other models of homeless intermediate care exist in countries where homeless clients display comparable traits to homelessness in the UK. For example, high substance use, mental health and challenging behaviour.

Van Laere (2005) details facilities available to homeless people in Amsterdam. The Salvation Army Shelter Infirmary and HVO hostel have offered intermediate care beds since 1994. People can be admitted through the Ambulatory Medical Team, social workers, police or other health professionals and can be admitted immediately. They are assessed for substance use, mental health, physical health and social situation and a treatment plan developed crossing all necessary disciplines. Nurses administer medicines including methadone through daily observed therapy and social workers, mental health workers, doctors and hospitals and local pharmacies are closely involved in the care plan. In 2001 out of 142 admissions 87% were admitted once and 12% twice. Almost half stayed for almost two weeks. Most patients had multiple health issues with trauma, respiratory and skin problems the main reasons for admittance. One in five were moved on to either nursing home or general hospital, and almost half left with destination unknown. Similar facilities exist in other cities in Holland.

Story (2004) discusses a mobile team in Paris that makes contact with the street homeless every night, offering health, social care and accommodation. They can refer people to medical and nursing care, including intermediate care beds. A mobile TB project provides TB screening and daily observational therapy to homeless people. It also has access to a 10-bed TB treatment centre. The TB team has one doctor, two social workers and a driver, and manage approximately 40 hard to treat cases a year. The 10-bed centre has shown significantly improved treatment outcomes for patients.

In the USA there are respite programs for homeless people in more than 35 cities. There are a variety of different models, including stand-alone centres and wards within homeless shelters. They are for homeless people who are in hospital and need a period of recovery after an illness or injury, or for homeless people who are ill, but not ill enough for an acute hospital admission. In Seattle the Medical Respite Program runs 17 beds for men within the Salvation Army William Booth Center and 5 beds for women within the YWCA. Both are laid out in a ward style rather than individual rooms. These provide short-term nursing care and recuperation. Nurses are available during the day, and doctors are available on-call. Non-clinical staff are available 24 hours. Nurses see each patient once or twice a day to monitor medical problems, do wound care, and provide health promotion information, carry out TB testing and administer medication. A psychiatrist and chemical dependency counsellor are also on staff. In Dayton, Ohio, the Good Samaritan Hospital runs a respite care program in 4 apartments, case managing the clients and offering medical supervision, meals three times a day, links to other services and transport for outpatients appointments, and patient advocacy for health and social services.

An evaluation of respite services in the USA concluded that discharging homeless patients to a respite service prevents readmission to hospital, and that there is a reduced trend to Emergency Room visits, and that the overall cost savings exceeded

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the costs of respite care. The time spent in a respite centre was found to be significantly beneficial to a persons overall health. The average length of stay in a respite centre is 44 days.

In Melbourne, Australia, the Sister Francesca Healy Cottage is an intermediate care service for homeless people. It is a six bed step-down from the local hospital, which is a few minutes walk away. Referrals are assessed by a nurse and must be medically stable before admission. The service offers care and support for maximum seven days, providing medication and treatments, meals, and personal assistance, with the emphasis on education and restoring independence. Move on must be in place prior to admission. Care attendants are rostered 24 hours, and a nurse is available. The cottage works closely with other disciplines to ensure a patient gets the most out of their stay, with specialist nurses, social workers and counsellors available from the local hospital. Some homeless hostels in Australia also have nurse-run sick bays.

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Methodology

A literature review was carried out in order to present recent findings on homeless people's access to health services and their health care needs, and to examine research on intermediate care. Sources used to gather information included the King's Fund reference library, which provides resources on health and social care; Medline, a bibliographic database providing online access to abstracts and citations from world wide medical journals; and Athens, the gateway to the NHS electronic library.

To compile the needs assessment existing information was pulled together from a range of sources in order to build a picture of the health needs of Lambeth's homeless population. Both quantitative and qualitative data was sourced.

A large part of the research consisted of interviewing stakeholders about their opinions of the health needs of homeless people, and their thoughts on the proposed models of homeless intermediate care. 29 people were interviewed. This included people from the voluntary sector such as hostel managers, day centre managers and the street outreach team. Health professionals were also consulted, including GPs, a discharge coordinator and A&E consultant, managers from the Three Boroughs Primary Health Care Team, and people working in intermediate care services. Within the statutory sector consultation incorporated the Drug and Alcohol Action Team, Lambeth Crime Prevention Trust, Supporting People, the Housing Department and Social Services. All interviews were recorded. Topic guides were sent to all interviewees in advance. Topics varied slightly depending on the interviewee's area of work but everyone was offered the opportunity to discuss:

- The perceived unmet physical health needs of the local homeless population
- Homeless people's access to primary and secondary care
- Communication between hostels/appropriate service and hospitals
- Discharge from hospital and issues of after care
- The advantages and disadvantages of each of the proposed models of homeless intermediate care.

When reaching the discussion of the proposed models, each person was referred to the topic guide in front of them and the brief definitions of each proposed model, and given a further verbal explanation. Interviewees were initially invited to suggest possible benefits and problems to each model, although they were only prompted again to comment on each model where it felt this was appropriate, for example in some interviews participants did not follow the order of the models and suggested closure to this section of the interview themselves. In these cases, it was felt the interviewee had nothing further to add on the models, and to prompt them would have been forcing an opinion where one did not exist. In other cases, interviewees addressed the advantages and disadvantages of each model in turn, with occasional prompting. It is also worth noting that prompting did not always elicit an opinion, for example, on asking if the interviewee could think of any advantages to a model, they may have said 'no', and moved on the next model.

A stakeholder event also took place to feedback information and opinions gathered up to that point. Attendees included both those interviewed during the consultation process and people new to the study. Workshops were held to discuss the proposed models.

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Four focus groups for service users were also held, with a total of 22 participants. Two focus groups were held at Thames Reach Bondway projects, where a peer researcher facilitated the discussions with Sarah Gorton, a member of the Steering Group, and two focus groups were held at a St Mungo's hostel, facilitated by Robyn Lane. All focus groups were recorded, and participants were given vouchers and travel expenses where appropriate. All focus groups followed the same topic guide and discussions covered the following subjects:

- Experience of A&E departments
- Experience of hospital admission and discharge
- After care issues, or issues of being ill and rough sleeping or living in a hostel
- The advantages and disadvantages of each of the proposed homeless intermediate care models.

As with the stakeholder consultation, a verbal explanation of each of the proposed models was given before discussing them in the focus groups.

Needs Assessment

Demographics of homeless population of Lambeth

Homeless Team data

Part of the Three Boroughs Primary Health Care Team, the Homeless Team provides health care to homeless people through open-access clinics in day centres and hostels throughout Lambeth, Southwark and Lewisham. The following data is taken from presentations at clinics in Lambeth July 2004 – June 2005, when the team saw 887 clients.

Age Bands	%
17-25	10%
26-30	8%
31-40	21%
41-50	26%
51-60	17%
61-65	4%
65+	5%
Unknown	9%

Race & Ethnicity	%
British	57%
Any other white inc. Irish	19%
Caribbean	6%
Mixed ethnicity	5%
African	5%
Black other	3%
Asian	2%
Other	2%

Gender	%
Male	71%
Female	29%

35% of the Homeless Team's Lambeth clients are known drug users, and over half of those are using intravenously. 53% of the team's Lambeth clients are known drinkers.

The most frequent problem clients see the Homeless Team about are skin problems. Infectious disorders, respiratory and digestive problems also occur regularly, with hypertension and musculo-skeletal problems also causing concern for clients.

The Stockwell Project data

The Stockwell Project is an advice centre for drug users. It offers advice and support on housing, benefits and legal issues, and runs a needle exchange. It runs a homeless clinic at the Pavilion Centre in Brixton, where in 2004-2005 91% of clients had a primary health care assessment, and 27% of clients were admitted to hospital. 91% of clients were on a methadone script.

The Stockwell Project also anonymously analyses risk behaviour of all its clients (its client group is made up of vulnerable drug users, both housed and homeless) at the main centre in Stockwell. 31% of clients take part in direct sharing needles, and 66% participate in indirect sharing. The frequency of sharing is also examined, with 11% frequently sharing. Only 44% never share needles, and only 26% always used a condom.

St Mungo's data

St Mungo's is a large provider of accommodation for single homeless people in Lambeth, with 177 bed spaces in the borough, so demographic data for their clients

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is a reasonable indicator for the sector in Lambeth. Between August 2004 and July 2005 St Mungo's made 172 lettings in Lambeth. Of these:

Race & Ethnicity	%
White British	47%
White European	13%
Black British	9%
White other	8%
Of mixed race	8%
Black Caribbean	4%
White Irish	3%
Black African	2%
Asian	1%

Gender	%
Male	81%
Female	19%

Age Band	%
18 - 29	24%
30 - 39	42%
40 - 64	34%

St Mungo's Cedars Road client needs 2005

Cedars Road has 120 beds.

Preliminary findings from St Mungo's annual client needs survey suggest that:

- 61% of clients at Cedars Road hostel have more than six needs other than their housing need. Every client has at least two needs.
- 56% have a physical health need
- 67% of all clients are engaging with the primary health care team
- 15% have had a recent hospital stay for a physical health issue.
- 93% of clients have a substance use need
- 61% of clients have a mental health need
- 72% of clients have a lack of basic living skills.

CHAIN

CHAIN is a secure, web-based client recording system used by outreach teams and hostels to record contacts made with rough sleepers across London. According to CHAIN, between August 2004 and July 2005:

- 346 clients had a street contact in Lambeth
- 35% of rough sleepers in Lambeth had a physical health need
- 36% had an alcohol need
- 48% had a drugs need
- 23% had a mental health need.

Between April and September 2005 the Lambeth SPOT made 26 contacts with clients in hospital.

A&E statistics

A list of hostel and day centre addresses in Lambeth were compared to addresses provided for attendances to Kings and St Thomas' A&E departments between April and June 2005. There were 167 attendances from the addresses provided. No one attended more than once.

- 37% of attendances were from females
- 51% arrived at A&E by ambulance, compared to only 25% of the general population
- 25% were admitted to hospital, compared to only 16% of the general population

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- 10% were referred to their own GP
- 8% did not wait to be seen

The high percentage of attendances by ambulance and the increased number of admittances to hospital suggests that homeless people are presenting at A&E with more acute illnesses than the general population. Anecdotal evidence suggests that those who did not wait to be seen left because of the need to drink or take drugs, or because they are intimidated by the formal environment.

Recent research findings

Drug users in Lambeth: An Assessment of Physical Health Care Needs, by Dr Simon Cathcart

- The above report on the physical health care needs of drug users in Lambeth addresses in part the needs of homeless drug users. The report estimates that there are 3000 problem drug users in Lambeth with approximately 500 of them homeless.
- The physical health problems of drug users are blood borne viruses (hepatitis B & C); bacterial infections; overdose; trauma; poor dentition; injury; hypertension; asthma; gastro-intestinal problems; heart disease; neuropathy; anxiety and depression. Physical health issues possibly associated with crack include skin itching, oral and vaginal ulceration, respiratory symptoms, and weight and nutritional problems. Hepatitis A has been recently identified as a problem among those with poor hygiene, e.g. the homeless.
- Transmission of sexually transmitted infections among female sex workers may be exacerbated by vaginal dryness and oral ulceration due to crack use. Condom use has reportedly decreased. It has also been observed that crack cocaine use by women has an inhibitory affect on their use of health services. (Sex workers make up a proportion of the homeless population, and there are dedicated beds for this client group within homelessness provision in Lambeth.)
- Problems such as poor health, inadequate hygiene and alcohol compound drug related morbidity among homeless users. They are a 'hard to reach' group who require innovative methods to get them into services.
- Improved services for homeless people such as injecting rooms, access to water for injecting and supervised dispensing need to be considered.
- Crack users may be difficult to engage in treatment and need effective therapies when they present to services. Cognitive behaviour therapy has been used and 'Indian head massage' is a popular choice among clients.

