Healthy London Partnership

Rapid Survey of Acute Pressures and Immediate Provision Needs

Summary Report

January 2022

Context

In response to the increasing number of COVID cases across London between December-January, and concerns that hospitals were working at very high capacity, a rapid survey was undertaken on 6th and 7th of January, amongst selected hospital teams. The aim was to identify people in hospital who no longer met the criteria to reside or no longer required a hospital bed (i.e. 'medically fit for discharge') and whose needs could be met if additional pan-London hotel beds were able to be set up. This would include people with relatively low support needs who were in hospital due to not having a safe place to discharge and people who were needing to self isolate due to being COVID positive. In addition, all teams were asked if they recently had problems finding suitable accommodations for anyone who was COVID positive. Due to the timeliness of this work and existing relationships in place, 6 London hospital Pathway Teams[1] were surveyed, including those based at:

- Guys' and St Thomas' hospital
- University College London hospitals
- King's College hospitals
- Royal London hospital
- Imperial NHS Trust hospitals
- St George's hospital

Caveats

- This was not an audit and not all questions were consistently asked due to time pressures of the teams. Where there were gaps in data, these were omitted from the calculations or captured under "unknown".
- As only 6 Pathway teams were surveyed, the findings are not representative of the comprehensive needs pan-London.
- This survey was conducted during a time where there was a peak in COVID cases, as well as other winter pressures.

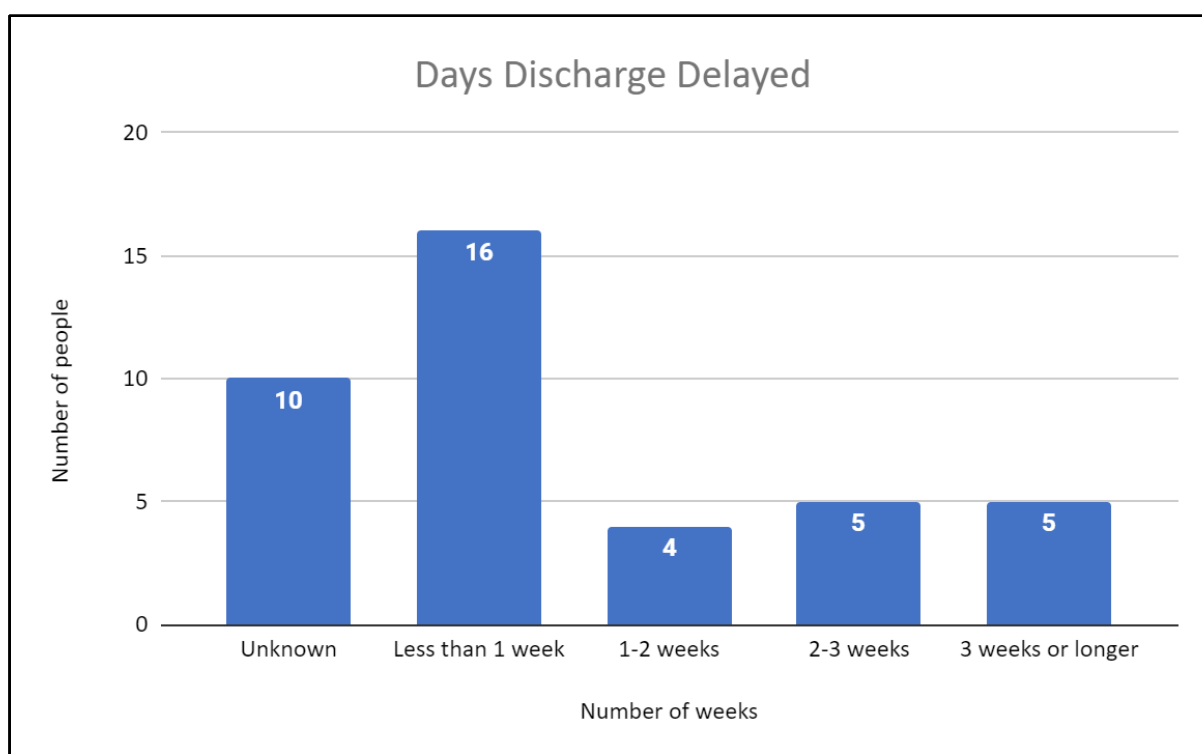
[1] Specialist teams trained to support people who are homeless and at risk of being homeless.

