Waverley Care's Milestone Intermediate Care Unit (MICU) Evaluation

December 2021 | Author: Gerry Mitchell

WAVERLEY care Positive about HIV, Hep C & Sexual Health in Scotland
EVOC INFORMATION .ORG.UK DEVELOPMENT ADVOCACY
cyrenians
NHS SCOTLAND
Edinburgh Health & Social Care Partnership

Contents

Foreword

EVOC were commissioned by the Edinburgh Health and Social Care Partnership to carry out this work in collaboration with members of the Milestone Steering Group.

> *The very nature of drug, alcohol and homeless services lies within the collaboration between the NHS, third sector, social work, and housing. Covid-19 has seen these organisations come together to work as one team. There is much to be learned from this work moving forward to reduce the harm to vulnerable people.*[1]

> *I came here so broken and uncertain, and the beginning of this journey started in room 9. I am leaving with so much hope and determination for the next chapter.*[2]

1. *Covid 19 Pandemic - The Edinburgh Response by Homelessness & Drug & Alcohol Services Partnership Working at its Best* 2. *MICU service user.*

Executive summary

1. This evaluation presents evidence of key benefits of the Milestone Intermediate Care Unit (MICU) provision, between April 2020 and October 2021. It summarises findings from interviews conducted during a recent evaluation of the service; performance data from the first 18 months of its operation; and secondary literature.

2. The MICU was set up in April 2020 in response to increased pressure for hospitals to make effective use of beds during the pandemic. It provides a clinically safe, effective and integrated place where patients can be discharged in a planned and positive way.

3. The provision comprises the ten-bedded residential unit at Milestone, offering 24/7 care, delivered and managed by Waverley Care, with staff from the Access Practice and other partners. There are pathways to the unit from in-patient care (step-down) delivered by the Cyrenians and step-up pathways through a range of community partners.

4. The service meets the strategic priority to reduce health inequalities by effectively targeting, reaching and engaging some of the most excluded people who have a clinical need and are either experiencing homelessness or at risk of becoming homeless, by providing access to health and other services at one location.

5. The MICU reduces secondary health care costs. From April 2020 to April 2021, it has supported 80 individuals, of which 43 step-down referrals were patients from NHS Lothian acute sites who without the MICU would have stayed in hospital. This was at a saving to NHS Lothian of 240 occupied acute hospital bed days, a total of £156,720.

6. The service supports clients to attend a wide range of outpatient follow-up appointments (especially orthopaedic) and in doing so, saves the cost of wasted appointments, in addition to potentially reducing numbers of further readmissions due to failed treatment.

7. One third of deaths among people experiencing homelessness are reported to be from treatable conditions. Treating chronic morbidities is key to addressing health inequalities in the homeless population. The MICU model of care addresses not only service users' immediate clinical needs but also includes their physical health and long-term chronic condition management (such as for cardiovascular disease.)

8. The MICU meets the Scottish Government's strategic goals of preventing and reducing homelessness by providing a package of care enabling service users to isolate, recover and address both additional health needs and the social, welfare, financial and housing support that will enhance their recovery and enable a successful discharge to safe and appropriate accommodation.

9. On admission to the MICU, 50 out of 80 MICU service users had no fixed abode (NFA) or were in temporary accommodation, while eight could not return to their tenancy. On planned discharge from the MICU, 83% of service users moved into sustainable accommodation. The MICU is likely to provide significant savings to City of Edinburgh Council housing services by reducing stays in temporary accommodation.

10. The MICU reduces the risk of drug-related deaths. Two-thirds of the MICU service users reported use of opiates/opioids and /or benzodiazepines. These drugs are implicated in 86% and 73% of drug-related deaths respectively.[3] The MICU provides the residential stabilisation recommended in the Medication Assisted Treatment (MAT) Standards for those at high risk due to their benzodiazepine use. It has supported 67 out of 80 individuals with opiate substitution therapy, targeted distribution of naloxone treatment and re-engaging with SMART and other recovery support groups.

11. Half of all MICU service users have been supported with treatment for alcohol use, including detox treatment and recovery support groups.

12. The MICU service prevents and reduces mental health-related harms and deaths by providing service users with trauma-informed and person-centred psycho-social care in an enhanced residential setting. It also temporarily registers them with the Edinburgh Access Practice, which provides access to community mental health services.

13. The MICU is the only service of its kind in Scotland: a person-centred, trauma-informed model using a whole systems approach in which service users can access a wide range of services in one place – a 'no wrong door approach.' People experiencing homelessness or at risk of homelessness often do not access and engage with clinical services because of the difficulty of navigating an overly complex system, which is, in addition, not delivering trauma-informed care.

3. *Society for the Study of Addiction, quoting National Records of Scotland data.*

Background

The MICU developed in response to increased pressure for hospitals to make effective use of beds during the pandemic.

Vulnerable people who have been admitted to hospital with complex needs and are homeless or at risk of homelessness tend to spend longer recovering in hospital[4] and often struggle in acute care settings and discharge themselves, leading to re-admissions, increased morbidity and risk of death. Rather than being discharged back to temporary accommodation where the chance of contracting Covid-19 was greater, the MICU was set up as a clinically safe, effective and integrated place where patients could be discharged in a planned and positive way.

Patients who are experiencing homelessness or are at risk of homelessness, with an addiction to alcohol and/or drugs, face a range of barriers to their care including stigma, discrimination, inequitable access, poor retention practice and lack of consistency. The MICU service provides a patient-centred, trauma-informed holistic package of care. Users can isolate, recover and address both additional health needs and the social, welfare, financial and housing support that will enhance recovery and enable a successful discharge to safe and appropriate accommodation. As such, it contributes to key national and local government strategic aims.

The service is now established within the system of local care, support and housing and has a track record of achieving remarkable outcomes for those who use it.

It has contributed to reduced in-patient stays in acute hospital wards, decreased re-admissions and a range of improved clinical outcomes and provided the supportive environment necessary to enable continued clinical care and completion of treatment that would not be possible in homeless accommodation. Service users with NFA on referral into the unit have been supported through a planned discharge into sustained accommodation.

In April 2022, the current funding package for the project (composed of Drug Deaths Task Force (DDTF) and Edinburgh Health and Social Care Partnership funding) expires. Continuation of the MICU depends on funding from multiple strategic partners which is being sought for a five-year period, to provide stability for the project to develop. The purpose of this evaluation is to present a summary of existing evidence to be used to support funding applications and highlight the risks of not continuing this service. A separate document sets out service development recommendations which would further improve the service user experience of the MICU and may help increase the number of referrals made through the acute and hospital pathways.

4. *Wadhera et al (2019) Trends, causes and outcomes of hospitalizations for homeless individuals: A retrospective cohort study.*

Milestone Intermediate Care Unit: Integrated and holistic care

"How was it not there before?"[5]

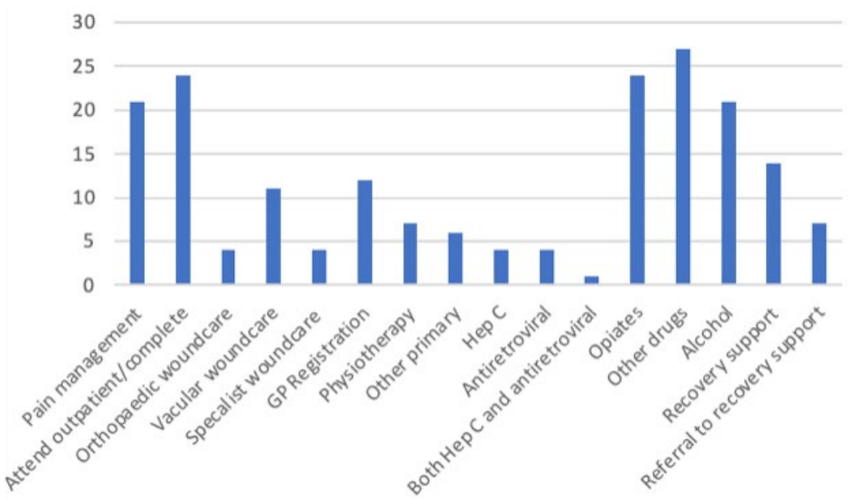
While set up at a fast pace as an organic response to the pandemic, the service has filled a gap in existing service provision. It is an exemplar of the models of care advocated by Scottish Government[6] and Public Health Scotland[7], delivering an integrated multi-disciplinary service built on partnership between the statutory and third sectors to meet the needs of marginalised communities. For a summary of current costs, see Table 1. The service is meeting Scottish Government goals in relation to Covid-19, reducing drug and alcohol harm and premature death, homelessness and health inequalities. See, for example, action plans in Ending Homelessness Together (2018), Hard Edges Scotland (2019), Rights, Respect, Recovery (2020), and Scotland and the Sustainable Development Goals (2020).[8]

The MICU model of care delivers:

- A service led through a team of hospital in-reach workers (who work for the Cyrenians as part of a broader project) with support from City of Edinburgh Council social work, housing & homeless services. These teams identify those in need of the service and work to ensure a safe, planned discharge to suitable accommodation.
- A service that removes the need for service users to negotiate numerous and complex referral systems,[9] and provides the supportive environment necessary to allow continued care and treatment that would not be possible in homeless accommodation. The range of treatments is illustrated in Figure 1. Clinical assessment and treatment is in one place including physical health and long-term condition management (such as for cardiovascular disease) by providing comprehensive assessment, diagnosis and treatment of comorbidities. It also supports engagement with a wide range of health and social support services.
- Access to both primary and secondary care practitioners, with funded sessions of nursing and GP time (through Edinburgh Access Practice) and NHS secondary care continuation of treatment plans delivered by in-reach hospital teams. This includes temporary GP registration for users during their stay in the unit (Edinburgh Access Practice), providing access to a wide range of services. And even though this is temporary, service users can permanently register (and the majority do).
- In addition to clinical care, the MICU provides broader support to enhance and expedite recovery. It links service users into broader community support, such as mental health and drug and alcohol services, welfare and financial support, and provides purposeful and meaningful occupation as an aid to recovery. It identifies duplication and unmet need/ gaps in a package of care and support by reviewing existing support workers (such as Police Liaison, Housing First, a social care worker or an advocate).