Consultation feedback on physical health conditions

During consultation, stakeholders were asked about the physical health conditions that they had seen in homeless people recently. It was suggested that 'they have different health needs and more enhanced health needs... than the general population'. Mental health was discussed, with depression and substance induced psychosis particularly highlighted. Mental health and social isolation were noted as contributing to homeless people's poor physical health, such as orthopaedic problems from self-inflicted injuries, and violent injuries sustained from their social vulnerability.

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Poor diet and a lack of interest in food are considered a large problem for the homeless population. Many clients were considered to be 'run-down' generally, and people stated that people's health needs were usually acute because they did not seek treatment until their conditions were advanced. It was noted that homeless people 'have a multiplicity of need which is not common in the general population even amongst the poorest people.'

The following health problems were highlighted by a variety of stakeholders:

- Musculo-skeletal problems
- Head injuries
- Limb injuries
- Broken bones from falling over or being hit by cars
- Falls and seizures associated with intoxication
- TB & drug-resistant TB from not seeing through a course of treatment
- Chronic airways disease
- Asthma
- Chest infections
- Pneumonia
- Chronic bronchitis
- Coronary heart disease
- Skin infections
- General cuts, gashes and wounds frequently become infected
- Abscesses due to injecting drugs including groin and arm abscesses
- Cellulitis of the legs
- Sepsis of the joints
- Bowel problems
- Diverticulitis
- Twisted bowel
- Advanced stage cancer
- Diabetes
- Lacerations
- Sores
- Deep vein thrombosis
- Endocarditis
- Streptococci
- HIV
- Hepatitis A, B and C
- Liver failure
- Immune system breakdowns
- Poor dental health
- Amputations
- Malnutrition.

It was estimated that 75% of street homeless people in the borough would, or at least should, be hospitalised in the next six months. Also, in one large first stage hostel in Lambeth, out of 120 residents only 3 or 4 were estimated to not have any medical problems that staff needed to monitor.

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Case Studies

The following case studies have been sourced from a variety of teams working with homeless people in Lambeth. They illustrate the range of health issues and situations that arise for this client group. While reading these, please consider to what extent each of the proposed options of homeless intermediate care would meet their needs.

Three of the more detailed case studies also include a map of an actual and a potential pathway through services, to suggest how intermediate care could have affected the outcome of these cases.

START team case studies

The START team is a community mental health outreach service for homeless people in Lambeth, Southwark and Lewisham. The team works to engage homeless people with mental health problems who are not currently engaged with mental health services, with the aim of reintegrating clients into mainstream services.

Case study 1

A female client of the START team went into hospital on a section, where doctors discovered she was suffering from advanced cervical cancer. The client gave consent for radiotherapy, although the START team felt it was probable that she did not really understand her condition and therefore what she was signing. She was discharged to a supported housing flat with the expectation that she would return for outpatient appointments. She abandoned the flat immediately and was later found dead in a B&B. The START team have suggested that if she had been able to access a homeless intermediate care service it would have been able to offer her more therapeutic nursing, and could have worked with her to help her to understand her treatment better and to facilitate attendance at outpatient appointments.

Case study 2

A male client of the START team, who was a heavy drinker, had liver failure and was in hospital for a week. He had ascites, where his abdomen had swollen causing him to have difficulty breathing, and frequent vomiting. He was discharged to a flat but was unable to look after himself properly. He was unable to process food and drink properly and was therefore very weak. The client has managed to remain in his flat but rehabilitation has been slow. A three-week period of intermediate care on discharge from hospital would have been ideal for this client, according to the START team. The client would have benefited from some intensive nursing support and occupational therapy to get him used to looking after himself in his own flat.

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Case Study 3

This male rough sleeper, in his early thirties, was HIV positive and epileptic. He was also an IV drug user and had mental health issues. He did not take his epilepsy medicine and was having fits every few days, collapsing and banging his head, or injuring himself in some other way. He was also regularly beaten up on the street, quite severely on occasion, and so was constantly presenting at A&E. His drug use had also taken its toll on his physical health and he was dehydrated and malnourished.

He went to A&E on many occasions but he was never admitted to hospital, although services working with him felt there was a need for him to be admitted. He did go to Wytham Hall but had to leave after a few days after damaging the property. He would have benefited from intermediate care in a setting that could have managed his complex needs whilst stabilising his condition, educating him about his medicines and feeding and hydrating him.

Case Study 4

This elderly client had a long history of alcohol problems and schizophrenia. His physical health was already in a very poor state with chest infections, heart problems and a stomach ulcer. Because of an old head injury he would have periods of confusion and had wandered into the traffic and was knocked down.

He was admitted to hospital with a broken leg but he would walk out with his leg in plaster to get a drink, and was aggressive to staff. The hospital found him difficult to cope with. He was discharged to a hostel where they found it increasingly hard to cope with his physical health needs. This client eventually died from his physical health conditions.

This client could have benefited from a period of intermediate care, in order to physically rehabilitate him after his broken leg, in a setting that could have coped with his chaotic behaviour and drinking.

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Homeless Team case studies

The Homeless Team, part of the Three Boroughs Primary Health Care Team, has open access clinics in hostels and day centres across Lambeth, Southwark and Lewisham.

Case study 5

Following deep vein thrombosis, this 32 year-old client has had a leg ulcer for the last four years. Skin has been grafted on to it twice but this has failed each time. The client was referred to the vascular team this year, which wanted to do three-layer bandaging.

Currently the client is scripted for 90ml of methadone and is also on painkillers. He is very depressed, still using drugs and drinking heavily.

If this client could access an intermediate care service he could be assisted with his pain control and depression, both more frequent dressings and different types of dressings could be tried, possibly getting a specialist in to find alternative methods of dressing.

Case Study 6

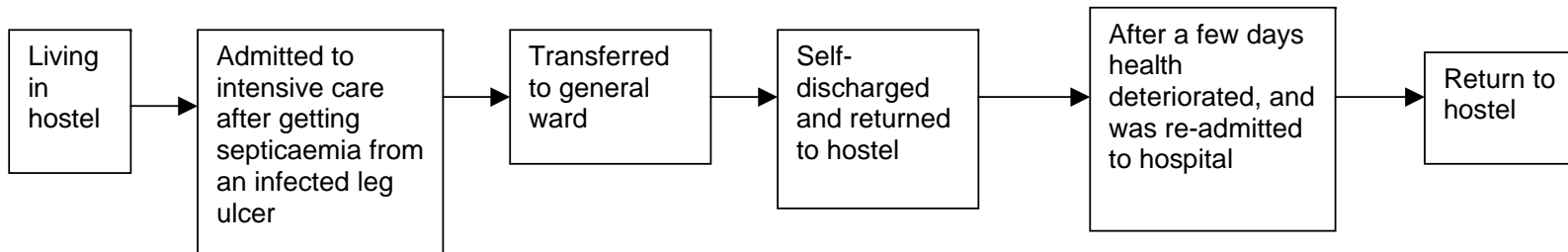
This female client is in her late thirties. A chaotic drug and alcohol user, she is very malnourished and dehydrated. She has asthma and uses inhalers. She has an open leg ulcer, and constantly injects into the wound. The wound ideally needs to be dressed every day, as the dressing comes off very quickly, often because the client exposes the wound to beg. She often misses clinics and therefore her wound often goes undressed for long periods.

She suffers from septicaemia and recently was in intensive care, where she was very sick for a week. She started to improve and was placed on a general ward, but self-discharged almost immediately and returned to her hostel. After a few days she became very sick again and staff called an ambulance, and she was re-admitted to hospital.

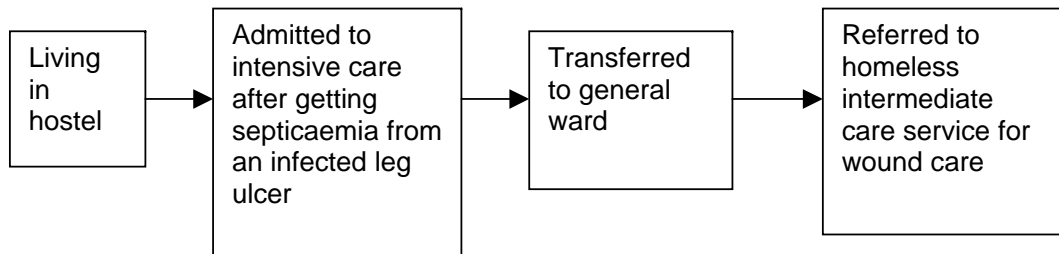
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Case Study 6

Actual pathway through services:



Potential pathway with homeless intermediate care service:



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Case Study 7

This Spanish client, who is in his late twenties, is an intravenous heroin and crack user. He has a chronic leg ulcer that needs grafting. He injects around this site. He has also suffered from deep vein thrombosis.

He used to have the opportunity to see the Drug & Alcohol Health Care Team at the Pavilion Homeless Clinic once a week and the Homeless Team at his hostel once a week, but as he now gets his methadone script at the hostel he has fewer opportunities to see a nurse to dress the leg wound. Ideally, the wound needs dressing on a daily basis, although often he won't present to the nurse for a number of weeks.

He could benefit from a period of intermediate care where his wound could be dressed on a daily basis.

Case Study 8

CJ is a resident in a hostel, and is in his early forties. A long-term chronic alcoholic, he has very poor self-care. He has eczema on his legs, and very poor circulation. Fluid swells up in his leg and as he does not comply with the bandages put on by the nurses the fluid becomes infected.

When the pain becomes bad enough he will tell staff at the hostel and they will send him to A&E. He will regularly spend a few weeks in hospital, where he will be given intravenous antibiotics and daily dressings. He also manages to reduce his alcohol intake during hospital stays.

When he is discharged he returns to the hostel and returns to his heavy drinking habits and poor self-care, and his leg becomes infected again.

Case Study 9

This 37 year-old client had been street homeless from February 2004 – October 2004, before moving into a rolling shelter until December 2004 and then transferring to a hostel, where he currently lives.

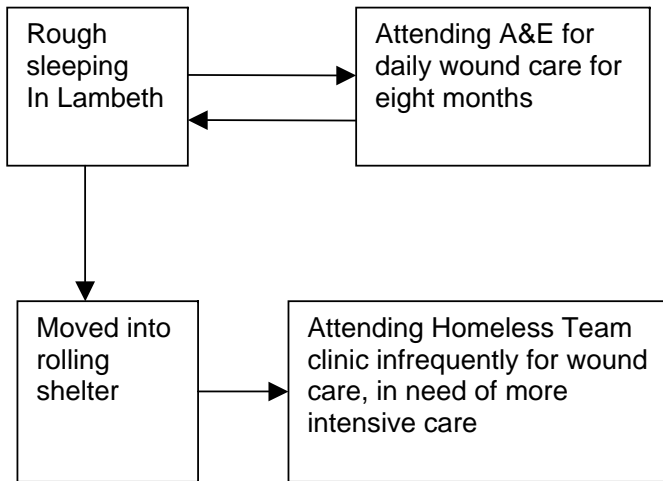
He is a chronic drinker and suffered a perforated duodenal ulcer in 2001. This led to a colostomy that has now been reversed. The reversal wound also became infected with MRSA, and has never healed. A mesh was placed across the middle of the stomach to encourage skin to grow across it. The client was attending A&E daily to get the wound dressed between February and October 2004. Nurses from the Homeless Team have been dressing the wound since then. The client has also suffered a hernia and this is pushing out the middle of the wound. The client had been in constant contact with a plastic surgeon, and had also seen a tissue viability nurse. The wound needs at least three weekly dressings, although the Homeless team nurse is only able to see him twice a week. The client is still drinking heavily, making it difficult to dress the wound.

The client doesn't like hospitals but might be persuaded to stay in an intermediate care facility, where they could use a different type of dressing such as a vacuum, which has been shown to work in these cases. He also needs a period of rest and to desist from strenuous activity, as the hernia is getting worse.