- The survey focused mainly on capturing information on current in-patients who were no longer meeting the criteria to reside/'medically fit for discharge' and was unable to consistently capture what was happening in Accident and Emergency departments (A+E) or details on people who had already been discharged - be it safely or unsafely.

Key Findings

Amongst people identified as homeless or at risk of becoming homeless, that were known to the Pathway teams, there were a total of 40 people across these hospitals who were considered 'medically fit for discharge' (or no longer meeting the criteria to reside).

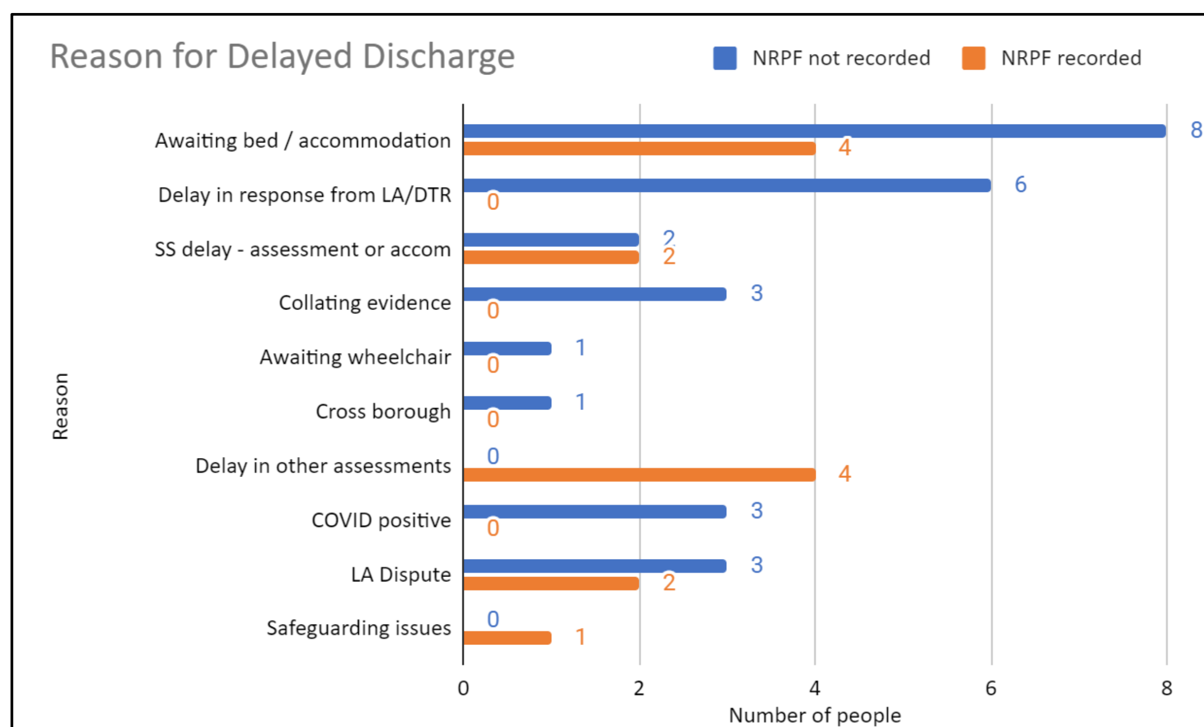
Delayed Transfers of Care



Information on the date where the patient was deemed 'medically fit for discharge' was provided in 30 out of the total of 40 cases (75%) and the number of days of delayed discharge at the point of data collection was calculated. Out of those where the date was known, just over half were delayed for less than a week (16/30) , while about a third (10/30) stayed at least 2 weeks (14 days or longer). Where the duration was captured as "weeks" or "months", this was recorded as 3 weeks or longer.

Reasons for delayed discharge

This section is divided into people with no recourse to public funds (NRPF) and people with recourse to public funds. This is to separate out the complexities around reasons for delay in supporting a safe discharge for each group.



No recourse to public funds

About a third (33%, 13) of the cohort were non-UK nationals with immigration issues meaning they currently had no recourse to public funds (NRPF) and had no safe place to be discharged to. Reasons for their delayed discharge included awaiting social services specialist accommodation or assessment (3), awaiting other assessments (4) such as for an asylum application, as part of the National Referral Mechanism (NRM) due to being likely victims of human trafficking or for clinical assessment / investigation being done as inpatient due to no safe discahrge destination, or awaiting other appropriate accommodation (1). Two people with NRPF had high support needs and were awaiting a bed following a referral to the Mildmay[2], and the remaining three had delays due to disputes with the relevant Local Authority or safeguarding concerns.