5. *Staff member – quote from evaluation interview.* 6. *Commission on the Future Delivery of Public Services, (2011).*
7. *Public Health Scotland (2020) Inclusion Health principles and practice.* 8. *Scotland and the Sustainable Development Goals (2020) specifically references the hospital in-reach service in Fife, similar to the MICU hospital in-reach provided by the Cyrenians, as key to achieving better health outcomes for those experiencing homelessness (p.36).*
9. *As advocated in A Just Capital: Actions to end Poverty in Edinburgh (2020).*

Figure 1: Wide range of treatments supported by the MICU (April 2020-December 2020)



Source: MICU data 2020

Table 1: MICU costs (April 2020-December 2021)

Role	Capacity needed	Role within project	Current provider	Cost/ annum
24/7 social care + housekeeping	2 to 3 staff per shift plus waking nights	Core service	Waverley Care	£790k
Nursing input (RGN)	2.5 days/week	Clinical care: all residents are registered as temporary Access Practice patients.	TAP	£22k
GP sessions	1 per week	Contribution to the team who supports the paths in and out of the unit.	TAP	£10k
Contribution to pathway support project	1 WTE	Harm reduction and recovery support; Linkage to services and aftercare planning. Motivation, practical and mpathetic support.	Cyrenians	£25k
D&A in-reach (including lived experience)	1 WTE		Turning Point Scotland / CGL	£40k
Expenses				£3k

Benefits of Milestone Intermediate Care Unit Provision

1. Reducing health inequalities by meeting the needs of a vulnerable group

Inequalities due to Covid-19 were evidenced earlier in the pandemic, with increased infection rates in deprived areas and twice the mortality rates in most deprived quintiles.[10] 41% of people experiencing homelessness are now considered at high risk - primarily due to high levels of chronic illness.[11]

High morbidity and mortality rates among the homeless population are well documented.[12] Standard mortality rates are eight times higher for men who are homeless and 12 times higher for women who are homeless.[13]

One third of deaths among people experiencing homelessness are reported to be from treatable conditions.[14] Therefore it is critical to engage with this vulnerable group earlier to prevent or improve outcomes for early onset chronic disease.[15]

A 2019 study highlighted the potential for early identification of individuals at risk to reduce levels of mortality among people experiencing homelessness.
It called for a model of care "proven to either prevent or improve outcomes for early onset chronic disease [...] with a much broader focus that encompasses physical health and long-term condition management, especially for more common conditions such as cardiovascular disease."[16]

In 2021, the largest evaluation to date of specialist discharge services for people experiencing homelessness in the UK showed that clinical advocacy increased access to planned (elective) follow-up care. This is an important outcome as one in three deaths of people in the homeless hospital discharge cohort were due to common conditions, such as heart disease, amenable to timely healthcare.[17]

10. *See for example: www.nrscotland.gov.uk/files//statistics/covid19/covid-deaths-21-infographic-week-23.pdf.*
11. *Story, A and Hayward, A (UCL Centre for Inclusion Health) quoted in Budd, J (2020) 'Homelessness and Covid' presentation.* 12. *See for example, Liu and Wang, 2021: www.nature.com/articles/s41572-020-00241-2* 13. *Aldridge et al, Lancet November 2017.* 14. *Drugs, heart disease and stroke, and, for men, alcohol and, for women, cancer are the most common causes of death (Waugh et al, Scot Gov. June 2018)*
15. *Waugh, A., Clarke, A., Knowles, J. and Rowley, D. (2018) Health and Homelessness in Scotland: People, Communities and Places, Scottish Government.* 16. *Aldridge RW, Menezes D, Lewer D et al. Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. [version 1; peer review: 2 approved]. Wellcome Open Res 2019, 4:49.* 17. *Cornes M., Aldridge R., Biswell E., Byng R., Clark M., Foster G., et al. (2021) Improving care transfers for homeless patients after hospital discharge: a realist evaluation. Health Serv Deliv Res 9(17).*

The MICU service:

- Supports a clinically vulnerable group of patients experiencing homelessness or at risk of homelessness with average age of death of 46.5 years for men and 41 years for women.[18]
- Their health profile is comparable to that of a general population cohort in their 80s:
    - 86.7% have a long-term physical health problem – an average of three conditions per person
    - 28% suffer with chronic pain
    - 87% have a long-term mental health condition
    - 36% have a history of attempted suicide or self-harm
    - 73% have a drug use problem, 37% have an alcohol problem
    - 70% have a triple morbidity of physical, mental health and substance use problems
    - 33% have a recorded history of childhood abuse or neglect
    - 30% had been in prison in the previous year[19]
- Supports Scottish Government policy on self isolation at home by providing a safe place to isolate for those service users experiencing homelessness.
- Given the profile of those accessing the MICU, and the barriers faced in accessing appropriate care and support, the benefits of the service as described in this evaluation have a disproportionate impact on health inequalities.

18. *Edinburgh Access Practice 2018 audit* 19. *Ibid*

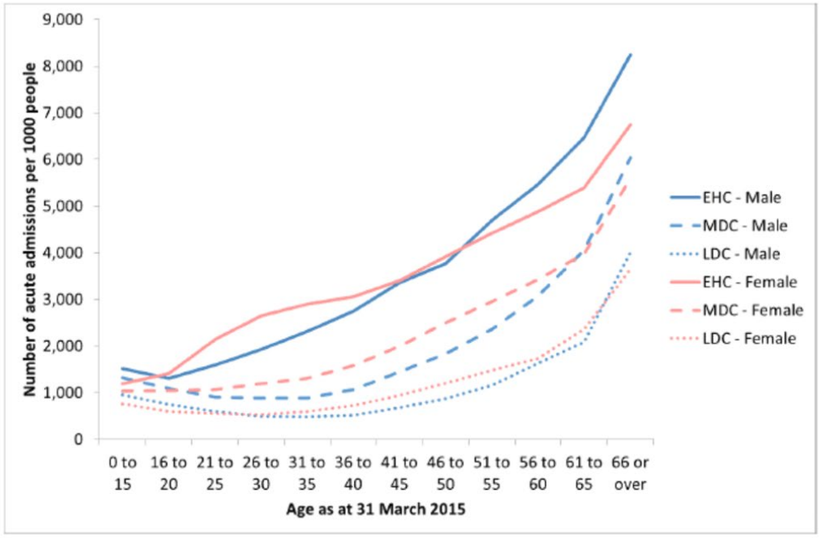
2. Reduces secondary health service costs

In 2018, the Scottish Government found that:

- Those experiencing homelessness have higher acute hospital admission rates than the most deprived cohort.[20]
- Accident and Emergency attendance rates of those experiencing homelessness are almost twice that of the most deprived cohort.
- Between 2002 and 2015, a higher proportion of the 'ever homeless' cohort[21] were more likely to have 5 or more acute admissions than the most deprived cohort. (See Figure 2)
- The 'ever homeless' cohort males had a total length of hospital stays of 1,507,223 compared to 343,885 days for the least deprived cohort. 12% of those admissions were 5+ days, compared to 9% for the least deprived.

Duration of admissions has been estimated to be three times longer for patients experiencing homelessness, due to poor hospital discharge arrangements, reflecting ongoing and unaddressed care and housing needs.[22]

Figure 2: Number of acute admissions per 1,000 people (admission rate) by age, sex and cohort



Source: Waugh et al (2018) Health and Homelessness in Scotland

20. *Waugh et al. (2018)* 21. *Ever-homeless men between 36 and 40 years old had the most admissions compared with their cohort. EHC females aged 26–30 years have the most acute admissions compared with their controls. Scottish Government (2018) Health and Homelessness in Scotland: www.gov.scot/publications/health-homelessness-scotland/pages/5.* 22. *Homeless Link (2014) The unhealthy state of homelessness: Health audit results.*

The Scottish Government's NHS Recovery Plan 2021-2026 has made a priority the need to develop alternatives to attendance at A&E and minimise the need for hospital admission.[23] Keeping care as close to home as possible is a key element of this strategy, so for individuals who are homeless or at risk of homelessness, access to these services remains very difficult to achieve. The MICU offers such access in a supportive and homely environment thus improving healthcare equity.

Research on step-down intermediate care services in the UK has found that:

- A&E visits are 18% lower among patients experiencing homelessness discharged at a site with a step-down service than at those without.[24]
- Homeless hospital discharge schemes are more effective and cost effective than standard care.[25]
- Schemes with direct access to specialist intermediate care (step-down) are more effective and cost effective than schemes without. It is managing the transfer of care–as the MICU service does–that is key, not just the exit from the acute sector.[26]
- They reduce the average length of inpatient admissions for those experiencing homelessness by 3.2 days (12.7 reduced to 9.5 days) which equated to a £1,600 saving per patient on average due to lower length of stay.[27]

Evaluation of a hospital in-reach service in Fife (2021) has found reduced hospital activity among those discharged as a result of the intervention with an average saving of £2,422 per patient supported.[28]

Waugh et al. found that the ever-homeless cohort has 60% more outpatient appointments[29] than the most deprived cohort and over double the number compared with the least deprived cohort. The ever-homeless cohort missed 28% of their appointments. In a study of over 1000 admissions, Field et al (2019)[30] found patients with experience of homelessness attended twice as many planned hospital care appointments following contact with a hospital in-reach service.[31]

23. *Scottish Government/NHS Scotland (2021) NHS Recovery Plan, 2021-2026.* 24. *Cornes et al (2021)* 25. *Ibid.* 26. *Ibid.* 27. *www.homeless.org.uk/sites/default/files/site-attachments/HOSPITAL_ADMISSION_AND_DISCHARGE._REPORTdoc.pdf* 28. *Healthcare Improvement Scotland (2021) NHS Fife and Shelter Scotland approach to supporting homeless patients attending hospital: Evidence and Evaluation for Improvement Team (EEvIT)*
29. *Waugh et al. (2018)* 30. *Field et al. (2019) Secondary care usage and characteristics of hospital inpatients referred to a UK homeless team: a retrospective service evaluation.* 31. *This led to engagement with, for example, follow-up endoscopies, procedures, and treatment such as surgery or cancer therapy.*

The MICU service:

- Provided step-down care of 43 patients in the first year of delivery who would otherwise have needed to remain an inpatient in secondary care, thus shortening individual length of stay. This included patients requiring:
  - IV or complex oral antibiotics requiring monitoring
  - Ongoing active alcohol detox
  - Ongoing active pain management
  - Ongoing active mental health support
- Delivered an associated saving to NHS Lothian of 240 occupied acute hospital bed days, equivalent to a cost saving of £156,720, and resulting in improved hospital efficiency. This is calculated by the price of a 24 hour stay in hospital by 240 bed days, which is currently £653/24 hours and does not include staff costs, medication or investigations.
- Considerably improved the quality of care provided to patients when taking into account that discharges to the community are more difficult and lack of available housing would have led to other health interventions not being met. The service supports clients to attend a wide range of outpatient follow-up appointments (especially orthopaedic, but including community physiotherapy, wound care, community occupational therapy, among other services).[32] In doing so it saves the cost of wasted appointments in addition to potentially reducing the numbers of service users requiring future hospital stays/acute hospital readmission due to failed treatment.
- Develops relationships with patients and prevents unplanned hospital discharges; the implications of which are far worse for those experiencing or at risk of homelessness. Of the 57 individuals admitted from acute care, 45 had no access to accommodation on discharge from hospital.
- Provided an alternative to inpatient treatment in 17 admissions for those who would otherwise not have been discharged even regardless of housing status – treatment delivered at the MICU would not have been possible in the community.
- Some individuals have required more than one admission due to the complexity of their needs. Case study 2 provides an illustrative example of how the service promotes on-going engagement with and support of MICU service users, which results in sustainable long-term outcomes.