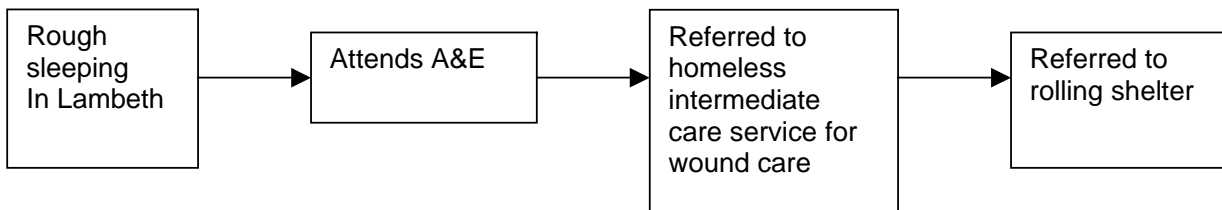
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Case Study 9

Actual pathway through services:



Potential pathway with homeless intermediate care service:



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Case Study 10

A 41 year-old male, this client has acute hepatitis B and C. He has been in hospital for two weeks where he had the acute phase of his hepatitis B managed. When he was discharged he was very malnourished and did not have a methadone script. He was discharged on a Friday night and because he didn't have a methadone script, he went straight out to score. It is likely the hepatitis B was caught from injecting which suggests he is likely to be sharing needles. This means that there is a public health issue, as his condition needs to be contained. He would benefit from safer injecting advice. He is jaundiced and lethargic, consequently he now won't eat, and won't move. He is getting pressure sores.

A month in intermediate care would be an opportunity to take regular bloods and medicine. It would also be a chance to feed and hydrate him. It is probable that this client would benefit from palliative care within an intermediate care environment. As he is a risk to other clients, they would benefit if he were educated about his condition.

Case Study 11

This 31 year-old client had acute alcoholic hepatitis. He was jaundiced. He was in hospital for three weeks. He was discharged and although he didn't get into detox, he managed to reduce his alcohol intake at first. He then started drinking heavily again. He missed his hospital appointments and did not take his medicine at all. He was dischargeable medically, but emotionally unprepared for discharge – he did not really understand the importance of his medicine and therefore did not take them.

He should also have been having bloods taken three times a week at the clinic run by the Homeless Team, but only ever had one set of bloods taken as he only went to the clinic once. He died recently in the Intensive Therapy Unit from multi organ failure, secondary to liver failure.

Two or three weeks in intermediate care would have helped to stabilise his condition and get him used to regularly taking his medicine. It would also have been a good opportunity to help him understand more about his condition.

Case Study 12

This 29 year-old female client has a personality disorder, along with diabetes, epilepsy and rheumatoid arthritis.

An alcoholic, the client uses crack and also self-harms. Due to this she is unable to take insulin herself. She was being treated in a day centre for her diabetes but behavioural issues resulted in her getting banned from the day centre.

She needs her blood sugar stabilising, which could take place in an intermediate care facility.

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St Thomas' Hospital case studies

The discharge team at St Thomas' Hospital provided the following case studies. The discharge team in a hospital will notify Social Services of a patient who requires an assessment for community care services using a section 2 form. Once the discharge team feels the patient is medically ready for discharge they will issue Social Services with a section 5 form, stating the date the patient will be ready for discharge. Once the patient remains in hospital beyond that date, for reasons relating to their community care needs, Social Services are liable for reimbursement. If the patient remains in hospital because of an accommodation problem only, the hospital will receive no reimbursement.

Case Study 13

Admitted to hospital: 12/4/05
Delayed from: 14/6/05
Discharged: 14/7/05

This 68 year-old homeless Lambeth resident had a melanoma on the sole of his foot. The wound took a long time to heal and needed grafting. The patient couldn't put any pressure on the foot so there were mobility issues. The patient was also a diabetic.

Because of the delay in discharging him he received his physical rehab in hospital. He couldn't go to LCCC or the Pulross Centre because of the lack of a discharge address. He was made a special boot in hospital. By the time he left he could bear weight but still needed to use a wheelchair.

The foot wound needed dressing on alternate days, so needed to have access to district nursing. It was essential he ate prior to taking his medication, but because of his mobility issues he was unable to prepare his own meals. He was eventually found supported accommodation in Lambeth.

Case Study 14

Admitted: 22/6/05 – had previously been in Feb 05
Section 5: 20/7/05
Discharged: 5/9/05 – has since returned to hospital

This Lambeth resident is a 57 year-old alcoholic. He had a flat in Kennington but abandoned it because the estate was too dangerous, and was sleeping rough. He had abscesses of the bowel, and needed surgical intervention. He was self-neglecting, but was technically able to self-care. He was referred to Psychiatry but they said he was capable of making informed decisions.

He was given a stoma after extensive surgery. He refused to work with his stoma - not changing the bags, or cleaning the wound or surrounding skin. There was risk of infection. He would continually leave the ward to go drinking.

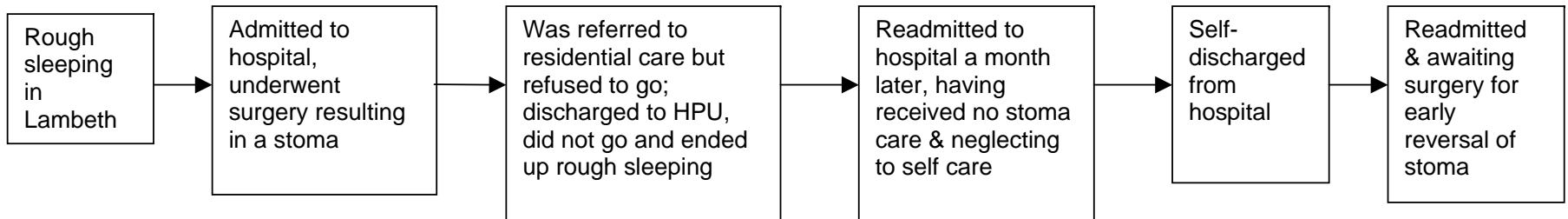
He remained on the ward due to both his housing issues and the stoma that he wouldn't care for, but the ward couldn't deal with his challenging behaviour. He frequently missed his medication as he was out drinking. He was referred to Social Services and they found him a residential care home in Streatham but he refused to go. He was then discharged (5/9/05) to the Homeless Persons Unit and also advised to go to St Giles day centre. He did not go.

His GP then called to say that he was sleeping rough on a bench outside her surgery. He was then readmitted on 9/10/05. As he had not followed up any accommodation offers the stoma nurse had been unable to visit him. He had also missed other outpatient appointments. He absconded from the ward on 12/10/05 and then was readmitted on 14/10/05. To date, the stoma is now infected and the surgeons have decided to reverse it (6 months early). He is currently in hospital awaiting surgery.

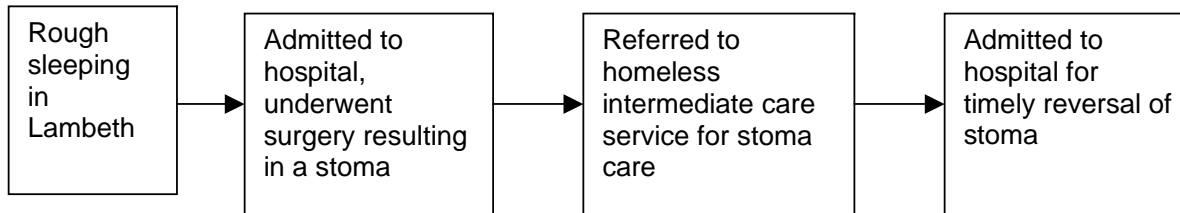
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Case Study 14

Actual pathway through services:



Potential pathway with homeless intermediate care service:



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Case Study 15

Admitted: 2/4/05

Section 5: 27/7/05 – the first was withdrawn and it was then reissued on 15/8/05

Discharged: 17/8/05

A 58 year-old alcoholic, he was admitted from a Lambeth hostel. He was suffering from a perianal fistula. He also had Korsakoff's syndrome, was doubly incontinent and self-neglecting. He was on anti-depressants. On admission he was presenting with strange toilet behaviour, placing faeces in pillowcases and drawers etc. He would also go out drinking from the ward.

He could not return to a hostel because of his high needs. He was categorised as suitable for residential care but with drinking, but it was really hard to find suitable accommodation.

Would have been suitable for intermediate care as he received physiotherapy and occupational therapy in hospital and they managed to get him to relearn toileting. On admission he had been doubly incontinent and bed bound. By the time he left he was walking with a frame or stick.

Case Study 16

Admitted: 31/3/05

Section 5: 1/8/05

Discharged: 13/9/05

A 43 year-old IV drug user, he had once lived in Wandsworth with wife and children, but got into drugs and went to prison. His wife took his name off the tenancy. He began sleeping rough in Lambeth 4 years ago. He was admitted to hospital with systematic septic joints throughout his body. He underwent surgery.

Physiotherapy worked with him to help him mobilise short distances, and he was eventually able to transfer to a frame. He could walk to the toilet but still needed a wheelchair. His knee had been completely removed and so he needed to keep his leg straight.

He was referred to Social Services on 3/5/05 – couldn't go to a hostel because he needed a wheelchair, so he was then referred to the Support Needs Assessment and Placement team (SNAP) in the Housing Department for a ground floor accommodation, as he was never going to regain his mobility and would always need a frame/wheelchair. An ongoing lack of communication with the SNAP team meant that he was referred to them five times. They then refused the client because of his former tenancy in Wandsworth. Eventually they accepted the client.

Accommodation was found in Dulwich via SNAP, the hospital also arranged a GP for him and sent him to Marina House for a drugs assessment, as he was taking methadone.

Stakeholder Consultation

Access to primary care

Primary care is the gateway to secondary services, and the level of access homeless people have to primary care services influences their usage of hospital services. Voluntary sector staff detailed the primary health services their clients are able to access. Hostels either have a sessional GP surgery in the hostel and regular clinics run by nurses from the Homeless Team or the Drug and Alcohol Health Care Team, or they are able to register residents with a local GP. Day centres also have clinics run by nurses.

However there are limitations to the primary care services available. Nurses are not case managing patients and on the whole are not prescribing; the effectiveness of their role depends to a large degree on the homeless client group following up referral onto other services, which many are not motivated to do. A homeless day centre offered support to clients by using volunteers to accompany people to appointments whenever possible.

Interviewees from health services also commented on homeless people's access to primary care. A hospital discharge co-ordinator said that many of the homeless people she came across were not registered with GP's, and therefore could not access district nursing on discharge. The transient lifestyle of homeless people was mentioned as a reason for non-registration, and it was suggested that many homeless people might have a GP, but that they might be in a completely different part of London, or they will have a local GP but do not go to appointments. A GP said that many homeless people refused care, and although they are told to attend hospital for treatment they decline to go. Fear was often cited as a primary reason for refusing treatment. Drug and alcohol workers also highlighted the issue of homeless people visiting their GP to collect a methadone script, but not mentioning any health problems for fear of it affecting their script. One person said:

'I think there is a stigma about our client group in places like GP surgeries and in A&E, though those places are overwhelmed anyway and do not encourage people to come in for health checks so it just does not happen really. So people really only go there when there is an emergency or to pick up their scripts.'

One hostel manager also felt that it was he and his staff who took the initiative on resident's health care needs, and regularly advocated on behalf of residents, as the GP surgery did not appear to have much ownership of the residents as individuals. Local GPs were generally seen to be engaged with homeless people although there was a worry that the existence of the Homeless Team gave rise to the idea that because there is a specialist service, other GPs did not need to work with the homeless population. It was suggested that because homelessness has been marked as enhanced services on new GP contracts, there is a perception that homeless people need not be catered for as part of the activities of all general practice.

Access to hospital care

All of the staff consulted with in the voluntary sector pointed towards the chaotic behaviour of clients as the key problem for them when accessing hospital care. It was recognised that clients display challenging behaviour, and can be rude and

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abusive to staff, and often this results in them being refused a service. Different clients presenting at A&E for substance use issues are known to be treated differently, which one hostel manager felt pointed to the behaviour of the client when presenting rather than the attitude of the hospital staff. One hostel manager suggested this was deliberate sabotage by the client – perhaps because of fear. It was also suggested that clients have difficulties articulating themselves appropriately or properly in A&E and when they are not understood they become angry, and are then removed or leave.