People with recourse to public funds

Approximately 68%, (27) had no immigration issues and had recourse to public funds. Of these, around 30% (8) were delayed mainly due to there being no immediate availability of appropriate accommodation. This included those waiting for appropriate supported accommodation (3), rehabilitation (2), short term 24/7 nursing care (2), or a temporary bed while complex issues were being sorted (1).

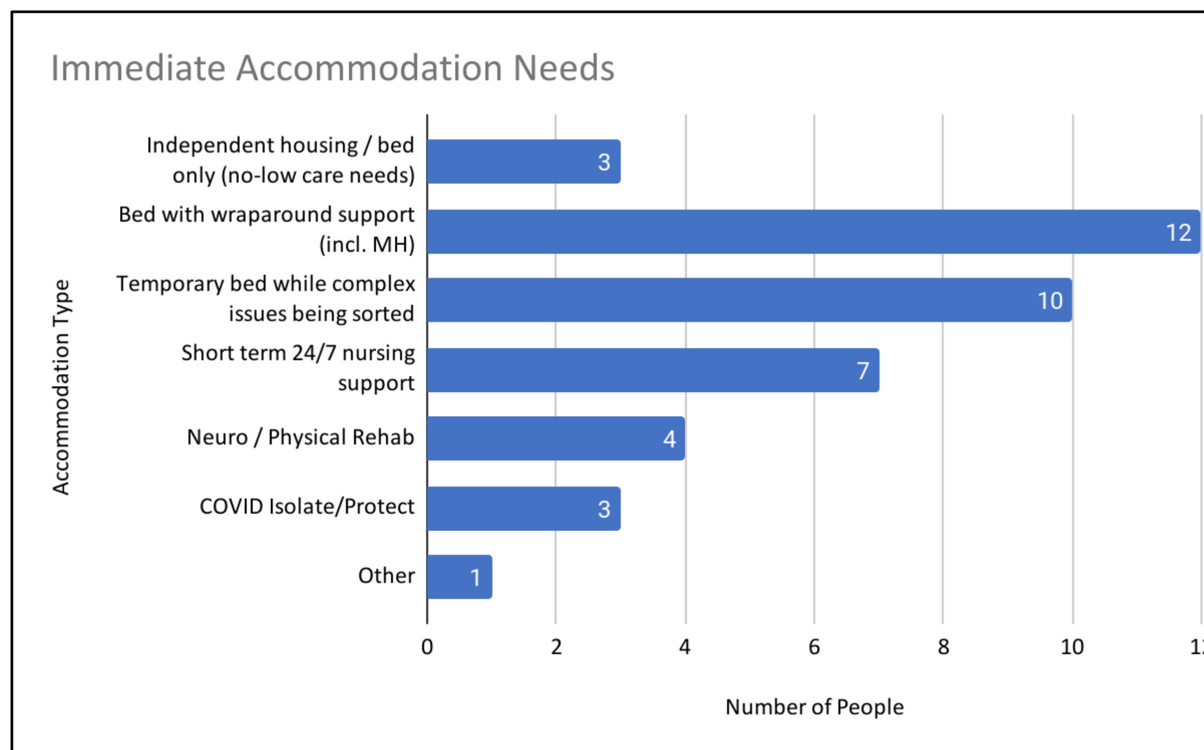
A further 22% (6) were awaiting housing or a response from the Local Authority following a Duty to Refer (DTR), while 11% (3) had issues around resolving disputes with the relevant Local Authority. Two people were waiting for a social services

[2] The Mildmay Mission Hospital provides 24/7 nursing support for people experiencing homelessness with complex health needs.

funded placement or assessment and three were delayed due to being COVID positive.

Other main reasons for delayed discharges (18%, 5) included collating evidence to support local connection or application for benefits (3), awaiting a wheelchair, or had issues relating to out of borough placements.