32. *Please note that calculating days of admission avoidance through community referrals is more complicated as they would require estimated lengths of stay in hospital.*

3. Prevents and reduces risk of homelessness

Unplanned discharge from hospital has a knock-on effect on housing and related support services. Without good health, service users find it very difficult to address their wider needs and move on to independent living. In 2017, Homeless Link and St Mungo's found that 70% of people experiencing homelessness were being discharged from hospital back to the streets without having their housing or ongoing care needs properly addressed.[33]

Edinburgh has the third highest number of homeless households in Scotland.[34] Edinburgh also has a much more limited availability of appropriate accommodation for the MICU client group compared to the rest of Scotland. 44% of Edinburgh's homeless households are in temporary accommodation defined as 'other' compared to an average of 7% for Scotland as a whole.[35] 10% of temporary accommodation in Edinburgh are flats compared to an average of 41% for Scotland.

At one point in the pandemic, Edinburgh had approximately 1400 people classed as experiencing homelessness, living in shared, temporary accommodation. This was a cause for concern as, in some cases, residents shared amenities, which coupled with multiple morbidities, increased the risk of Covid.[36]

Healthcare Improvement Scotland's evaluation of NHS Fife Victoria hospital in-reach service,[37] indicated that:

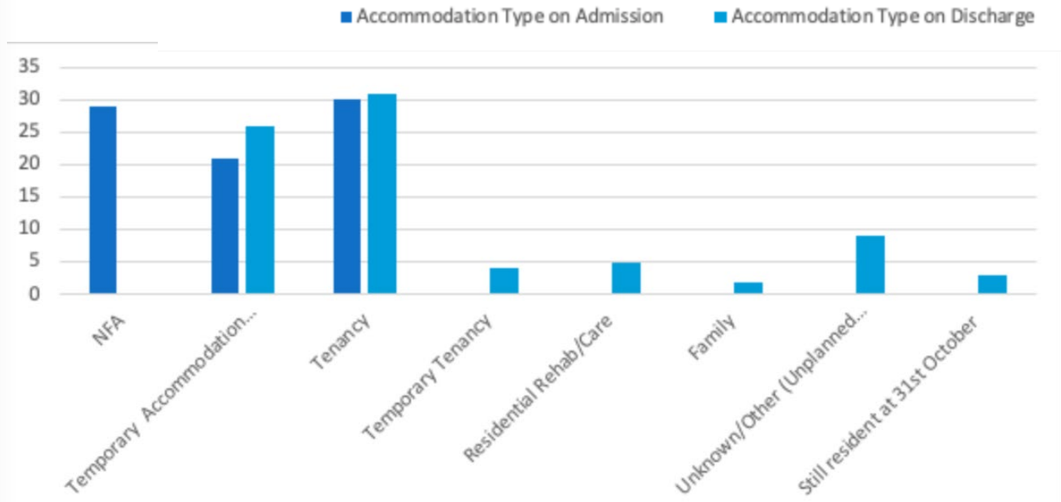
- It increased the number of people in Council/Registered Social Landlord accommodation, and temporary accommodation.
- Reduced the number of people who have NFA and/or are street homeless.
- Over half the participants indicated their health status affected their housing options.
- It should be noted that the MICU model differs in that it supports service users with applications for accessible housing or advocating for modifications to existing accommodation.

The MICU service:

- Reduces the number of service users who would have been discharged to NFA or temporary accommodation by supporting them into sustained accommodation and therefore reduces their risk of homelessness and reduces housing costs associated with temporary accommodation. See Figure 3 below.
- Allows individuals more time to find suitable accommodation which is key to the service's positive housing outcomes. Advocacy and support provided at the MICU can significantly fast track the service user's securing of an appropriate tenancy.
    - 50 out of 80 MICU service users had no fixed abode or were in temporary accommodation on admission to the service.
    - 83% of service users who engaged in a planned discharge process at the MICU moved into sustainable accommodation.

33. *Homeless Link, Inclusion Health and St Mungo's (2011) Improving hospital admission and discharge for people who are homeless, London quoting Homeless Link (2010) The Health Needs of Homeless People, findings of a national audit.*
34. *Scottish Government (2021) Homelessness in Scotland.* 35. *In Edinburgh, 2,590 open homeless cases were in temporary accommodation (See tables 39a&b). Of which, 665 (26%) were in B&Bs and 1150 (44%) in 'other' (no breakdown is provided of this category, and therefore an assumed definition is 'shared houses.') Scottish Government (2021) Homelessness in Scotland: 2020-21, Main tables (June 2021).* 36. *Source: Evaluation interview data.*
37. *Healthcare Improvement Scotland (2021) NHS Fife and Shelter Scotland approach to supporting homeless patients attending hospital.*

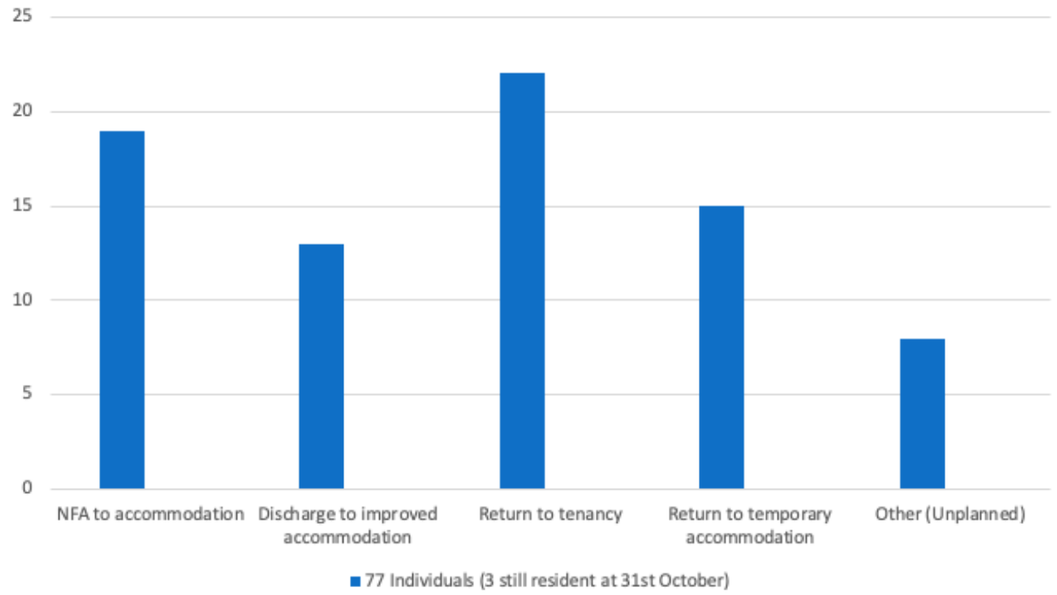
Figure 3: Service users' self-reported housing status on admission to the MICU compared to discharge (April 2020 - October 2021).



Source: MICU 2020-2021 data

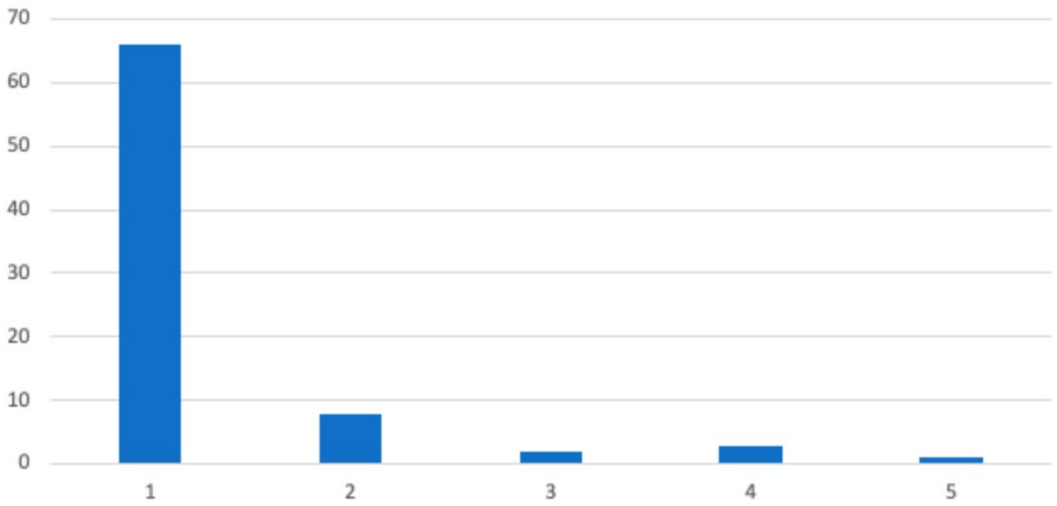
- Associated cost reductions for temporary accommodation are evident but hard to quantify. The average net cost of B&B type temporary accommodation to the Council is £14,396 per annum or £39.44 per night but this assumes some housing benefit recovery, and due to the complexity of need of those accessing the MICU, it is unlikely to be representative of the temporary accommodation utilised.
- Supports clients to have their housing priority re-assessed due to health needs:
    - Five individuals who had no fixed abode on admission were discharged to a tenancy.
    - Four additional individuals accessed a new tenancy.
- Supports service users who require modifications to be made to existing accommodation or new accommodation as a result of their complex co-morbidities:
    - 32 individuals left to more appropriate accommodation.
    - 25 individuals returned to previous accommodation with increased support.
- The MICU will also sometimes increase costs by supporting a service user who has not been receiving treatment and support/and not accessed any services while experiencing homelessness. In this case, the way the service positively changes the lives of its users, who would otherwise be caught in long-term and repeated homelessness, is the real measure of its value.
- Supports tenants to sustain their tenancies (by referring service users to ongoing support in the community and by providing the offer of returning to the MICU for respite):
    - 48 successful referrals for ongoing support in the community.
    - 31 referrals were made to re-engage service users with existing support whilst resident at Milestone.