Homeless people often live chaotic lives and are not used to adhering to rules and regulations, and they don't conform to social mores or etiquette, and this is not going to change just because they become ill. A hostel manager described a female client who is known to present at three different hospitals with the same condition but has never managed to follow treatment through, consequently the hospital staff become increasingly frustrated with her. Hostels also have to be careful when calling ambulances, as residents often refuse to be treated or be taken to hospital, and the ambulance service raises concerns over wasting their time. Homeless people also do not want to sit in hospital for a long time, and as soon as they feel ready, they want to go back to their usual daily routine. One hostel manager currently has two residents who refuse to attend hospital for treatment; fear of dying in hospital is the suspected reason for refusal.

A GP suggested that the restrictions on drinking and smoking in a hospital environment were unrealistic for homeless people, and suggested that this was a large part of the reason for the self-discharge of the client group and the factor that made a hospital stay unviable.

Hostel and outreach staff also pointed out that fear of hospitals was a big issue with homeless clients, especially clients with experiences of psychiatric institutions, or health care in second or third world countries. One person suggested that people feared hospitals because:

'They are quite intimidating places, they are very formal and organised and a big institution. There is this big hierarchy and doctors and all these important people, and perhaps you are not very well educated or English is not your first language, or you have perhaps been in care as a child or have been in prison'

It was suggested that the staff in hospitals were sometimes afraid of homeless people, and that this leads to discrimination and poor treatment. Pressure on resources and perhaps a lack of understanding of issues facing homeless people are also part of the problem. Health professionals also recognised that homeless people experienced discriminatory treatment in hospital, and it was also suggested that when people become known in A&E the staff will deal with any immediate needs but do not check to see if there are any other health problems.

A GP in the urgent care unit in A&E felt that it was difficult to identify whether someone was homeless from the initial A&E assessment sheet, especially if they had provided a hostel, day centre or temporary address for the sheet. There were concerns about the inability to inform homeless people about outpatients appointments as there was no adequate address to send information to, meaning that treatment follow up opportunities were lost. Also, when homeless people do re-present at A&E, there is no way of accessing information on past treatment as records are stored away after a short period, and there is very limited data on the system. It was also suggested that those who were drunk or smelt of alcohol were

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possibly diverted away from treatment in the urgent care unit as it was felt alcohol would distort their presentation.

It was also pointed out that homeless people frequently do not receive the level of methadone they are accustomed to when they are in hospital, and that this makes it more likely they will leave the ward in search of a fix. One hospital worker felt that homeless people were sometimes seen as hopeless cases, and that staff sometimes had the attitude that:

'They are homeless, they are going to go to the streets anyway, why bother?'

Voluntary sector services commented that staff do advocate for clients in hospital, such as attending A&E with clients or visiting them in hospital and talking to nurses there, and that persistence on the part of the worker would often assist in getting a client seen. It was also pointed out that hostels and outreach services do not have enough resources to enable staff to do this very often, especially as it can be a very time consuming exercise. Staff in hospitals also commented on the importance of advocating for a patient, and those with a better understanding of the complexities of homeless patients often found that they had to advocate on their behalf with other health professionals.

When people go into detox or rehab time is spent preparing them for the stay, and it was suggested that perhaps preparing homeless people for a stay in hospital would help them to see through a course of treatment.

Discharge from hospitals is seen as a major issue for homeless patients. Voluntary sector workers felt that hospitals were under pressure to discharge homeless patients to them when the hostel would be unable to cope with their mobility or care needs. It was also commented that homeless people are sometimes discharged to council or B&B accommodation, without appropriate support and that the voluntary sector often initiates some kind of support to ensure the client remains in their flat. One day centre had experienced clients being discharged to their doorstep without any accommodation in place and it was felt that hospitals did not understand the role of voluntary sector services well enough. Self-discharge was also highlighted as a major issue, with people leaving wards to score or get alcohol and not returning, or leaving out of fear or restlessness. Because they self-discharge, they do not receive adequate treatment and this results in the development of more serious health problems and then they have to be re-admitted.

A discharge co-ordinator at St Thomas' Hospital felt that homeless patients are often very problematic to discharge both because of the difficulties of determining a local connection and also finding suitable accommodation to discharge them to.

'We have a patient right now, he is an alcoholic, was self-neglecting so the hostel manager refused to have him back and he is one of our delayed discharges.'

The discharge co-ordinator stressed the importance of ensuring patients were discharged in a safe and timely manner, but that liaisons with Homeless Person's Units (HPU) are often fraught with difficulties. Excluding patients from hospital was also necessary on occasion with homeless patients displaying particularly challenging behaviour, although it was very much used as a final measure. Housing services noted that they do not always have accommodation appropriate to a

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patients needs and that this caused problems when hospitals wished to discharge patients to the HPU.

After care

One of the reasons for the need for intermediate care is that hostels do not have the capacity to look after people who are ill. Hostel managers were asked to discuss the after care they could offer to residents. Although hostels are not funded to provide physical health care to residents, they all try and offer as much support around physical health care needs as possible given their resources and funding restrictions. Discussions revealed that there are varying levels of care that hostels are able to provide to residents, with the minimum being verbal support and reminders to attend appointments and to take medicine. Four of the five hostel managers said they would be able to support residents with any special dietary needs. The fifth hostel is not catered.

Some hostels are able to store and dispense medicine, others may just be able to remind people to take it. Some have ground floor rooms and rooms with disability adaptations and are therefore able to move residents around to accommodate a resident with mobility issues. Two hostel managers pointed out that they have no ground floor rooms and no lift. One health professional said that homeless people are often unable to return to a hostel from hospital because of the physical environment of the building.

One hostel has a health worker who co-ordinates physical health care for residents and can help primary care services to organise aftercare support for residents on their return from hospital.

Overall, hostel managers highlighted the limitations they had in providing adequate aftercare, with one manager stating:

'Unless {residents} are quite motivated and they are very sure of where they are going in terms of their treatment and keeping themselves moving, {they} really suffer I think in an environment like this without that kind of ongoing treatment and that ongoing support that isn't possible to kind of give to them all of the time really, not 24/7 anyway'

Another hostel manager said that follow up care after hospital discharge was very difficult to organise, and this was confirmed by another hostel manager, who stated that the hostel may feel it has to refuse to have someone back if their health needs are too high.

Managers felt that although there had been occasions where district nurses had attended to residents, they had struggled with the complex needs of the client group. A doctor stated that it was very difficult for hospitals to organise outpatient appointments when patients did not have a forwarding or reliable address, or because of their transient lifestyle had moved on by the time the appointment letter had arrived.

Client engagement

A recurrent theme that ran through many interviews was the issue of engagement. Homeless people are recognised as a chaotic client group and all specialist services tackle engagement as a key issue. Interviewees felt that mainstream services had particular difficulties engaging with this client group for a number of reasons.

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Compliance with a course of treatment was highlighted as problematic, with clients not attending appointments, or not taking medication either at all or responsibly with any substances they might use. One drugs worker explained that:

‘A lot of people are presenting HIV positive now and probably need anti-retroviral treatment but are too chaotic to comply with it’

A TB caseworker also highlighted the difficulties of ensuring transient clients stick to a course of treatment and the potential risks to themselves and others if they stopped taking their medication. One GP felt that one of the biggest difficulties he faced was with homeless patients who refuse to go to hospital. There was no consistent reason for refusal, other than they ‘hated’ hospital. As another person pointed out, homeless people do not trust institutions, and this is often put down to experiences of care homes as children, or of prisons.

One interviewee drew a particularly descriptive image when he said:

‘The mainstream population would be running to A&E with these wounds; these people are invariably running away from A&E with these wounds’

It was suggested that homeless people often ‘normalise’ their health condition, because, as one nurse described it:

‘They have got so used to being in a state of what you or I would consider ill health, but that has become normal to them, so being unwell is actually ending up in hospital whereas the fact that they are walking around with a massive ulcer on their leg and various abscesses and hepatitis C and all these other things going on - that is normal for them’

Several interviewees commented that homeless people do not prioritise their health. One nurse suggested that:

‘A lot of people that are homeless and drug users have other priorities whether it is getting housing, getting funds for the day, getting drugs for the day, whatever it is, health will come way down on the list.’

A drugs worker felt that health services had unrealistic expectations of homeless people, often expecting them to curb chaotic drug use when they become ill, when in fact many will continue to use drugs ‘up to the point of death’.

People living in hostels are easier to engage than rough sleepers, as the hostel can help to facilitate engagement with substance use services, but rough sleepers are difficult to engage because of their transience. A voluntary sector worker detailed how engaging clients with their health and treatment was a vital skill when working with homeless people, and that a conducive physical environment also helps. Mental health also has an impact on non-engagement. The emotional and psychological issues that can cause a person to avoid compliance or to normalise their health conditions have to be tackled, such as issues of self-esteem and self-worth. A statutory sector worker suggested that once chaotic clients are engaged, it is necessary to provide a holistic service addressing all their needs to ensure they stay engaged. A mental health worker suggested that having mental health needs was a barrier to accessing services. People with mental health issues may interpret their physical health symptoms differently, perhaps attributing them to their mental health condition.

The impact of drugs and alcohol

The impact of drugs and alcohol was mentioned by many interviewees especially either those working in the voluntary sector or those who work directly in the drugs and alcohol field. The effects of taking drugs and alcohol are seen as the most prevalent reason for physical health needs in this client group, and the general feeling was that substance use was both the cause of most homeless people's physical health needs and the reason for their inability to access to health services. The actual physical health conditions that develop from sustained substance abuse have been discussed in the needs assessment so this section only briefly mentions those, and focuses on the impact on someone's behaviour.

A nurse in the drugs and alcohol field highlighted the problem of the frequent multiple health needs of clients, with the example that many clients that are HIV positive also have additional physical health issues linked to their IV drug use such as infected wounds, deep vein thrombosis and hepatitis. The level of complex and multi morbidities means that clients are often in a serious condition. One hostel manager said that she had taken rough sleepers directly from hospital where they had undergone serious surgery related to their IV drug use. Another hostel manager commented that:

'There is just the general toll of taking drugs for any length of time, and the bulk of our residents are aged between 25 - 40 and most of those have been using heroin and crack for over 5-10 years, and the strain that this puts on the body brings it own problems.'

The effects of alcohol on the body were also highlighted, such as the problems of being drunk and falling over and associated injuries, and the impact on internal organs.

It was felt that because of the prevalence of drug and alcohol abuse in the client group the associated illnesses and wounds are normalised by the clients, as it is common to see them on each other. One nurse felt that a large part of her teams work is getting clients to understand how serious both the risks and conditions are. An outreach worker felt that there was now very little difference between drinkers and drug users today as there is so much poly substance use. A substance use professional said that a change in injecting practices over the last few years, for instance injecting heroin and crack together, has led to more clients having long term physical health issues and that there had been a rise in blood borne viruses. Dangerous injecting behaviour was also highlighted, such as sharing needles and combining substances. A hostel manager highlighted the effects of crack on people's mental health, such as paranoia, deep depressions or static highs. The chaotic nature of the client group also means it is difficult for them to keep appointments and take medicine on a regular basis.

That clients use drugs or alcohol as a way of coping with pain was highlighted, with one hostel manager saying:

'People are using whatever drug or alcohol that they are taking as self-medication, as they have been unable to access treatment for those issues elsewhere'

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Most interviewees thought that substance users prioritise their need for substances over any other issues, including health. Clients may have ignored any physical health issues while they were concentrating on their addiction.

Several people described scenes where a client's need for drugs was prioritised over their health:

'We see clients in pyjamas with Zimmer frames outside the tube station'

'We often see hospital pyjamas walking around Brixton and even people with hospital gowns on'

'You will see people limping around with enlarged limbs due to infection, with makeshift bandages hiding quite serious abscesses'

On top of these issues people also highlighted that constraints within mainstream services act as a barrier to accessing health care. For example hospitals can only allow people to take the drugs provided by the hospital and so for those clients who need to take drugs on a regular basis they find it difficult to complete a course of treatment or even access services. Homeless people are known to attend A&E but because of their addiction to drugs or alcohol they often abandon the wait to be seen in search of a fix or drink.