Immediate Accommodation Needs



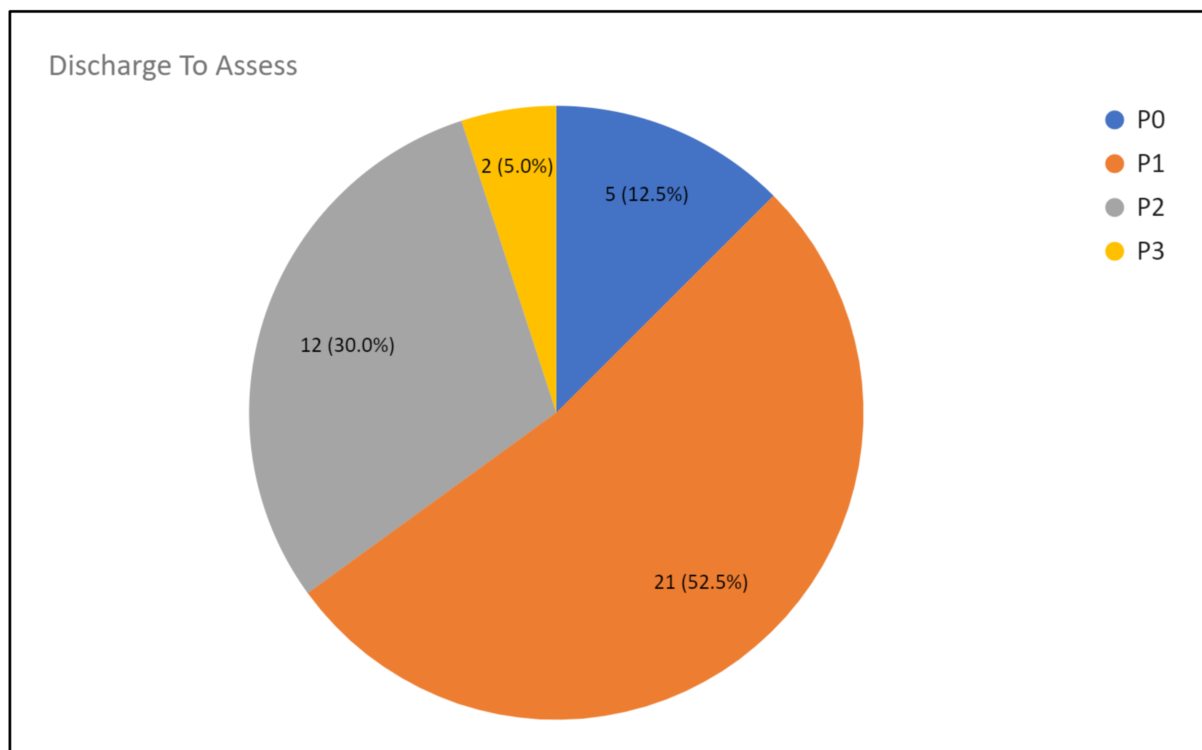
More than half of the total cohort (57%, 23) had immediate complex needs such as requiring neurological or physical rehabilitation (4), short term 24/7 nursing support (7), or accommodation with wraparound support, meaning a collaborative approach to support and services that is person-oriented (12). Sixteen of these (40% of total population) were deemed to be appropriate for admission at the Mildmay, of which six had a referral made. The remaining seven did not require the high level of support offered by the Mildmay but needed somewhere with wraparound support, including specialist mental health. 18% (7) of the total population also required wheelchair accessible accommodation (they all had immediate complex needs and so fell into one of the above categories).

A quarter (10) of patients had less complex health needs that could have been addressed in temporary accommodation, but needed continued case working. Issues included awaiting responses from the Local Authority, applications for benefits, housing or asylum, resolving Local Authority disputes (including legal disputes on responsibility) and waiting for appropriate accommodation.

The remaining 18% (7) were considered to have little or no care needs, thus requiring accommodation only (3), COVID Isolate or Protect provision (3), or were waiting to be repatriated overseas.