Figure 4: The MICU service users: accommodation outcomes 30 April 2020 – 31 October 2021



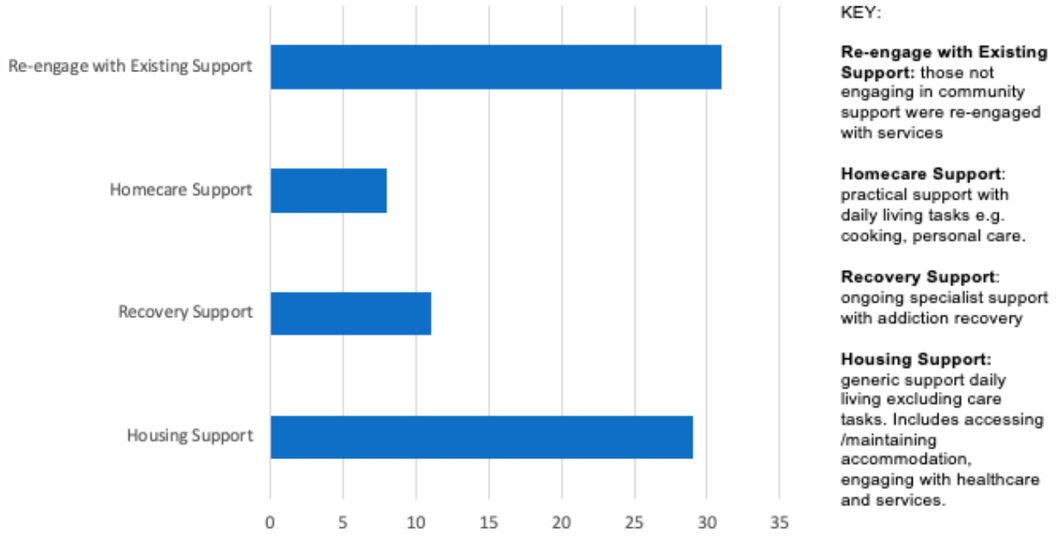
Source: MICU 2020-2021 data

Figure 5: Number of the MICU admissions per service user (April 2020 to October 2021)



Source: MICU 2020-2021 data

Figure 6: Community support outcomes for the MICU service users (April 2020 – October 2021)



Source: MICU 2020-2021 data

4. Prevents and reduces alcohol and drug-related harms and deaths

Evidence shows that the proportion of people with drug and alcohol-related health issues is much higher among those who have had multiple experiences of homelessness. It also shows that drug and alcohol related deaths account for most deaths in those people with repeat homelessness.[38]

In 2019, 70% of deaths of people experiencing homelessness were drug-related, by suicide and/or alcohol specific.[39]

- 94% of drug deaths involve more than one drug.[40]
- Opiates and opioids are implicated in the majority of drug-related deaths (86%).[41]
- Benzodiazepines are now implicated in 73% of Scottish drug deaths.[42]
- This complex and most at risk client group are 10 times higher to be admitted to initial assessments at drug treatment services.[43]

By 2027/28, hospital usage figures associated with people with substance use issues are predicted to be as follows: [44 & 45]

- 192,600 hospital bed days (estimated cost: £101.8 million (based on 2012/13 costs), of which £73.2 million would be attributable to older people with substance use issues.[46]
- 30,100 hospital stays, of which, 21,800 would be emergency hospital stays.

The MICU Service:

- Models a clear example of the public health approach promoted by the Scottish Government's Rights, Respect, Recovery strategy in preventing and reducing alcohol and drug use, harms, and related deaths.[47]
- Provides the opportunity to engage people and support them to stay on medication assisted treatment (MAT) for which national standards were introduced by the Scottish Government earlier this year. This is often challenging for people initiated on treatment in hospital and discharged to homeless hostels or temporary accommodation. Being in treatment is a protective factor for patients and reduces the risk of harm and premature death. The MICU can provide the relevant support to ensure their patients can access MAT and remain on it. [48.49 & 50]

38. *Ibid.* 39. *National Records of Scotland (2021): 10. (Please note that these are experiential figures).* 40. *Scottish Government (2020) Evidence-Based Strategies for Preventing Drug-Related Deaths in Scotland: Our Emergency Response.* 41. *Waugh, A.; Clarke, A., Knowles, J. and Rowley, D. (2018) Health and Homelessness in Scotland: People, Communities and Places, Scottish Government.* 42. *Society for the Study of Addiction, quoting National Records of Scotland data.* 43. *Waugh, A.; Clarke, A., Knowles, J. and Rowley, D. (2018) Health and Homelessness in Scotland: People, Communities and Places, Scottish Government.* 44. *Referred to as people with a drug problem (PDP) in the publication.* 45. *Referenced in Scottish Drugs Forum (2017) Older People with Drug Problems in Scotland: Addressing the needs of an aging population: The Expert Working Group on Older People with a Drug Problem: Final Report* 46. *Referred to as older people with a drug problem (OPDP) in the publication.* 47. *Scottish Government (2018)* 48. *See Scottish Government (2020) Evidence-Based Strategies for Preventing Drug-Related Deaths in Scotland* 49. *Scottish Government (2021) Medication Assisted Treatment (MAT) standards: access, choice, support.* 50. *Public Health Scotland (2021) Medication Assisted Treatment (MAT) Standards for Scotland*

- Supports individuals at high risk of drug-related harm and premature death in an enhanced residential setting, improving their access to OST and other drug and alcohol interventions:
  - 64 individuals reported use of between 1 and 3 substances, with 29 service users reporting use of two substances.
  - 40 of service users reported use of opiates.
  - 34 of the 41 individuals supported by MICU with substance use, reported use of benzodiazepines.
- Provides the residential stabilisation recommended in the MAT Standards Informed Response for Benzodiazepine Harm Reduction[51] for those at high risk due to their benzodiazepine use:

"Where risk is extremely high due to previous nonfatal overdose or physical or mental comorbidities, a period of inpatient or residential stabilisation, if available, should be considered. The benzodiazepine working group has already made an early recommendation to the Drug Death Task Force to support access to residential beds to provide a place of safety for those who are at highest risk of benzodiazepine harms and are in the process of scoping out existing resources and models of care."
(Scottish Drugs Forum, 2021: 2)

- 67 out of 80 individuals were supported with detox/stabilisation, opiate substitution therapy, re-engaging with SMART and other recovery support groups. Of which:
  - 19 engaged with recovery support whilst resident.
  - 11 were successfully referred for ongoing recovery support in the community.
- Engages patients (that other service providers may find challenging) in effective, controlled community prescribing (including targeted distribution of naloxone treatment) or to coordinate an admission for standard, abstinence focussed inpatient treatment.
- Engages service users with a range of support services that they would otherwise be unlikely to seek help from. Provides an opportunity to engage patients with harm reduction information, advice and interventions. All staff can be upskilled to have opportunistic and planned discussions. All patients can be provided with a harm reduction kit on discharge from the MICU but as a minimum should be discharged with a naloxone kit.

51. *Scottish Drugs Forum (2021) MAT Standards Informed Response for Benzodiazepine Harm Reduction, Interim Guidance, August 2021, p:2.*

5. Prevents and reduces mental health-related harms and deaths

The prevalence of mental health conditions among those who are experiencing homelessness or at risk of homelessness is well documented. The MICU target group have a higher risk of premature mortality than the rest of the population, especially from suicide and unintentional injuries.[52] There is clear evidence of a relationship between repeat homelessness, drugs, alcohol, and mental health.[53]

The MICU service:

- Targets the most complex and most at risk client group: five times more likely to be admitted to mental health specialist services.[54]
- Impacts on mental health-related harms and deaths by providing service users with trauma-informed and person-centred psycho-social care in an enhanced residential setting.
- Provides on-site care from a support team comprising of in-reach from workers and peer supporters from community drug and alcohol services, who deliver interventions and meaningful occupation within the unit and offer engagement with treatment services on discharge.
- Temporarily registers service users with the Edinburgh Access Practice, which then allows them to receive a diagnosis and access to the Community Psychiatric Nurses based at the practice and/or referral to other mental health services. This process would be much lengthier without a referral.
- Arranges capacity assessments and packages of care developed in a safe setting.

52. Waugh, A.; Clarke, A., Knowles, J. and Rowley, D. (2018) Health and Homelessness in Scotland: People, Communities and Places, Scottish Government. 53. Ibid:140 54. Rees, S. (2009) Mental Ill Health in the Adult Single Homeless Population: A review of the literature, Public Health Resource Unit, London: Crisis.

6. Prevents and reduces prevalence of infectious diseases

Those experiencing homelessness have a significantly higher prevalence of infectious disease than the general population.[55]

The MICU:

- Reduces the prevalence of infectious diseases such as MRSA and Strep by supporting users to begin, re-engage and complete appropriate treatments and services. This builds on existing expertise of Waverley Care in supporting people with BBVs.
- It prevents and reduces prevalence of infectious diseases by supporting service users with:
  - Testing for BBVs.
  - Starting and re-engaging/supporting completion of Hep C treatment:
    - Four service users completed the treatment, which, usually a 12-week course, is unlikely to be completed without support.
    - Provide ongoing management of complex infections including administration of intravenous antibiotics and monitoring of complex oral antibiotic regimens as required, facilitating interface care (ambulatory care) to a group traditionally excluded from these services.

7. Person-centred, trauma-informed care

Reducing stigma is a strategic priority for Edinburgh City Council, the Scottish Drug Death Taskforce, Scottish Drugs Forum, Scottish Families Affected by Alcohol and Drugs (SFAD) and Scottish Recovery Consortium (SRC).[56] Stigma creates adverse consequences in delivery, e.g. patients may be discharged rather than having their transfer delayed[57] or pain medication may be withheld due to judgements about substance use.