Co-ordination between services

Several people interviewed talked about the problems of co-ordinating health care for homeless people. Issues focused on the lack of awareness or understanding of what services did, poor communication between services and the lack of a lead to co-ordinate multiple services for a client.

Intermediate care services felt that hospitals are not always clear on the intermediate care services criteria for accepting patients, and day centres also noted that hospitals did not appear to fully understand the type of support day centres are able to offer. Hostel managers suggested that communications between hostels and hospitals are one directional, with hostels having difficulties accessing information on clients who have been admitted, when they are going to be discharged and what their aftercare needs are. Data protection and confidentiality were suggested as reasons for this, but also the turnover of nurses on wards, and the lack of understanding of the hostels role. It was noted that it often depended on the willingness of individual members of staff whether they would assist the hostel or not.

Positive relations can be generated though, such as when a client becomes know to a hospital ward and a relationship with the hostel is developed. In some cases hostels had developed good joint working with hospitals, such as facilitating hospital trainees visiting the hostel. It was felt that when communications were well developed, a smoother transition of care was created for the client.

There are examples where hospital staff do make efforts to communicate with hostels and outreach services, as part of the discharge process, but they do not necessarily feel supported by the structures around them, as one person stated:

'But if you are not getting the co-operation of colleagues and community...but if you are not getting the support from social services to put rehab in or anything, we give the best we can.'

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It was felt that health services are not 'joined up', and that primary care services did not always appear to be aware of patients admissions to hospital and any aftercare needs they might have, and so hostels feel the need to organise health care packages for residents. A worker from the Three Boroughs Primary Health Care Team concurred with this, saying that it was difficult to access discharge information from hospitals for their clients.

The need for a case management approach for health services for clients was highlighted. One hostel manager suggested that homeless people accessed services randomly:

'I think the problem is perhaps pulling a lot of those strands together, because I think as a client you could wander from once place to the next and get bits of treatment, but I am not sure that this is ever communicated round.'

One health worker felt that because clients are often accessing multiple services but without any negotiation of whom is case managing them, their needs remain unmet.

Mainstream versus specialist services

Several of the people consulted with commented on the implied need for a specialist service to cater for homeless people with physical rehabilitative needs. There was general agreement that the role of specialist services is to build bridges for vulnerable people to access mainstream services, rather than to isolate them from mainstream services entirely.

Homeless clients are recognised as having significantly complex needs and therefore there is a need for services that can engage them. Homeless people themselves were felt to have an appreciation for existing specialist services and possibly felt more comfortable accessing a service that understood the client group's varied needs. Specialist services also provide a way for mainstream services to learn how best to work with challenging client groups.

On the negative side it was suggested that specialist services encourage labelling people as homeless and that this discouraged mainstream services from working with them. Also, because specialist services have different expectations of behaviour from clients the need for them to behave appropriately was not challenged, it did not facilitate movement towards accessing mainstream services.

The proposed options for a homeless intermediate care service

Although asked specifically about the advantages and disadvantages of the models, many interviewees made general comments about each of them as well. These often took the form of service criteria and policies that the interviewee felt would be integral to the development of the service. These are addressed at the beginning of the findings on each model.

Option 1: Adapt the current intermediate care facilities in Lambeth – i.e. focused training and information to better equip them to take homeless patients

General comments

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The Development manager for intermediate care services in Lambeth made general comments on the concept of adapting or enhancing the current services for the homeless population. She said an important factor to consider is the remit of the services, which are to assist patients with physical rehabilitation and not mental health or substance dependency, and also that the service is time limited. She did feel that where there are areas of concern, clear pathways and agreements with local homeless hostels or services would help alleviate some of the fears intermediate care staff have about accepting homeless patients. Other people also highlighted this point, saying that better links between the intermediate care services and hostels should be developed regardless of the outcome of this project. It was suggested that the homeless agencies could do in reach into the intermediate care centres to work with homeless patients and train the staff in dealing with multiple needs. At the stakeholder event it was suggested that a discharge plan rather than a discharge address on admission would make services better able to accept homeless patients.

It was also suggested that reassurance and education for the other patients would help them cope with any difficult behaviour. Another health worker suggested that given the problems faced by mainstream services in taking homeless clients, perhaps a specialist homeless section within the current services might be the way forward, although she acknowledged that this may also stigmatise the client group. The development of strict protocols with the homeless patients themselves was also advocated.

Advantages

Three key advantages to this model arose in the stakeholder consultation: the high level of clinical skills and experience of administering nursing in an intermediate care setting; the existing close links with general practice; and the fact that you would be mainstreaming clients.

Health professionals focused on the clinical skills within intermediate care, pointing out that intermediate care nurses have a lot of skills around wound care and that many of the physical health issues of homeless clients are similar to elderly patients, who make up the majority of the patients in the current intermediate care services. The nurses would be skilled at providing nursing within an intermediate care setting, and have more time to give to patients than in an acute clinical setting. Doctors interviewed also felt that the existing close links with general practice would be an advantage to this service, and that this would be important for continuity of care.

Many of the interviewees who suggested advantages to this option felt that the fact that you would be linking homeless clients into mainstream services was extremely important. One health worker suggested that this option could be a:

'Pathway into mainstream services. There is a need for a more joined up approach to things and why should homeless people be excluded?'

Enabling homeless people to use these services would tackle inequalities and prejudices and would help to break down the barriers that homeless people face when trying to access appropriate mainstream services. Mainstreaming also has the advantage of being cheaper than creating new facilities.

One hostel manager felt that his clients would benefit from the parameters in place in the existing intermediate care services, and that the set time frame of intermediate care would be of benefit to homeless people in the sense that it provides them with clear boundaries and expectations. Another hostel manager liked the idea of

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homeless clients accessing the current home-based intermediate care services, the Rapid Response team or the Supported Discharge team, as clients would benefit from receiving treatment in their current accommodation and also this would be a cheaper option.

Disadvantages

Many of the people interviewed each voiced a number of disadvantages to this model. The main problems were the differences between homeless patients and the general patients, especially as the general patients tend to be elderly; the need for a discharge location for all clients on admission; the complex needs of homeless clients and the need to be registered with a GP.

Health professionals in particular felt that there would be a lot of issues in mixing the homeless population with the current patients in the bed-based facilities. As one doctor put it:

'The majority of patients going through the intermediate care facilities tend to be elderly and tend to be extremely fragile both emotionally and physically. Now, to put that group of patients intermingled with the homeless population who are much more spread across the age groups, who because of their complex needs may tend to be much more vocal and noisy and have issues about having their mates in (might be problematic)'

A GP suggested that he would be reluctant to send homeless patients to Lambeth Community Care Centre or to the Pulross Centre because of the impact on the other patients. The manager of a young persons hostel also felt that clients from her hostel would not mix well with the other patients in the intermediate care centres. This disadvantage was also voiced at the stakeholder event.

One of the main concerns of the current intermediate care services was the issue of discharge for homeless patients. Intermediate care by definition is time limited to six weeks, and the services have experienced problems in the past when discharging homeless patients. The Development manager for the service said:

'Sometimes the hostels ... have said yes we will take them back when they can do stairs, or we will take them back whenever, will often then backtrack on that. So the staff in the services have always got a fear that the commitments entered into at the beginning of an admission often are not honoured'

It was also mentioned that problems can arise with Social Services discharge plans too. This then leads to a misuse of staff in the service who may then have to spend a considerable amount of time arranging housing issues rather than carrying out their core duties. Another issue when discharging a homeless patient is assessing their needs in the accommodation they are going to, and for example the services felt that they:

'Have {not} got those sorts of relationships with the hostels where we can go in and do a home visit in the hostel, normally they won't let you put wall bars in or raised toilet seats'

It was pointed out that intermediate care beds do not receive reimbursements from the local authority when discharges are delayed, making delayed discharge a costly

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issue for intermediate care. The hospital discharge co-ordinator also mentioned that the centres would not accept patients without a discharge address, which suggests that homeless patients will rarely be referred to the intermediate care centres from hospital. Discharge issues would be a barrier to enhancing this service for homeless people, and that no matter what other changes were made to the service, if homeless people block beds that other patients need, it will not work.

Homeless people have much more complex needs than the general population and staff in the intermediate care services are not experienced at dealing with these additional needs. The intermediate care services were clear that the staff's focus was on physical health problems, and that they did not currently have particular training or experience of working with homeless people. One interviewee suggested that to ensure the service catered for the homeless population effectively, the staff would need a lot of skilling up because of the range of complex needs of the population. One health worker felt that the intermediate care services might:

'Feel pressurised because ... complex patients need a lot of resources and whether that would then deflect away from mainstream.'

Substance use dependency was highlighted as a major issue when caring for homeless patients in intermediate care services. The present staff do not have the skill or capacity to deal with drug and alcohol problems, and one hostel manager said that most of the serious physical health issues of her clients were the result of substance use and she did not feel the current facilities would be able to cope with those issues. One voluntary sector worker also felt that the substance use issues of homeless clients would have an impact on the other patients in the centres. He felt that for homeless people to access the current services there would need to be a harm minimisation approach to drugs and alcohol, which was not currently NHS policy, so this might be problematic. A drugs and alcohol worker felt that the proximity of the Pulross Centre to Brixton – and therefore the drugs market – was a drawback to this option.

One person commented that the lack of registration with a GP might be a barrier for homeless people accessing intermediate care, and it was also suggested that the general rules and regime of the centre might not be flexible enough for homeless people.

Another issue mentioned was the lack of links between intermediate care and the voluntary sector and other services with experience of working with homeless people. Concern was expressed about the capacity of intermediate care services to engage the homeless population and to be flexible enough to retain them. Self-discharge was recognised as an issue for homeless patients.

'The clients do not conform, the clients are unruly, difficult, their behaviour is not necessarily the best, they are not cooperative, they do not conform to the medical model very well, they are argumentative and many do not comply with staff. Now that can be very disruptive in a mainstream facility.'

A number of other potential drawbacks to this model were also mentioned. Concerns were raised that GPs might withdraw their contracts with the centres over concerns for their general patients; that the centres might have homeless patients dumped in them; and that enhancing the service for homeless people might create problems for the recruitment and retention of staff in those facilities.

Option 2: Developing a nurse-led floating support service that would case manage clients in their hostel or other temporary accommodation

General comments

Interviewees made several general comments about developing a nurse-led floating support service specifically offering intermediate care for homeless people. These general comments centred on ensuring that any such floating support service would be flexible and understanding of the chaotic nature of the client group. The service would also need to have very clear criteria for accepting patients within a range of specified conditions because of the limited level of care such a service could provide. Partnership working was seen to be a key factor to developing a fully functional floating support service.

Advantages

The main advantages that were cited by many interviewees are that a non-building based service has the ability to be flexible in its approach, both in the way it worked with the clients and the range of clients it could serve; it can work closely with many other agencies in order to engage clients; and for clients currently in accommodation, it would help them maintain that accommodation and promote their independence.

Almost all of the interviewees who discussed this option and those at the stakeholder event pointed out that it has the ability to be run in a flexible manner, and for this reason, many interviewees expressed a preference for this option. It was felt that this service would have the opportunity to cope with the chaotic nature of the homeless population and could respond to them in their own setting such as B&Bs, vulnerable housing and squats, as well as hostel dwellers and rough sleepers. Current intermediate care services noted the difficulties that could arise with patients not being in when nurses arrive for appointments, but felt that a service specifically for homeless people may be best placed to be more flexible around such issues and hopefully close ties with other services may reduce such instances. Three people who work directly with rough sleepers felt that a floating support service would best serve their client group, especially if the service could actually engage clients on the street.