Care and Support Needs

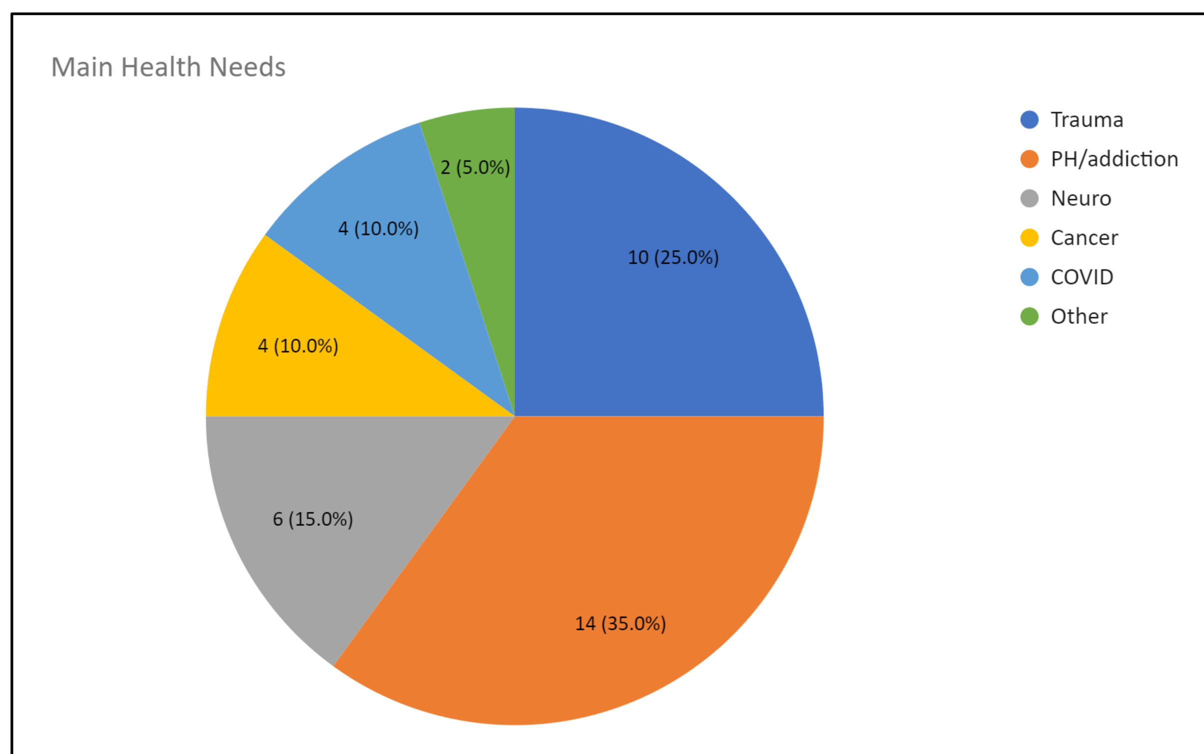
In reviewing the care and support needs of each case, people were grouped into the relevant Discharge to Assess (D2A) Pathway. Where the person's full care needs were unclear, a clinical judgement regarding the most appropriate D2A Pathway was made based on the information provided.



More than half (53%, 21) of cases were categorised as Pathway 1 (P1), meaning they required accommodation (existing or new) with assessment and active support from health, housing and social care (including floating/peripatetic support). This also includes some people with NRPF (with little to no care needs) who could be discharged to hotel accommodation while further assessment of their care and support needs are being undertaken. Approximately 30% (12) were those categorised as Pathway 2 (P2). These people required short term intermediate care “step-down” accommodation for rehabilitation or on-site 24/7 nursing/carer support. A small number (5%, 2) were grouped as Pathway 3 (P3), who were anticipated to require a long term, specialist homeless medical respite facility with on-site 24/7 nursing/carer support, such as a care home (though in the meantime would benefit from further rehabilitation and assessment in a facility such as the Mildmay). Only 13% (5) were placed into Pathway 0 (P0) requiring new accommodation without active support from health and social care or being able to return to their previous accommodation where their support needs (if any) could be met.

Main Health Needs

It was clear that there were common themes that ran across the cohort of people studied. To illustrate the level of need, each person was assigned a dominant theme based on their case information, admission being the main influencing factor. It is recognised that the chosen theme does not capture the full health needs of each person.



For most of these cases, there were overlapping key themes and additional care and support needs with a number having multimorbidity (presence of more than one condition). For example, more than half of people (53%, 21) mentioned above also had mental health difficulties.

Physical and/or addition

There were (35%, 14) across the cohort with 'physical health' and/or 'addiction' issues. Physical health conditions included diabetes with complications, COPD, Myocardial Infarction, liver disease, newly diagnosed HIV, chronic deep vein thrombosis, sepsis or other infections, falls with or without head injury, pneumonia, osteomyelitis and gastrointestinal bleeding. A combination of physical health problems and addiction was present in at least half (7) of these cases, some of whom had significant safeguarding concerns including self neglect and people who had also been cuckooed[3].