The MICU service provides:

- *"Somewhere you can properly rest, in peace and quiet. And time to really think, away from the chaos and constant stress of homelessness and addiction."*
- *"It kept me safe, gave me a chance for a fresh start."*
- *"I honestly think I would be dead if I hadn't stayed there."*
- *"A safe, non-judgemental space. Place where [service users] are not stigmatised."* [58]

55. *Waugh, A.; Clarke, A., Knowles, J. and Rowley, D. (2018) Health and Homelessness in Scotland: People, Communities and Places, Scottish Government.* 56. *See for example, Partnership for Action on Drugs in Scotland (2017) Recovering Connections: Changing stigma to respect. Edinburgh: PADS.* 57. *A finding in Cornes et al. (2021), (see footnote. no.20).* 58. *Quotes from evaluation interviews – first three from service users and last two from staff members.*

- Person-centred, trauma-informed support in a safe space where users can stabilise. Around-the-clock care and support provided away from the city centre but close to public transport, on an established site with space and greenery.
- Re-admission when needed, which is valuable, and in some cases, life-changing. See case study 2 for an illustrative example. See Figure 5 for the number of admissions of service users.
- Development of trusted relationships with service users which is a vital element of facilitating engagement with a range of health and social care services.
- Cyrenians staff model trauma-informed practice in clinical settings, which contributes to reducing stigma that is still present among some clinical settings.[59] Changing the cultural attitude to patients both with an addiction to drugs and/ or alcohol and who are experiencing homelessness or at risk of homelessness, is an explicit objective of the service.
- Planning and delivery of care involving people with lived experience (PWLE):
  - There is significant lived experience within the staffing in the project at present and this is expected to continue.
  - The staffing structure of the project includes paid posts which are intended to attract people with lived experience of substance use, homelessness and recovery and several of the partners employ large numbers of people with lived experience.
  - Staff with lived experience contribute to an improvement in clinical staff attitudes to service users. They model person-centred, trauma-informed practice; develop training and education for the clinical workforce and improve understanding of stigma.
  - Transformative evaluation has informed the service: a methodology which emphasises continuous learning from patients. This has meant systematic gathering of views and many of those who have used the unit have been exceptionally positive about it.
- Beyond the evidence presented in this report thus far, the fully-rounded way in which this service impacts people's lives is perhaps better illustrated in two case studies on the following pages.

59. For a useful explanation of the different types of stigma, see: Partnership for Action on Drugs in Scotland (2017) Rec*overing Connections: Changing stigma to respect.*

Milestone Intermediate Care Unit: Illustrative case study 1[60]

In early July 2020, we received a referral for a 45-year-old man who was in hospital with multiple complex physical and mental health needs.

He had previously been in prison, and prior to his release in May 2020, had made repeated attempts on his own life due to the fear and uncertainty impending homelessness and the loss of structure and routine that prison provides.

Prior to his admission to the Western General, he had been in and out of Rapid Access Accommodation with long periods of rough sleeping in between. Staff at Rapid Access spoke highly of him, but disputes with other residents left him feeling threatened and at the time rough sleeping had seemed the better option.

The primary trigger for his admission was an infected injection site in his leg. However, in the chaos following his release from prison he had been unable to maintain the drug regime for his Hepatitis C and HIV, and his physical health had deteriorated as a result. His chaotic lifestyle also had a significant effect on his mental health.

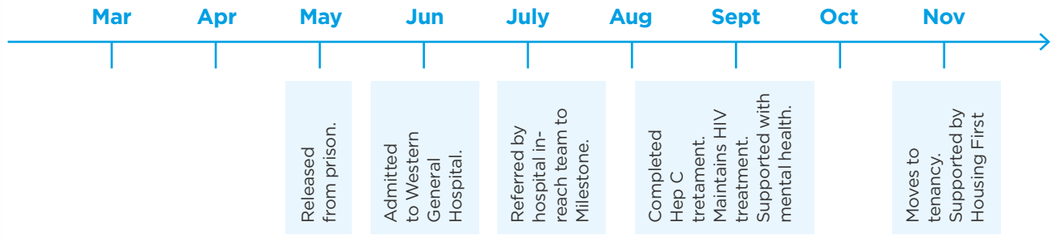
He was referred to Cyrenians Hospital In-reach on July 7th and once medically fit for discharge from the Western General, he was admitted to Milestone Intermediary Care Unit on 27th July.

After 2 months in a safe, calm, private setting with regular medication prompts, support to attend outpatient appointments and daily support with his emotional wellbeing he and his support team had completely turned his health around. During his admission, he completed his Hep C treatment and maintained his HIV treatment. He became more confident and reported a significant improvement in his mental health.

Cyrenians Hospital In-reach staff supported him throughout this process and worked with the City of Edinburgh Council to ensure that when he was ready to leave Milestone, he was accommodated in a way that avoided the chaos he had experienced in the weeks following his release from prison. In tandem with that, he was also referred to Housing First with a view to securing a permanent home.

In early November he got the keys to his own permanent tenancy - four months from the date of his first contact with Cyrenians Hospital In-reach. This would not have been possible had he not had the period of safety and support at the MICU.

Figure 7. The MICU timeline case history for Service User B (May – November 2020)



60. *Provided by the Cyrenians.*

Milestone Intermediate Care Unit: Illustrative case study 2

J was referred to the Hospital In-reach service in April 2020, having been admitted with infected injecting sites.

J had been rough sleeping since his release from prison (having spent most of his adult life in prison), had no support in the community, was not registered with a GP and, at point of hospital discharge, had no money, clothes, accommodation, or community support.

J agreed to a short Milestone admission from hospital to enable GP registration, wound care and to continue methadone titration. He was clear that on admission he needed to discharge after a few days to access his bank card from an acquaintance before his next benefit payment and despite numerous attempts did not engage with Cyrenians following discharge.

J was referred again to Cyrenians when re-admitted to hospital in July, and again had been rough sleeping after losing his accommodation. J was keen to engage with staff at this time and discharged to Milestone for a four-week admission to allow re-titration and stabilisation, appropriate accommodation to be sought, access to funds and referrals to be made for ongoing support.

J engaged fully with the service and was discharged to appropriate accommodation. He continued to engage with Cyrenians, despite returning to active drug use and moving from accommodation to accommodation, in addition to several near fatal overdoses and three hospital presentations. Support to engage with his legal team resulted in avoidance of a custodial sentence.

J was accepted to the Housing First programme in November and Cyrenians supported his engagement with his new worker. With this intensive support, J stabilised and moved into his own tenancy in February 2021, having had only one hospital admission in this time.

J had remained abstinent and settled in his tenancy until April when a deterioration in his mental health led to a return to using illicit benzodiazepines, resulting in three short hospital admissions (overdose). At this point he felt unsafe in his tenancy and a two-week admission to Milestone was agreed. J engaged well, remained abstinent, and was confident on discharge to return to his tenancy.

J continued to manage his tenancy and engage in support, including specialist mental health support to address his significant childhood trauma. Unexpected discharge from this service was devastating for J and he was actively suicidal. A same-day admission to Milestone offered a place of safety, prevented a return to chaotic drug use and an opportunity to access funds to support trauma treatment. Two weeks later, J returned to his tenancy, and, to date, J continues to engage in support and maintain his tenancy.

Figure 8. MICU timeline case history for Service User J (April 2020 – October 2021)

2020	**April**	Rough sleeping following release from prison. Admitted to RIE.
	May	MICU admission, GP registration, OST titration.
	June	Disengaged from services in the community.
	July	Re-admitted to RIE, referred to the MICU, re-titration of OST, access to funds.
	August	Stabilisation on OST, referral for ongoing support, disharged to accommodation.
	September	Engages with Cyrenians in community, two further acute presentations.
	October	Custodial sentence avoided, engagement with Streework in addition to Cyrenians support, one further acute presentation.
	November	Assigned Housing First worker. No acute presentations.
	December	Engages in support. No acute presentations.
	January	Engaged in support. No acute presentations.
2021	**February**	One acute presentation. Allocated permanent tenancy.
	March	Settled in tenancy, engaged in support.
	April	Deterioration in mental health, two acute presentations.
	May	Further acute presentation, step-down to the MICU, stabilisation & return to tenancy.
	June	Engages in mental health support, unexpected discharge, crisis, further admission to the MICU.
	July	Sucessful discharge to tenancy, no acute presentations.
	August	No acute presentations.
	September	No acute presentations.
	October	Remains in tenancy and engaging in support, no acute presentations.

Appendices

Appendix 1

Outline of Milestone Intermediate Care Unit

MICU is delivered and managed by Waverley Care, with staff from the Access Practice and different partners. These include third sector organisations, community/recovery groups, housing, primary and secondary health care, social services and specialist drug and alcohol services (see Figure 9 for a list of MICU partners). Milestone itself is a ten-bedded Intermediate Care Unit. It offers 24/7 care in a registered residential setting for people who are: vulnerable; experiencing homelessness or at high risk of homelessness; and who have complex needs which include physical health conditions. There are pathways to the unit from in-patient care (step down) delivered by the Cyrenians whereas the step-up pathway is through a range of community partners and the residential unit. It is an intervention promoted by the DDTF (priority Test of Change number ten[1]) with a well-established rationale and evidence base. The components of the service and its associated pathway include:

- 24/7 care and support
- Clinical assessment and treatment
- Ongoing psychosocial care
- Assessment, case management and pathway support

Strategic oversight of the day-to-day delivery is provided by partners in the monthly steering group meeting. It is funded by Waverley Care's existing contract with the Edinburgh Health and Social Care Partnership (EHSCP) and additional funding agreed to pay for extra staffing required to care for those with complex needs.

The funding for Waverley Care does not cover the costs of additional services provided by the NHS and the Cyrenians to Milestone clients on a goodwill basis in the early stages of the pandemic when people were redeployed and access to acute settings were limited. This is therefore not sustainable going forward, but essential to the running of the service. Waverley Care owns and maintains the building and this cost is not included or supported by current funding.

The partnership is coordinated through a steering group which meets monthly. Though complex, the diversity of the partnership is a central feature of the integrated care model provided and the variety of strategic goals it addresses.