A floating support service was viewed as the option that would be most capable of working effectively with other services. Many interviewees pointed out the links that could be made with the current street outreach service, including the street outreach service itself, which suggested that it would be able to link the nurses with particular clients. One nurse suggested that a floating support service could work with the mobile needle exchange, day centres and the current drugs outreach services. Supporting People felt that such a service could compliment the general tenancy support services available in the borough. As one interviewee phrased it:

'You are increasing the capacity of outreach services because they are going out in partnership and you are increasing our levels of service provision and our levels of engagement to this client group'

Hostel managers also felt that they would be able to work well with this option. They suggested that it could be well linked in with project staff to ensure that clients were available for appointments, the health workers would be able to communicate with staff in the hostel around issues of a particular client and that a more 'joined-up' service would create more consistency for the client. At the stakeholder event it was

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pointed out that a floating intermediate care service would open up more discharge opportunities, as hostels would not be so worried that they were going to be dumped with clients whose care needs were beyond their capacity.

A doctor thought that this option would work well if it was done in conjunction with physiotherapy and occupational therapy services and also if local GPs provided medical input, and that the hostel or support provider worked with the service.

Keeping clients as independent as possible and facilitating the maintenance of their accommodation was highlighted as a key aspect of implementing a floating support service. It was viewed as a preventative service – the housing department suggested that it might help in cases where people were in danger of losing their accommodation because of a period of ill health. Several people suggested that this option would be likely to save costs in other areas.

Hostel managers also felt that this service would be beneficial as it would not interrupt the ongoing work the hostel was doing with the client and the relationships that had been built between the additional services at that hostel and the client could continue. One interviewee felt that keeping the clients in a familiar environment and linked in with existing support services would ensure relationships with clients were sustained throughout periods of ill health.

Another positive aspect of the floating support model that was discussed by interviewees was the possibility of one to one working. An intermediate care service would have a case management approach and interviewees felt that if a relationship could be created between a health professional and the client then this would help to engage the client throughout the necessary period. This issue highlighted many people's concerns that there is no one person who currently takes responsibility for the physical health of most clients. One mental health worker suggested that the floating support service could in part be modelled on the Care Programme Approach (CPA). A TB health worker also felt that any service that worked on an individual level with a client would help to ensure the health needs of the client were met.

The perspective of voluntary sector services was that homeless clients often responded well to nurses and other health professionals, with one hostel manager saying:

'It has a lot of professional clout and I think that they actually feel quite valued when someone is treating them in that way, and they are more likely to respond to treatment and be around for the treatment I think.'

It was suggested that a floating support service would be more able to assist clients with accessing mainstream services by facilitating a dialogue with a nurse in the mainstream service.

The existing Homeless Team within the Three Boroughs Primary Health Care Team was felt to be a good starting point to developing a floating support service. Interviewees felt that the Homeless Team had the skills to work really well with difficult clients and that to build on this would be a useful development. It was also suggested because of the existence of the Homeless Team, developing a floating support service would be cheaper than creating a building based service.

Disadvantages

The restriction on the level of care it could provide was the main disadvantage for this option expressed during the consultation. Other disadvantages highlighted are the lack of adequate resources and environment, and the non-engagement of clients.

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A street outreach professional pointed out that a floating support service might find it difficult to provide a high level of care to rough sleepers, saying:

'Actually being out in the cold or being in somewhere that is really dirty is not going to help, and nurses going in there would kind of patch things up but they might not actually be able to get to the bottom of the problem'

And there would be issues around accessing and sterilising equipment. Also, the lack of a consistent venue to provide the care and the transient nature of rough sleepers would mean that it would be difficult to provide a service over a period of time. One doctor said that the service would not be able to provide 24-hour care, and would not help clients who were not physically independent, pointing out that lack of facilities in most hostels – doorways too small for wheelchairs, no hoists in bathrooms and lack of grab rails - might prevent mobility impaired clients from returning to a hostel and therefore making use of a floating support service. Other interviewees also highlighted the problem of providing a high level of care through this service. In particular as a non-building based service the access to necessary equipment would be limited, especially for physiotherapy and occupational therapy services, which would be considerably restricted.

A number of interviewees highlighted the problem of transport in terms of staff getting out and visiting people, especially given the geographical size of the borough. People are occasionally placed in temporary accommodation outside the borough, which would have an impact on the team. A peripatetic worker noted that when a client is high risk, there has to be two members of staff to visit them and this can be a large drain on team resources when you are visiting clients multiple times a week. It would be costly to make repeated visits to clients who were not in for appointments. One nurse felt it would still be difficult for hospitals to discharge homeless people and link them successfully with a floating support service.

Hostel managers were concerned that non-engagement would be an issue for this type of service, and it was felt that the service would only be visiting the client for a short amount of time in a day and this would effectively reduce the possibility of compliance with any treatment. As one drugs worker put it:

'Whilst you're doing that people are already returning to their previous lifestyle and could be kind of doing stuff that is detrimental to their health whilst you are trying to almost shore up a dam'

Another possibility raised was that clients would become too dependent on the service and that it could de-motivate them to actually go out and access help for themselves.

Disadvantages about staffing and awareness of the service were also of concern to interviewees. One doctor said that there were difficulties in recruiting nurses and therapists both generally and within services specifically for homeless people and this would impact on a floating support service. It was also felt that awareness of the current Supported Discharge and Rapid Response teams was not good among GPs because:

'Unless you are closely involved it is a bit hard to understand and get a picture of what this thing is'

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And that this might be a problem for a service dedicated to a specific client group, both in terms of raising awareness of the service within primary and secondary care, but also, as one interviewee stated, with any partnership agencies who would need to understand what the service was trying to achieve and also see themselves as partners in it.

Option 3: Create an 8-10 bed intermediate care unit within a homeless hostel

General comments

As with the other two options, general comments on the development of a unit in hostel focused on the policies and procedures that would need to be drawn for the service.

The intermediate care Development manager suggested that it might be more practical to have a 12-14 bed unit, as you may not need to employ much more staff to cover that number of beds than you would with an 8-10 bed unit. Different models of staffing the unit were suggested, such as having a mixture of general and mental health nurses and an overall workforce skilled in physical rehabilitation, mental health and substance use. Or health care assistants could be employed on the unit, with a physiotherapist, and perhaps have visiting nurses. One voluntary sector professional suggested one nurse on shift assisted by hostel workers to deal with any non-clinical issues and support from substance use and mental health workers. The importance of having staff experienced in motivating the client group was highlighted, and a clear interface between clinical and non-clinical staff should be in place.

Interviewees suggested rotating the staff with mainstream services or with nurses in the Three Boroughs Primary Health Care Team. This would ensure that the clinical staff had access to professional development, peer support and clinical supervision. This would also ensure that the skills and experience of working with vulnerable clients was fed back into mainstream services.

A joint health and housing management structure was proposed. A harm minimisation approach to substance use issues could be implemented, following the method used in mental health units. A GP suggested that regular GP and consultant sessions would be necessary.

Both health and voluntary sector people agreed that the building should have the appearance of a proper intermediate care setting, to ensure it looks like it is intended for that purpose so any hostel proposing to house such a facility would need to be refurbished to bring it up to clinical standards. The issue of gender would need to be considered closely, as an open ward style unit could not be mixed. Single rooms would be conducive to a mixed gender service.

Advantages

The most popular advantage to this option was the access to a variety of staff and the subsequent holistic service the homeless population would get from being in the unit. As one health professional put it:

'You have on site expertise in homelessness, you have people who are able to help you diffuse situations, who understand around substance misuse, who are used to working with complex needs patients. You also

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have, in the concept of the nurse-led unit, the clinical skills to support that and to maintain the medical care for these patients, so you have both sides of the coin'

Health, voluntary and statutory interviewees all felt that the variety of support available to clients accessing such a unit would be a really valuable benefit to it. Nurses and therapists would be supported in their work by non-clinical staff experienced at dealing with complex needs, motivating clients and generally being there to support them through the process. The range of health staff was also felt to be important, with access to a full multidisciplinary team including physiotherapy, occupational therapy, doctors and nurses. The manager of the Three Boroughs Primary Health Care Team suggested that his team already encourages this joint working between health and housing and so the foundations are already in place to build such a partnership. Similar successful models were also mentioned, such as substance use units within hostels and the success of health units in hostels in other countries that have managed to reach clients who were otherwise not accessing health care.

Another benefit would be that the continuity of care for residents within the hostel and those who moved into the main hostel after being in the unit, as it would be a smooth liaison between health staff in the unit and the general clinic in the main hostel. The benefits of rotating the staff and giving health staff the opportunity to develop their skills at working with vulnerable clients were highlighted. It was also felt that hostel staff would benefit from increased awareness of the health issues of the client group. It was suggested that a significant number of hostel residents could have avoided hospital admission had they been able to access such a facility.

The opportunities for resettlement were also viewed as an advantage to this option. To build discharge planning into the process of admitting clients to the unit was highlighted, and if the unit was in a hostel the opportunities for move on into the main facility would be increased. This would also ensure that the unit did not become blocked with clients who no longer needed health care. Clients admitted from the main hostel would not have their resettlement process interrupted, as they would still be linked in with the resettlement worker. Also the rehabilitative concept of intermediate care would match the hostels desire to increase clients ability to live independently.

A hostel set up to cope with clients who have short term mobility issues would be welcomed, as many hostels have difficulties accepting those clients because of the physical structure of the hostel. Hospitals would also feel more confident about referring patients to such a unit. A hospital discharge co-ordinator highlighted the problems she has discharging homeless patients to the current intermediate care service because of their lack of move on accommodation and complex needs, and felt that a unit specifically for this client group would alleviate many of the problem cases she experiences. A TB caseworker also felt that this option would be really beneficial to homeless clients who have just been started on a course of TB. A doctor said that a unit in a hostel would be an easier model to 'sell' to referral agencies, as a physical place is easier for people to visualise than the other models:

'I think it would be an easier thing for other services to sort of visualise and to refer into, I think for someone working in a hospital, someone working in general practice, think it is much easier to grasp what such a service might be and therefore to remain aware of it to refer into it.'

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The idea of having a unit with a focus on the homeless population was seen as a benefit to the client group by many. The ability to provide a health service to clients with complex needs in the same location that they can receive support for any substance use, mental health, social, educational and employment they are likely to have was seen as a very positive move, and giving homeless people the opportunity to recover from ill health when they are rarely able to access that sort of environment was highlighted. Voluntary sector workers thought that such a unit would facilitate access to health treatment for clients who were often unable to access it, and that homeless people might find the concept of moving into a unit in a familiar environment more acceptable:

'I think having the unit that people could go in to as an alternative to hospital would be really appealing for some people, I think what puts off some of our clients going into hospital is the rules and regulations, you know, basic things like you are not allowed to smoke and you are not allowed to drink.'

It was also felt that the unit would provide a good opportunity to give malnourished clients much needed nutrition, and the health promotion possibilities would be advantageous to the community too.

Interviewees suggested the financial benefits to the NHS. Creating a unit would be cheaper than having clients in an acute bed. Also clients would not access A&E inappropriately. As one health worker phrased it:

'There are savings to be made, but it is not about savings, it is about people's right to a good standard of care and that is what the PCT is there for. These people are entitled to the same level of care as the rest of the population, and it is the PCT's job to provide that.'

Disadvantages

This option also elicited a variety of disadvantages, with the biggest focus on staffing, management and financial issues.

Supporting People suggested that it would be a costly service to run in terms of staffing, in terms of hostel staff spending a large proportion of time in the unit keyworking clients there, and the expense of covering their duties in the main hostel. Hostel managers were concerned over the level of nursing care that would realistically be able to cover the service, feeling that 24-hour nursing cover would be too costly and therefore project workers would be expected to cover the unit, although with current staffing levels it would be impractical to have a permanent project worker in the unit. They also felt that project staff might not be happy about seeing residents 'dripped and monitored' and also because project workers work in the hostel to do key working, not provide health care, they might not be keen to work in the unit.