Cancer

[3] "Cuckooed" refers to a practice where a person's home has been taken over by others and used to facilitate exploitation (usually involving drugs).

Additionally, 10% (4) of the total cohort had cancer.

Trauma

Around a quarter of people (10) were admitted due to injuries relating to trauma. This includes fractures and amputations, many of whom reportedly jumped from windows, moving cars, off a bridge or into oncoming traffic, and a person with multiple stab wounds. Of these, mental health was a suspected influencing factor in at least 70% (7) of these cases.

Neurological

Of the total, 15% (6) of people had neurological problems such as a brain tumour, neuropathy, spinal issues, functional neurological disorder or were recovering from a stroke.

COVID / Other

A small number (10%, 4) had COVID as their main health need, while the remaining 5% (2) had other needs such as being in a difficult social situation or their previous accommodation was deemed temporarily uninhabitable.

Unsafe or Self Discharges

While the main purpose of the survey was to capture information on individuals who were deemed ‘medically fit for discharge’, some of the teams flagged other cases (8 in addition to the 40) for concern. These individuals had potentially been unsafely discharged (5), or had self-discharged to the street (3). Due to pressures of time, not all teams were asked for this information as it was not easily on hand.

Of those unsafely discharged, 2 had been discharged to the street from A&E due to immigration issues or NRPF, 2 had been discharged to inappropriate accommodation (lack of wraparound support) which they subsequently left, and the remaining person was discharged to the street due to disputes with the relevant Local Authority.

Learning

In undertaking the process of capturing this data, the following was learned:

- Building relationships and rapport with the teams has shown to be very helpful in establishing timely responses to urgent requests
- Need to respect the team’s limited time and work pressures by being organised and succinct.
- Establishing a clear protocol for capturing data will ensure consistency in questions asked and a more complete data capture.
- Broadening the cohort criteria may flag other cases of interest not considered.

Summary

This short survey determined there was no immediate evidence that stepping up additional pan London hotel provision would significantly help, however, it also highlighted several other issues impacting on timely and safe discharge for people experiencing homelessness. It demonstrated the wide range of complexity of need, often including a combination of physical health, mental health, addiction, housing and social care factors. Despite being deemed 'medically fit for discharge', many needed continued specialist case working, a period of rehabilitation, in-reach support or specialist accommodation.

There were 16/40 (40%) people who were considered needing very high specialist accommodation, such as the Mildmay, for a period of time (i.e. they would benefit from further rehab and / or nursing support), 7/40 (18%) people had high complexity needing somewhere with wrap around support (including specialist mental health), and a further 10/40 (25%) needed accommodation where complex case working could continue (without high level or specialist support). Relatively few people required accommodation alone 7/40 (17%).

There were a number of non-UK nationals with NRPF or people who were being supported to make asylum applications or being referred to the national referral mechanism as a result of being victims of human trafficking. In this cohort, the majority of this group had high levels of health or social care needs, meaning that there was likely to be a statutory duty to support them. However, assessments needed to build a case for whether a statutory duty is owed can take a significant amount of time. In addition, many non-UK nationals need immigration support in order to address their status to enable them to regularise their stay in the UK and give them access to public funds and support. This can be vital in addressing these issues long term so there needs to be an appropriate setting where this can take place.

Without being discharged to an appropriate destination with adequate support many people experiencing homelessness end up back in hospital, on the street or in unsafe settings, further exacerbating their poor health and health inequalities.

A joined up approach and commitment across health, housing and social care is needed to facilitate timely and safe discharge for this cohort.

Next Steps

The project team from the Healthy London Partnership, Out-of-Hospital (OOH) work programme is planning to undertake a more comprehensive snapshot audit across all London hospital Pathway teams, as well as other discharge planning teams across one of London's Integrated Care Systems. The aim is to obtain a view of current caseloads, challenges/barriers to discharges, and to identify where there may be gaps in available step-down provisions and/or suboptimal discharges for people experiencing homelessness across London. This will also feed into

discussions on how this data may be more routinely captured to be able to inform commissioning and discharge decisions.

In addition, the programme is undertaking further work with Local Authorities to develop a directory to support health teams when contacting housing teams. Meetings are also being convened to improve shared understanding. All of this should hopefully reduce some of the housing delays.

Acknowledgements

This work would not have been possible without the support of the Shared Outcomes Fund, OOH Care Models funded project team at the Healthy London Partnership and the support of the London hospital Pathway teams.