[1] Drug Death Task Force Innovation Fund Sub-group proposal (MULTIPLE COMPLEX NEEDS), Corra Foundation 2021

Figure 9: List of MICU partners (as of November 2021)

DELIVERY PARTNER	MICU ROLE
Waverley Care	Deliver core registered care
Edinburgh Access Practice[2]	Specialist primary care providers for people experiencing homelessness in Edinburgh.
Access Point	City of Edinburgh council specialist housing officers and social workers for people experiencing homelessness and have complex needs.
Cyrenians	Manage the pathways in and out of the unit and provide case management.
NHSL Acute Healthcare	Provide referral and outreach clinical care for those in the unit
City of Edinburgh Council Housing	
Regional Infectious Diseases Unit	Acute care
Western General Hospital.	Acute care
Change, Grow, Live	Provide the in-reach drug and alcohol support for those in or leaving the unit.
Turning Point Scotland	Provide the in-reach drug and alcohol support for those in or leaving the unit.
Edinburgh Alcohol and Drug Partnership	Core funding and coordinating future funding
Edinburgh Health and Social Care Partnership	
NHS Lothian Public Health	Support planning and evaluation
Harm reduction team/Drug Liaison nurses	Drug Liaison nurses: nursing care provision, integration with non-fatal overdose process.
NHS secondary care: Outpatients, Western General Hospital and Royal Infirmary Edinburgh	

<u>Step-down</u>

The Cyrenians hospital in-reach project is a 2.5-year pilot (to the end of September 2022) funded by a private grant making trust, with 2.5 full-time equivalent key workers employed, increased to 3.5 in October 2021, that provides “the link with the hospital at MICU.” Their strategic aims are to improve health outcomes for those experiencing homelessness and to reduce the cost to the NHS by decreasing readmission rates and reducing delayed discharge. This is achieved through Cyrenians hospital in-reach workers:

- Managing referrals from the acute and community pathways (see Figure 11 below).
- Making daily contact with clinical staff at the Royal Infirmary of Edinburgh and at the Western General Hospital.[3]

[2] Edinburgh Access Practice is a specialist GP practice with services attached to it. These include addictions care (prescribing of opiate replacement therapy), a mental health team, p/t psychologist, psychiatrist, pharmacist, welfare rights worker, podiatrist, community midwife, optician, community health worker and hepatitis C and women’s only clinics. From 1st November 2021, the Access Practice has moved into new premises and is known as The Access Place.

[3] This includes staff in the Department of Psychology medicine, drug and alcohol liaison nurses, the six acute medical units and other wards. 33% of the total referrals for the Hospital In-reach service come from AMU6 ward (toxicology).

- Early identification of eligible patients, which allows time to find out about them and prepare a care plan).
- Attending a hospital-based health inclusion team meeting that identifies vulnerable patients.
- Supporting service users with inpatient treatment
- Preventing self-discharge by developing relationships with service users to identify the right referrals, gain their trust and prepare them for discharge.
- Facilitating discharge planning
    - support access to healthcare and community treatment/resources
    - provide information about Milestone (see Appendix 9 for service information given to service partners and prospective residents).
    - plan accommodation with community partners
- Fostering awareness amongst clinical staff of the needs of this service user group
- Facilitating clinical referral and completing further assessment to facilitate discussion at the MICU weekly multi-disciplinary team meeting. (Please see appendices for clinical and community referral criteria and referral forms).
- Collecting feedback from service users on both planned and unplanned discharges. (Please see appendices for service user survey for planned discharges).
- Appendix 7 provides a summary of outcomes from the Cyrenians in-reach service from March 2020 to March 2021.

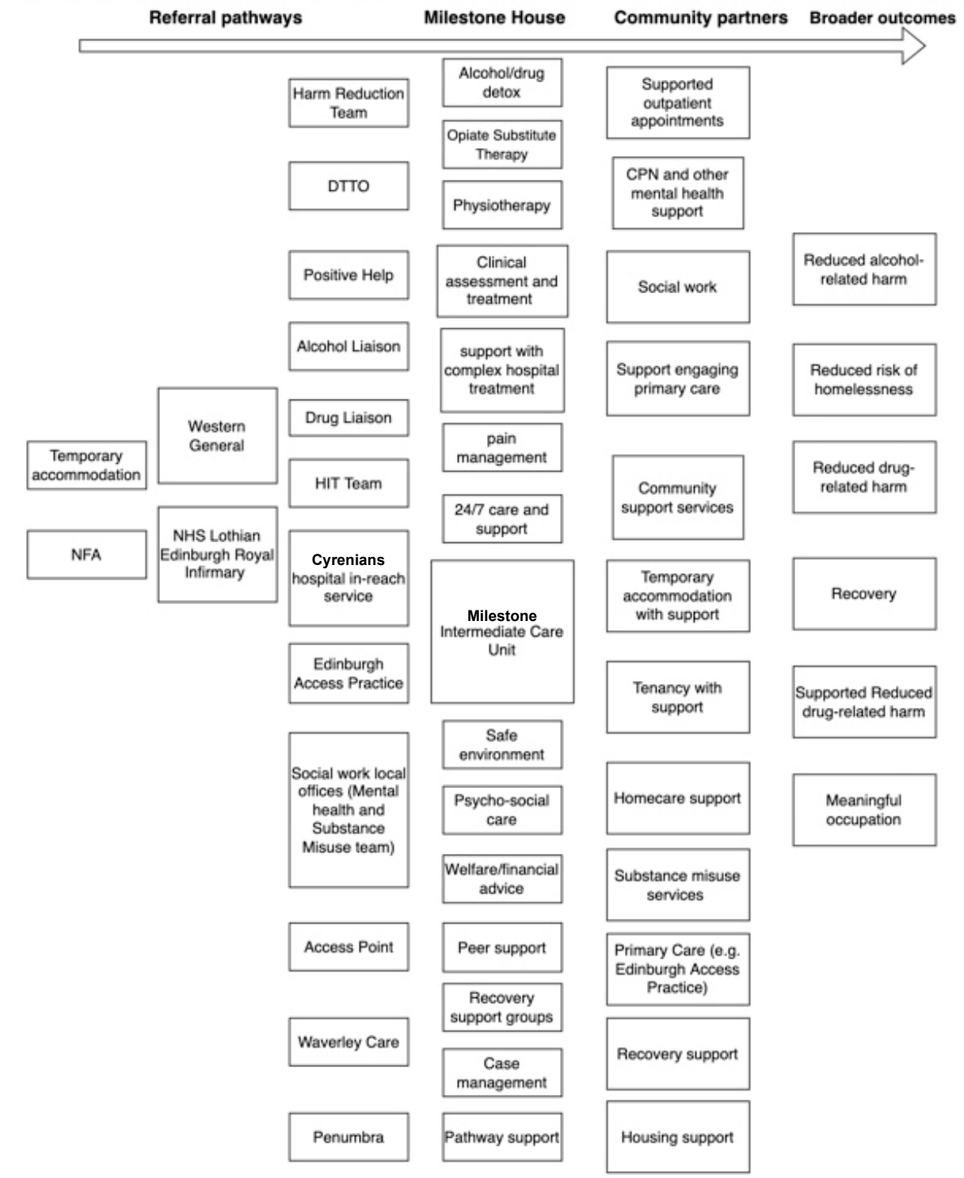
<u>Step-up</u>

Service users in the community can be referred by a range of providers, including NHS Lothian Harm Reduction Team, The Access Point (TAP) and social work local offices. The variety of the referrals demonstrate the extreme vulnerabilities of service users coming to the unit from the community. They include referrals made from:

- the community inclusion health huddle, for those at high risk of harm from drugs or who have had a near fatal overdose (NFO)

The need for the community referral pathway - due to its complexity - to be further developed in line with the hospital pathway has been acknowledged by managers in the MICU service.

Figure 10: Milestone Intermediate Care Unit: referral pathways, provision and outcomes

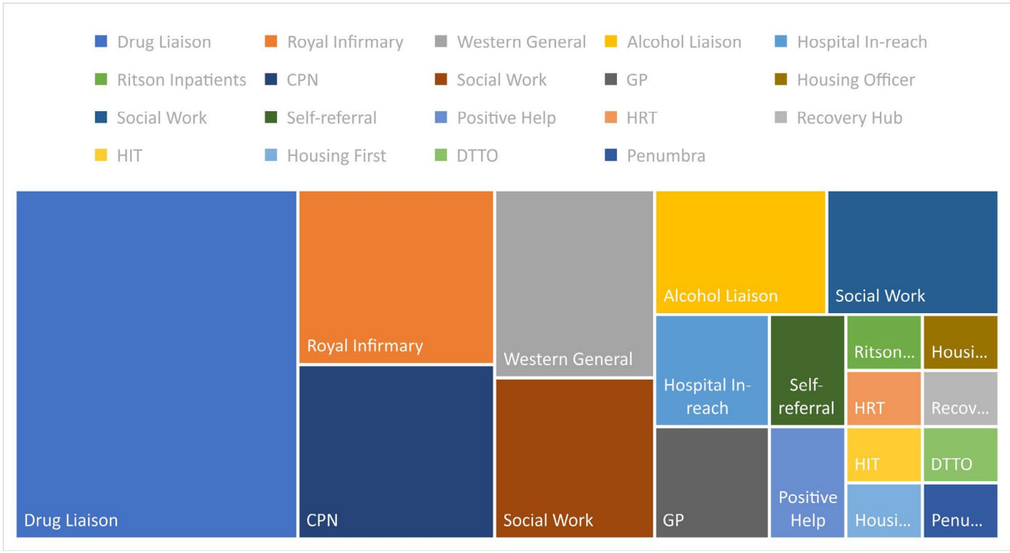


Milestone Residential Intermediate Care Unit

Milestone is a ten-bed unit, with accommodation laid out in two bungalows, with independent access to outside space from ensuite rooms; a shared sitting room and kitchen. Waverley Care provides 24/7 staffing of the unit and round the clock care and support. Clinical assessment and treatment is provided through a combination of primary and secondary care practitioners who added this work to their existing duties at the outset of the pandemic:

- NHS Primary Care (Edinburgh Access Practice) - three GP sessions a week,[4] one of which is based in the Royal Infirmary to support identification and assessment of potential Milestone referrals.
- NHS Secondary Care continuation of treatment plans from in-patient delivered by in-reach by the hospital teams
- NHS Harm Reduction Team (initially a Drug Liaison Nurse followed by a practice nurse from EAP and wound care nurses) - IEP and harm reduction interventions.
- Ongoing psychosocial care, links with ongoing therapeutic support, and engagement with recovery resources.
- Figure 11 shows the range of referral pathways into Milestone Intermediate Care Unit:
- 47 acute referrals: Drug Liaison; Royal Infirmary Edinburgh; Western General Hospital; Alcohol Liaison; Cyrenians Hospital In-reach and Ritson Inpatients.
- 18 referrals from The Access Place: Community Psychiatric Nurse (CPN), Social work; General Practitioner (GP) and Housing Officer.
- 15 referrals from the community: Social work; Self-referral; Positive Help; Harm Reduction Team (HRT); Recovery Hub; Waverley Care Health Inclusion Team (HIT); Housing First; DTTO and Penumbra.
- Lengths of stay at MICU are envisaged as between two and four weeks, although this will be agreed on a case-by-case basis and discussed/reviewed at the weekly multi-disciplinary meeting (see Figure 12 for length of stays to-date).