One nurse wondered how you would approach recruiting and retaining staff to work in such a unit, feeling that it would not necessarily attract nurses who are interested in homelessness and substance use issues, and also that finding nurses with the right balance of intermediate care, homelessness and complex needs would be difficult. It was pointed out by one health professional that general intermediate care was not seen as a particularly attractive area to work in and therefore this option might be even harder to recruit to. The intermediate care Development manager

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also felt that 24-hour nursing would be expensive, and also that therapists are expensive.

Both voluntary and statutory sector interviewees were particularly concerned with the costs of running a unit within a hostel. It was felt that Supporting People funding and Housing Benefit money might be lost, and that one person said that:

'I am not entirely sure the demand will always justify that level of service'

It might create dual Housing Benefit claims if a resident had an existing tenancy with another hostel. Supporting People pointed out that the costs of overstaying in the unit might be expensive, considering the current difficulties with finding move on accommodation. Concerns were raised at the stakeholder event over managing voids, as such a service would need beds that can be available in an emergency, in which case a voids issue would be inevitable.

The cost of supplies, equipment and security to protect it was also raised. Health professionals commented on the cost of actually setting up such a project, and suggested a unit would require structural and organisational changes to the hostel, and that this might take some time to set up.

The practicalities of managing a unit are seen as a notable disadvantage, from the overall management structure to issues such as referral into the unit and resettlement out of it, management of drug and alcohol issues, food, clinical issues and visitors.

Hostel managers expressed concerns that the unit would be 'outside' the health service, and that this might create problems for nurses working within it, such as with clinical support, or that there would be issues around which areas of the unit were to be managed by health and which to be managed by the hostel. Statutory services also felt that having multiple functions within one hostel would create management problems. One person also felt that hostel services were not advanced enough to cope with a specialist intermediate care service in addition to existing services in the hostel.

Issues of referral into the unit, and resettlement out of the unit were also discussed. Having a unit in a particular hostel might lead to a perception of preferential treatment for clients of that hostel or service provider. Concerns were raised about whether other providers or services would be able to refer into it. Also potential referrals might have been evicted from the hostel in the past, or have had bad experiences there or be under threat from current residents or people in the area, and it was felt that clients with these issues would then be excluded from the service. For residents from other providers, moving into a large first stage hostel might be seen as a step back and they may be resistant to that. Move on was felt to be a problematic area, and it was suggested that it might create tensions within the main hostel if people were seen to move into the unit and then on to other accommodation. Also statutory services felt it would be difficult to manage the six week limit of intermediate care in a hostel environment, as move on may be hard to come by and therefore people would be taking up beds when they no longer required health care. One hostel manager visualised problems persuading residents to co-operate with the process, saying:

'You can't get them off quick enough, the fact that they don't leave once they are on there, or they don't want to go in the first place, so do you start forcing people to go to these places, and then what do you do, do

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you exclude them because they won't go to the bed in hostel that they are already living in?'

Hostel managers also voiced concerns over the way the unit might be misused, both by other services referring inappropriately or by residents using the unit as simply a sick bay, without the motivation to move on from the service. Statutory services felt that the unit itself might be a misuse of hostel beds, as they viewed them as being lost to rough sleepers.

The use of drugs and alcohol in the unit and the proximity to other users in the main hostel was an issue for concern to drug and alcohol professionals and interviewees from the voluntary sector. Health workers wondered about the legalities of managing substances and the problems of administering effective treatment to residents using substances. Difficulties would arise with people leaving the unit to score and not returning for treatment, and of being surrounded by other users in the hostel, which would be especially problematic for those who were new to the environment. One interviewee felt that:

'If you start recuperating you want the quiet and not have the chaos that comes with the hostels, and the drinks and drugs that are surrounding it, what other clients are using, it just does not seem to be so conducive to recovery'

The issue of meal times was also touched on, such as whether people in the unit would get meals there or in the main hostel canteen. Hostel managers also felt that clinical issues such as keeping the ward clean and sterilised would be difficult in a hostel environment. Managing visitors to the unit would create problems, as it could be a potential health risk, also it might mean the unit would not be a quiet place for other residents and it would not necessarily give them the opportunity to escape from normal hostel life in order to recuperate. One hostel manager also worried that residents using the unit might become stigmatised, or labelled, by people in the main hostel.

Hostel managers also had concerns around having a resident from one hostel accessing this service in another hostel for a number of weeks, and the problems this might cause with benefits, and keeping their bed vacant for a number of weeks for them to return to it, although possible when residents went in to hospital, they felt it wasn't clear if that would be possible in this situation. Also, it was felt that the relationship developed in the first hostel might be affected by the move to another hostel, and linking them into services in another hostel might be counter-productive. Hostel managers also felt they would miss out on communications with the health providers without face-to-face contact.

Additional suggestions

During discussion on the options several people suggested that a combination of enhancing the current intermediate care services and developing a floating support service for homeless patients would be a good way forward, as then homeless patients would remain linked in with the specialist services and resettlement options they require, but if their level of need required it they could access the beds of the current services, while the floating support staff could do in-reach to the centre to assist staff there with managing homeless patients.

A combination of a floating support service and an intermediate care unit within a hostel was also suggested, with the unit having fewer beds, with the nurses in the

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floating support service using the unit as a base and also working on rotation with the nurses in the unit.

At the stakeholder event it was suggested that a combination of all three options could be developed. It was suggested that options one and two would be relatively straightforward to execute, as the current services and the Three Boroughs Homeless Team already exist.

Service User Consultation

Accident and Emergency

For many homeless people, A&E is often their first point of contact with health services. This means that the response they receive there will often impact quite strongly on their decision to seek health care. People suggested that they are reluctant to go to A&E because of the negative attitude they feel staff have towards them, and often don't go until they have to be taken in by ambulance:

'Who wants to go to A&E and see them just for them to tell you to go away, treat you like shit?'

'You don't feel good turning up when you look as if you have come from the street, but you want to get treated, but you get a longer wait'

'A couple of times I have left it until I was so ill that I got took out of here in a stretcher, I had a DVT and I've got my infection on my lung and I just left it and left it until I was nearly dropping unconscious'

Homeless people sometimes feel that they get labelled in A&E and that this determines their level of need, not the condition they present with.

'I feel as if I have an invisible 'H' on my head for homeless and it carries a social stigma, it means you're put to the back of the queue, you are not a priority'

'That's not my experience, I was in the London for my leg and they were as good as gold.'

'They stigmatise you don't they, they think... oh you're a druggie or a drinker and all that and everything else, they have got you, they stigmatise you right away, you're a trouble maker, you know what I mean, you might be nothing'

'They don't want to touch you, they think you're a drinker, they think you're a drug abuser, even people with mental health problems this stigma comes on them'

'He took the fits and they judged him as a drinker, I had to tell them 'look he has got the medal round his neck – he's having a fit, he's not a drinker.'

They don't like, give you any confidence that they want to help you...Unless you have got a physical wound that they can see, it's pouring with blood or something, or you've stopped breathing then you are not going to get much help'

There was a strong feeling from some service users that when they attend A&E other patients are prioritised over them.

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'It seemed I was waiting forever, I probably wasn't but it seemed to me as though everyone else was seen before me and I was always at the back of the queue'

'I felt like I was at the back of the queue, and I was made to wait a long time. The worker I was with left after a couple of hours and I waited on my own for a couple of hours more. I was seen in the end but I had the shakes. I could see people being booked in after me, and then going on to get seen before me. I felt like they made me wait because I was homeless or a drug user, they made me feel like a second-class citizen'

'I think it's more about drink than homelessness – straight away a screen comes up, a look on their face and you're at the back of the queue'

'I've always stuck it out, we all know you have to wait, the triage nurse helps, at least you know you are in the process'

People feel they get treated badly if they say they are from a hostel, but if they arrive at A&E by ambulance treatment is better. Also, if they go to A&E with someone who can advocate for them, this often seems to improve the response they receive.

'If you get somebody, an advocate, they can explain it to them and they put people at ease, the hospitals and that. It's easier for everybody'

There was also an acknowledgement from some users about their part in the interaction

'I've been drunk and caused trouble, it works both ways'

People did also report positive experiences of A&E:

'I've been to A&E quite a few times, at least 6 times for overdoses and once because I was attacked. St Thomas' Hospital and Chelsea and Westminster are both really good, they really understand your situation and help you. I felt like I was treated well in both those hospitals'

Although one man, who had reported a positive experience of A&E following a physical assault on the street, felt this wasn't the case when the police took him in on another occasion when he was ill and rough sleeping:

'I had pneumonia and I was actually escorted into the hospital by a policeman – I found a different response from the staff then. It was like I looked like a criminal of some kind'

Hospital admission

Many people have strong fears about going into hospital, which can stop them from getting treatment. Being in hospital can mean that they have to face the realities of their situation but with no support to deal with it:

'You are in your society here {in the hostel}, you feel you are wanted, you are in a safe place, you're not if you are removed to hospital. It's an alien environment, you're like a fish out of water and you're desperate for a drink. And when your drink is away from you you're ashamed at

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the state you're in, your nails, your hair and your feet, you're embarrassed'

'Visiting time is a terrible time, everyone else has their families round them and you have no-one and it brings you up against what you've lost'

'When you have been on the streets a long time you can't stand the hospital because of the claustrophobia, you need to be out and it is too confined'

'They are scared of finding out what is wrong, they are scared of dying, they are scared of being somewhere no-one will care if they die, they are scared of not coming back'

People had experienced negative attitudes from staff when in hospital:

'The consultant had this stereotype towards homeless people. The same view of us as the rest of the staff'

'In hospital I saw the doctor and he looked down on me, and then at the end he told me I was all dirty and to look at my hands – they were covered in dirt. He said no wonder I was unhealthy. He was really rude'

'The last time I went in hospital I got MRSA ... and I thought that time I was treated really bad ... because nobody told me that I had caught MRSA... their attitude was like, well what difference is it going to make to you if you knew anyway?'

There were also concerns that hospitals don't really understand substance use issues, and people talked about the some of the problems they had experienced with their methadone scripts when in hospital:

'The hospitals don't understand self-medicating. I smoke cannabis as it helps the epilepsy. Epilepsy is all about tensing up, and the cannabis relaxes me. The hospital doesn't understand that. They have a really rigid idea of medication'

'If you are a heroin addict, they make you beg, you know, they like to see you really withdrawn, they like to see you really sick... like with the sweat dripping off you, you're throwing up'

'I was already on a script, first of all I couldn't tell him because I was unconscious, but when like I finally come out I was obviously withdrawing and I said to him how much I've got, and they said, no we can't give you that amount... until we speak to your doctor. But it was over a weekend so they couldn't contact my doctor'

Although some people had heard that getting your script in hospital wasn't a problem, the implied discussion of it suggests that it is an issue of concern to people:

'People here have told me that you can get your methadone script in hospital. No one has ever said that is a problem. People have told me you can get your script there so that is good'

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Hospital Discharge

Self-discharge was said to be very common. The need for a drink or a fix was often given as a reason for leaving the ward, but also their fear of hospitals magnified their desire to leave. People talked about why they or their friends might have self-discharged from hospital, and the problems this then causes:

'I think he had a bad experience with some of the nurses, that was the first time he had been there, it was a very bad experience, that's why he didn't want to stay, so he just tried to come back onto the street again'

'I stayed for a day or so but then I had to leave, I didn't want to stay there as I get paranoid. And I needed a drink'

'People try and keep you in, the nurses are nice but you are powerless- all you can do is try and get your next drink.'