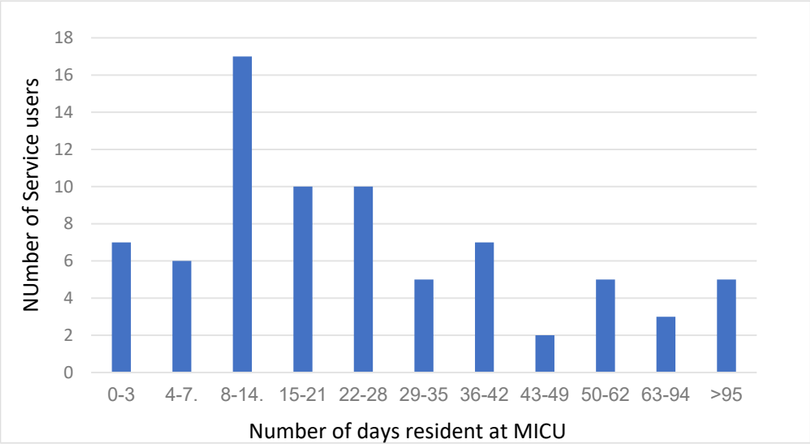
Figure 11: Referral pathways to Milestone Intermediate Care Unit (April 2020 – October 2021)



Source: MICU 2020-2021 data

[4] The steering group is in the process of confirming whether this provision has increased to four hours.

Figure 12: Service users' length of stay at MICU (April 2020 to October 2021)



Source: MICU 2020-2021 data

Service user profile

The group served at the MICU are some of the most marginalised and clinically and socially vulnerable in the city. An audit of 150 patients at Edinburgh Access Practice[5] is indicative of the MICU service user profile (see figure 13):

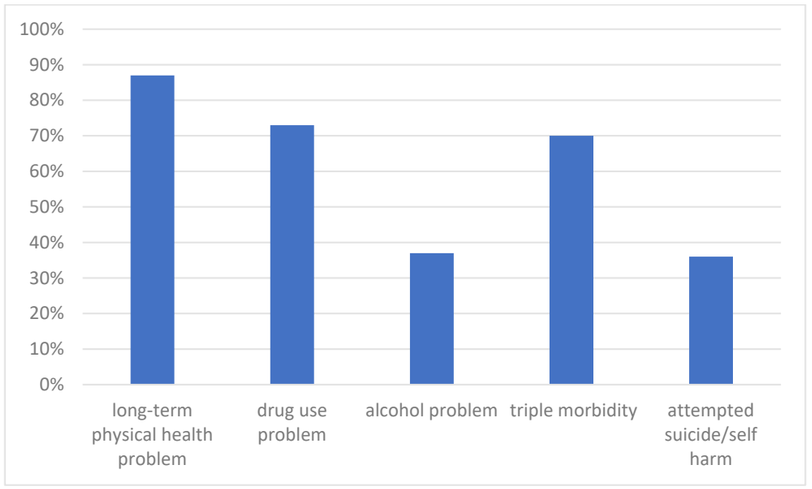
- 86.7% of patients had a long-term physical health problem
- Of those, patients had an average of three conditions
- 73% had a drug use problem
- 70% had triple morbidity of physical, mental health and substance use problems
- 37% diagnosed with alcohol dependency
- 36% had history of attempted suicide or self-harm.
- Average life expectancy of 47 years
- Health profile comparable to general population cohort in their 80s.

The 80 patients admitted to Milestone since the opening of the unit have many of the characteristics identified by, for example, the Scottish Drugs Forum expert working group on older people with drug problems[6] as indicating high risk of drug-related death (DRD); multimorbidity, poor treatment concordance, social isolation, poly substance use and an age profile comparable to the drug users at highest risk of death (see Figure 13) Figure 14 shows age distribution and gender of MICU service users from April 2020 to October 2021.

[5] Zeitler et al (2020) Comparing the Impact of Primary Care Practice Design in Two Inner City UK Homelessness Services. *Journal of Primary Care and Community Health*, 11: 1-13.

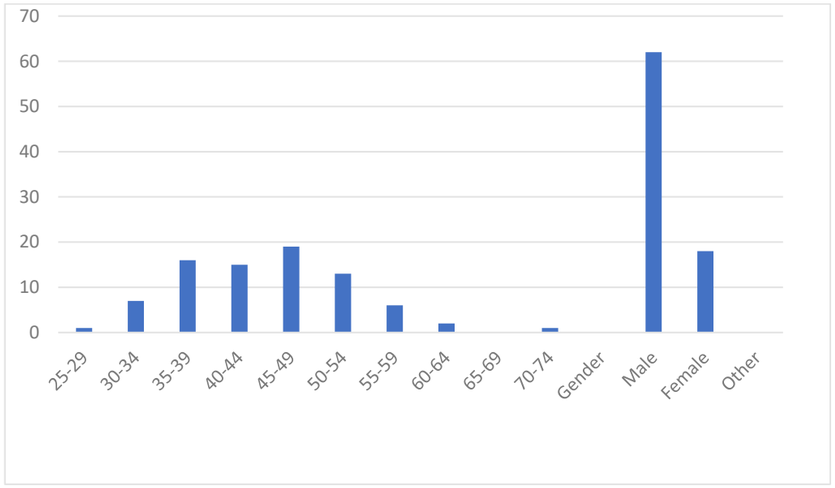
[6] Scottish Drugs Forum (2017) Older People with Drug Problems in Scotland: Addressing the needs of an aging population: The Expert Working Group on Older People with a Drug Problem: Final Report. Available at [accessed at 30 September 2021]:https://www.sdf.org.uk/wp-content/uploads/2017/06/Working-group-report-OPDPs-in-2017.pdf

Figure 13: Edinburgh Access Practice 2018 health profile of patients



Source: MICU 2020-2021 data

Figure 14: MICU service users by age and gender (30 April 2020 to 31 October 2021)



Source: MICU 2020-2021 data

Appendix 2

Definition of intermediate care

“Intermediate care is a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care.” (NICE guideline: Intermediate care including reablement (2017)).

“A range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement” (ibid).

“A short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care. The care is person-centred, focused on rehabilitation and delivered by a combination of professional groups” (King’s Fund, 2002).

It is delivered as part of “an integrated part of a seamless continuum of services: linking primary care with community health, social care and acute hospital care and that support from these linked services is essential for the successful development of intermediate care, to ensure that its benefits are fully realised” (Department of Health 2001b).

It must include the development of an individual care plan, be time limited, with clear entry and exit points and responsibility for managing transitions, and part of a whole system approach to the delivery of health and social care to people experiencing homelessness.

Interim care services are not about marginalising homeless patients from mainstream services; providing transitional care pending long-term placement (a hotel service) solely the responsibility of one professional group (a dumping service), indeterminate care (a dustbin service) or a means of funding all good things for people experiencing homelessness (a honeypot service).

Adapted from the Department of Health (2001b). *National service framework for older people.* London: Department of Health.

To ensure a consistent approach to developing, monitoring and benchmarking services across the country. The NHS and Councils are expected to apply this definition [from January 2001] in reporting investment and activity plans for intermediate care. For these purposes intermediate care should be regarded as services that meet all the following criteria; that they:

- are targeted at 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
- are provided on the basis of comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- have a planned outcome of maximising independence and typically enabling patient/users to resume living at home
- are time limited to normally no longer than six weeks, and frequently as little as one to two weeks or less
- involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

Appendix 3

Evaluation methodology

This research set out to focus on the experiences of those delivering the MICU since the beginning of the pandemic and to find out their views on the objectives and expectations of the service, understanding of their role in it; their appraisal of its successes and challenges; how it should be modified and developed going forward.

The research was conducted between August and October 2021. It included a literature review; collection of secondary data, attendance at steering group and MDT meetings as well as on-line semi-structured one-hour interviews (please see interview schedule in Appendix 4) with the steering group members, delivery partners, management and front-line staff. Some staff were interviewed more than once. All interviews were recorded, with each respondent signing a consent form prior to the interviews.

Delivery partners interviewed for this evaluation/involved in preparing this case:

Interview respondent	Job title	Organisation	Date interviewed
John Budd	GP	Access Practice	06/09/21
Laura Aitken	GP	Access Practice	22/09/21
Tam Armstrong	Support worker	Waverley Care	21/09/21
Karen Duff	Support worker	Waverley Care	27/09/21
Karen Hamilton	Deputy Manager	Waverley Care	15/09/21 and 20/09/21
Rachael Kenyon	Service Manager	Cyrenians	14/09/21 and 15/09/21
Jac Lindsay	Support worker	Waverley Care	24/09/21
Carmen McShane	Social care manager	Turning Point Scotland	13/09/21
Liz Marr	Senior manager	Waverley Care	31/08/21 and 15/09/21
Elizabeth Redgrave	Support worker	Waverley Care	22/09/21
Claire Mackintosh	Consultant	NHS Lothian RIDU	01/10/21
Michael Marr	Facilities Manager	Waverley Care	11/10/21
Linda Smith	Drug Liaison Nurse	NHS Lothian	02/11/21

Appendix 4

Interview schedule

Interviewee:

Date of interview:

Introduction
Sign consent form
Interviews will be recorded, but any reference to individuals/organisations will be anonymised. After the project, all recordings will be deleted (GDPR)
– Expected duration: 1 hour. Do you need to leave at a certain time?
– Questions: No right or wrong answers
– Remind participants that they are free to 'pass' any of the questions.