'They had given me some treatment but I left so I wasn't OK. I ended up having to go back in when I got worse'

The lack of a local connection had meant some homeless people found discharge a particularly distressing experience:

'My experience is that it is really difficult because you don't belong anywhere so no one wants to pick up your treatment. I had an accident and I was homeless and I was moved from hospital to hospital. In the end when they wanted to discharge me I had no money, no ID, I'd lost everything and I told them I had nowhere to go and I was in Mile End, not my area and my face was all mashed up still and out here. They found an address of somewhere for me to go in Soho and I was put in a taxi but we drove around and round and there was nothing there, except a place that was boarded up. In the end the taxi driver took me back to the hospital and they put me in a room that was for relatives for the night and the next day sent me to the Homeless Person's Unit but they wouldn't deal with me because I wasn't from the area'

Some of the people who had been rough sleeping prior to a hospital stay talked about how the hospital had found them accommodation to be discharged to:

'I was in hospital for four days and I was discharged back here {the hostel}, that was OK, I felt it was OK to be discharged'

'After I was in the London they said I couldn't go back on the streets because my leg wouldn't heal. They put me in a B&B and I had to go back to the hospital for the dressing, they looked after me and made sure I had somewhere to go'

Several people highlighted transport issues as a major problem when accessing health care. Most of the time the lack of transport was most problematic for homeless people on discharge from hospital, but people also felt it affected their ability to attend outpatient appointments:

'Transport to and from hospital is an issue, you don't get the fares for appointments. In an emergency they take you in by ambulance and then they treat you and throw you out at midnight expecting you to walk

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back here, you're feeling bad and it's a long way and you've no money. Why couldn't they have a contract with a cab firm and help you out?'

'At St Thomas' after I'd been seen I told them I couldn't get home as I didn't have any money and they didn't want to know. They told me to call the hostel to get them to sort it out but I didn't even have any money to call. I had to walk all the way back to the hostel, it took me four hours and my leg really hurt because of the cellulites'

'At St George's they wouldn't get me any transport and I had to make my own way home, I told them my legs were like jelly, that's what happens when you have an epileptic fit. It is really embarrassing having other people stare at you in the street when you have to walk like that. It took a really long time to get back'

After care and experiences of being ill on the street or in a hostel

Participants discussed what it was like being ill, but not necessarily ill enough to be admitted to hospital, and living in a hostel or on the street.

'Ever since being on the streets my health has been affected, it's being out in all weathers and not getting the vitamins- your immunity needs to be built up.'

'The drink anaesthetises you and when you stop drinking you are in a lot of pain. A bobby broke my wrist putting handcuffs on me, I heard it crack, but I was anaesthetised and I did nothing about it, now I've got arthritis.'

The general feeling was that people 'coped' with the situation because they had to. One man talked of walking with crutches whilst living on the street for eight months, and the problems of sleeping on hard, cold surfaces with a bad leg. Other people talked of friends who had been in wheelchairs and the difficulties they'd had when living in a hostel, such as accessing the building and using the toilet.

For those who had been discharged to a hostel after a hospital stay, the general opinion appeared to be that hostels offered limited after care, but that they did the best they could.

'You don't get after care. You just get checked on and that is it'

'I asked staff to remind me about some tablets because I knew I would forget, and they were going to remind me to take them once a day – but they forgot. I think it just got missed off, you know, what with different staff and agency staff'

'I've had staff help me out after I've been in hospital, I've personally had them bring up food to me in my room'

People felt that there didn't seem to be any continuity of care, and that the hospitals did not contact the hostels about their care needs on discharge.

Discussions of the proposed options for homeless intermediate care

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The last part of each focus group was dedicated to discussing any advantages or disadvantages that the participants could see to the options.

Option 1: Adapt the current intermediate care facilities in Lambeth – i.e. focused training and information to better equip them to take homeless patients

Many people felt that they should not be excluded from the current intermediate care services, and liked the idea of having a place where you could go and recover from an illness, with the opportunity to reduce their drinking.

'This is a good idea. It would be good to be somewhere that could care for you when you were in that sort of state'

'There should be places where we can go and recover. The longer you are off the drink your brain starts to be there again, they can start to talk to you, you can go and detox and gradually get yourself back together but if you are straight out {of hospital} of course you go straight back for the nearest drink'

'Well if it can break your drinking for a bit and get you eating again that's a good thing'

The difference between the current users of the intermediate care beds – elderly people – and homeless people did not strike people as a huge problem, so long as there was careful gate-keeping of the type of people accessing the service.

'I don't think the age difference would make a difference. I think it would be a very good idea to intermingle the elderly with some of the homeless ill people as long as we didn't have a known bully or people that got out of order when they drank placed amongst them'

People did express concerns about mixed gender wards, and in fact some people disliked being on wards at all, preferring to have their own rooms.

'You cannot sort of mix somebody that is drinking with some old folk or someone else because it is going to have an affect on somebody else'

'It would be good to have all the facilities and staff but if there was some sort of segregation you could put different policies in place.'

People felt that the most important issue was for the service to be able to understand people's substance use needs, and that this was such a big step for mainstream services to take that it would be difficult:

'It wouldn't help. The drugs issue overrides that altogether and overrides that kind of place... they would have to be trained to be able to deal with those situations for the homeless for the drug users... that's the first issue to deal with, you have to deal with that issue and then you can deal with other issues'

'What about the issue with drugs? They'd have to be understanding'

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Option 2: Developing a nurse-led floating support service that would case manage clients in their hostel or other temporary accommodation

There was particular appreciation of this option from some people because it meant that they would not have to leave familiar surroundings. Also, because of positive experiences with the Three Boroughs Homeless Team they felt this service would work well for them.

'I'd rather them come here, I know it here, otherwise its like going to another hospital, having to get to know other people'

'You need to be somewhere you know when you are ill'

'I'd rather be in my room, with my radio and familiar things and someone come here to look after me'

People thought this could be a very positive option if it could help them with organising and attending appointments and around taking medications. It was important that visiting nurses would have the time to listen to any worries.

Others thought that a visiting service would not be a good idea because it would not motivate people to think for themselves.

'This would be a bit of a cop-out for the residents. They wouldn't have to do anything themselves, they wouldn't have to go and see the nurses or go to the doctor. I don't think this is a good idea'

It was also felt that a visiting service could only cater for those with low-level needs, and that those who were bed bound or using a wheelchair would struggle in between visits.

'If someone is really ill and they need help like going to the toilet or emptying the urinal bottle then having a nurse come once a day is not enough. You would need regular checking and attention and having someone turn up at a specified time would just not work because what would happen in all the hours in between?'

'This would be OK if you only had minor problems'

It was suggested that this would be an expensive option to have the nurses visiting a lot, and that there would be resource problems for the team:

'If you just had visiting nurses they wouldn't always have the right equipment'

Option 3: Create an 8-10 bed intermediate care unit within a homeless hostel

The idea of having a unit in a hostel generated strong feelings from people, both in support of the idea and against it. Some participants felt it would be good to have nursing care in a hostel because of the support they would then get around substance use issues.

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'It would actually probably be better than a hospital because I think a lot of hospital nurses don't have the experience {of substance use issues}'

People also appreciated the idea of being able to go somewhere quiet, but not having to leave the familiarity of the hostel environment. Others could recognise times when they would have benefited from being able to access a rehabilitation unit in a hostel. It was thought a unit would be somewhere where all the viruses were contained and being managed.

'This is a really good idea. They need a sick bay here. Somewhere you could go and recover'

People talked about the benefits of having visitors and how a unit in a hostel would encourage that, although it was recognised that there would need to be careful checks over who was coming in to ensure people weren't coming in to intimidate people or extort money:

'It makes such a difference if someone comes to see you when you are in hospital, they really cheer you up, so if you are here in a sick bay that would be really good'

Others voiced concerns that it would be 'second-class' health care. Hostels were felt to be the wrong place to care for sick people. People felt that this type of service would divert homeless people away from hospitals, to the benefit of hospitals, but not the homeless. It was also felt that it would be difficult to draw the line about who could access care from such a unit – it was suggested other residents of the hostel would turn up and expect treatment after a bad night.

'If it was in a separate building fine but there's just no way it would work if it was in a hostel unless only the staff could get in and out, otherwise of course your mates will come in and bring you a drink and you're right back there'

'I'd rather go somewhere like LCCC than a bed in another hostel, at least there you know you are getting proper nurses and proper doctors'

It was felt that homeless people should be able to access mainstream services and that more time and money should be spent trying to make that possible.

Recommendations of the Steering Group

During the process of collecting data and consulting with stakeholders for this project, a number of related issues were highlighted. Although these issues have been covered in previous literature, it is felt they are still worth highlighting in this report.

Identification of housing status

This report has highlighted the need for improved monitoring of a person's housing status on presentation at A&E or admission to hospital. At present there is no way of identifying whether a person is homeless or living in temporary accommodation from the data collected currently. Therefore on an individual basis this limits opportunities for continuity of care and linking a person in with appropriate services, and opportunities to plan discharge are reduced. On a collective basis it means there is no way of monitoring how homeless people use, and receive treatment in, hospital services. A system for monitoring housing status is suggested in Homeless Link's guidelines for writing a protocol for the hospital admission and discharge of homeless people.

Discharge from hospital

A discharge plan for homeless people should be put into place on admission to hospital in order to avoid delayed discharges or discharges to inappropriate accommodation. For this to happen effectively, homeless people need to be identified upon admission. The Department of Health published 'Discharge from Hospital: pathway, process and practice' in 2003 which suggested this. Homeless Link in conjunction with the London Network for Nurse and Midwives has produced guidelines for writing a protocol for the hospital admission and discharge of homeless people. This will be on the Homeless Link website www.homeless.org.uk from December 2005.

There is also anecdotal evidence that homeless people frequently self-discharge from hospital. It would be useful to be able to monitor that in order to identify trigger points and develop ways to reduce this.

Information sharing

Stakeholders from the homeless sector, from hospitals, from intermediate care and from the Three Boroughs Primary Health Care Team all felt that there was a need for an increased understanding of each other's roles, and a need for improved information sharing. This could be done through joint training, awareness raising workshops, and by providing each other with more information on the role of each service and referral criteria.

Hostels health worker

Hostels could benefit from having a health worker within the team, or a person with overall responsibility for building relationships with health services, as health services felt it was difficult to communicate with hostels when they didn't have a named person to talk to. One hostel in Lambeth, Thames Reach Bondway's Graham House, has a health worker with responsibility for co-ordinating health services for residents and it is felt that this is a beneficial role within the hostel.

Homeless intermediate care service

The main objective of this study was to assess the need for an intermediate care service for homeless people in Lambeth. It is felt that the study shows there is a need for this type of service, with a combination of the proposed options recommended as the best way to cater for the varying needs of the client group.

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There are to be further discussions to determine exactly which options should be combined and what design the service should take, but the following points will be factored into the final service:

- **Discharge plan for intermediate care**

Within the current intermediate care services, the need for a discharge *address* on admission should be changed to a discharge *plan*, facilitated by improved links with homeless services in order to avoid delayed discharges. This would be a step towards ensuring that homeless people are not automatically excluded from referral to the current intermediate care services.

- **Gate-keeping for the service**

A combined homeless intermediate care service would require an overall gate-keeper, and it is suggested that this role would best sit within the TACT team, who currently provide a single point of access to all the intermediate care services in Lambeth.

- **Physical health needs data collection**

The lack of data available on the physical health needs of homeless people suggests the need for improved data collection around the following areas:

- Current conditions
- Severity of condition
- Current treatment/medication
- Conditions currently unmet and why
- How long a person has had a condition
- Mobility status
- Recent health services accessed

A homeless intermediate care service could collect this data as part of its referral and assessment procedures. In order to make use of the data on a collective basis a database would need to be created – possibly the Homeless Team's current database could be enhanced or redeveloped to fulfil this function. This information would help to build a more comprehensive picture of the health needs of the client group and inform future service provision.

- **Service evaluation**

In addition to the above data, to fully evaluate the service, data would be collected in the following areas:

- Demographics, additional needs, housing status on both accepted and refused referrals
- Reason for refusal of service
- Patient's health status on admission and departure as assessed by both the patient and provider
- Reason for departure, departure accommodation type and location.

- **Engagement tool**

A key theme arising from this study is the difficulties services have with engaging clients. Further work could be done within an intermediate care service for homeless people to develop ways of ensuring clients engage on an ongoing basis with the service, perhaps using explicit and proactive approaches with the client, including finding out why people disengage from services, what trigger points might be and how to avoid them, at the beginning of their referral. Work on engaging the clients may also include involving service users in the set-up of the service.

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This report was produced in partnership with:



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