A Role
A1. Can you describe briefly (2 or 3 sentences) your current role and what it is that you do?
A2. What are the main skills needed in your role?
A3. What are your main responsibilities? Who do you report to?
A4. How long have you been with Access Practice? (above)
A5. Who do you work with?
Partners/Managers/Colleagues/Patients
A6. Could you give me a rough breakdown of your activities (time spent on each)
Daily/Weekly/Monthly
A7. Out of these, which do you enjoy most?/And which least?

B The Interim Care Unit
B1. Please tell me a bit about how this developed?
B2. Who initiated?/How funded?
B3. What usual barriers were bypassed in setting up this model
B4. Please tell me a bit about how it works? Referral process?/What services are offered?/How are they delivered

C Service user profile
C1. Please tell me a bit about the people you've worked with who have stayed at MH
How many?/Health condition/needs/socio demographics/where they live
C2. During their stay, how many times would you see them? (if average, 25 day stay)
C3. Once they'd left, how many times would you see them?/Follow-up?
C4. Do the same clients come through more than once?
C5. What would you say are their main needs?
C6. What are their main barriers to accessing care?
C7. What are their main barriers to self-care?
C8. What do service users say about MH?
C9. Which group's needs are best met at MH?
C10. Please give me an example of a service user that MH has worked well for
C11.Please give me example of a service user MH not worked so well for

D Accountability/Evaluating
D1. Who do you report to?
D2 How do you evaluate your part in this service?
D3. Feedback on how best to evaluate it
D4. Ideas on including PWLE in the evaluation
D5. What are main challenges with how it is delivered?
D6. What does WC bring to the service as a provider?
D7. What does WC need to develop?
Additional question: What would an ideal ICU look like?
D8. What are pros and cons of keeping WC as provider?
D9. What are main strengths of WC?
D10. What would you ensure is built into the next phase of funding and delivery?

E Reflections
E1. Lessons learnt from this model?
E2. What will be different as pandemic ends
E3. Main challenges of this way of working (pros/cons)
E4. Challenges with evaluating

Closing questions
– Is there anything that you would have liked us to ask you or to discuss that we didn't?
– Can you think of anyone else who would be interested and/or available to speak to us?

Any data that would be helpful
Any literature
Any audits
Further contacts suggested

Appendix 5

Service user service

This is completed on planned discharge.

All feedback will be collated anonymously, thank you for taking the time to assist us in monitoring and improving the service.

1. Did your physical health improve during your stay at Milestone?

No Improvement
Some improvement
Significant improvement
Comments-

2. Did your mental health improve during your stay at Milestone?
No Improvement
Some improvement
Significant improvement
Comments-

3. Were you supported in your recovery from alcohol/substance misuse during your stay at Milestone?
No support
Some support
Significant support
Comments-

4. Were you supported to move to suitable accommodation on leaving Milestone?
No support
Some support
Significant support
Comments-

5. What did you like best about the Milestone service?

6. What difference did your stay in Milestone make?

7. Do you have any suggestions to improve the Milestone service?

Appendix 6

Service user service feedback

What did you like best about the Milestone service?	
Environment (6)	**Staffing (5)**
Peace and quiet	Staff always on hand
Quiet, no hassle	Lovely non-judgemental staff
Loved the wildlife and the peace	Staff available through the night
spotlessly clean, nice place to be and very relaxing	The staff and the support and everyone so caring
Serenity – quiet and nature	**Good Food (3)**
environment was lovely	**Time out to recover (1)**

What difference did your stay in Milestone make?
It saved my life
It helped with my recovery
None, they gave me a roof over my head and that was it
Gave me time to heal and also think about things.
Overwhelmed/flabbergasted at level of support available
Time to get things sorted

Kept me safe, gave me a chance for a fresh start.
I honestly think I would be dead if I hadn't stayed there.
It got me out of hospital
Stopped me going back to drugs and my ex.
Safe place to be, with good food
Absolutely lifechanging

Do you have any suggestions to improve the Milestone service
Meaningful use of time/social interaction (12)
Boredom- more to do because addicts will find their own things to do to keep busy! More to do would be good, it's a bit boring stuck in a room It was a bit boring. Don't mind being on my own but I got bored sometimes Not really- isolation was difficult but that was because of Covid
Activities- pool, darts, quizzes, competitions. Yoga/meditation/mindfulness Group activities would be good More activities like art, tie-dye, swimming More activities- cooking, movie nights, team activities etc
Training courses/education opportunities (online), especially the ones you get a certificate for like food hygiene- like they do in prison. More chances to do things like cleaning, cooking, laundry. I felt deskilled when I moved and having to learn how to do things again with a disability, its hard Cooking/life skills

Wish I could have spent more time outdoors Outings! Being able to get out for a while would help people stay sane Allow people to leave the premises with family, like day release, don't keep them locked up like a prisoner
Staffing (7)
Maybe employ a drug/alcohol counsellor Make sure staff give out prescribed medication at the right time, not an hour and a half late It would have been reassuring to have staff pop into my room to see if I was ok Allocated worker from the care team with weekly 1:1 time Employ less judgemental people () accused me of being a junkie and told my visitor not to bring in drugs which was not the reason I was there. NA/AA/etc meetings would be really good Treat people with respect.
Food/Diet (2)
More choice of healthy food Healthier food would stop people putting on too much weight

Appendix 7

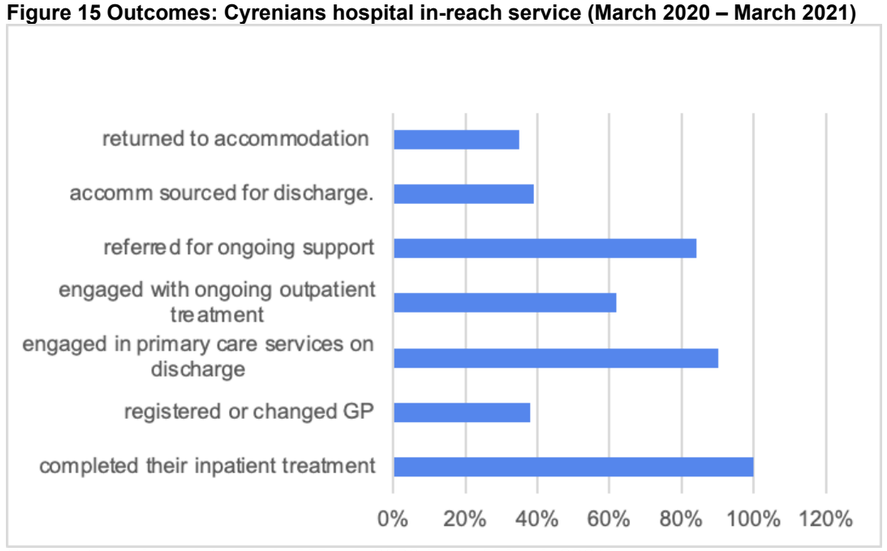
Cyrenians data on hospital in-reach outcomes (March 2020 - March 2021)

The in-reach service was provided to service to 156 unique individuals in the first year of operation (to end March 2021). Of these, 29 (18.6% of in-reach clients) were admitted to the Milestone service. Of the 29 individuals, 19 (12.2%) had little or no other support and were case managed by Cyrenians and 10 (6.4%) had other support in place and the in-reach team facilitated the assessment/admission/discharge planning process but did not case manage.
(In addition to the above the in-reach team supported a significant number of Milestone admissions who were not referred via the hospital service - i.e. not experiencing homelessness)

From April-Sep 2021, the in-reach service provided a service to 138 unique individuals. Of these, 19 (13.7%) were admitted to the Milestone service. Of the 19 individuals, 12 (8.7% of in-reach clients) had little or no other support and were case managed by Cyrenians and 7 (5%) had other support in place and the In-reach team facilitated the assessment/admission/discharge planning process but did not case manage.

Figure 15 below shows the outcomes of 156 individuals supported in the first year of the in-reach service (End of March 2020 - End of March 2021) of which 91% were from the Royal Infirmary:

Figure 15 Outcomes: Cyrenians hospital in-reach service (March 2020 – March 2021)



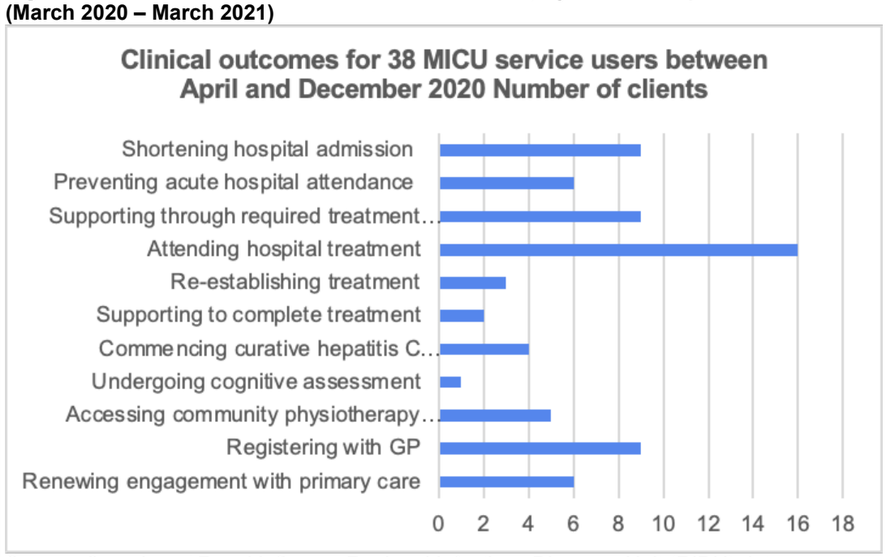
Source: Cyrenians data [End of March 2020-End of March 2021]

Appendix 8

Cyrenians data on Milestone residential unit outcomes

As Figures 15 (Appendix 7) and 16 show, there are a wide range of positive outcomes for users of the MICU service. Relieving pressure on hospital beds was an initial focus for the service at the beginning of the pandemic. The MICU aims towards enabling service users to resettle in safe accommodation on discharge, with care packages in place. However, even in the few circumstances where this has not been possible, interviews with management and front-line staff across the service made clear that those service users had still benefited from being at MICU. "It is about positive contacts for a short period of time" and that this short intervention has a range of other positive outcomes, additional to preventing bed blocking. These include enabling detox from alcohol, initiating clinical treatment for drug dependency, having a period of stabilisation before returning to more chaotic lives, in having a wound treated, re-registering with a GP or being supported to attend their hospital appointments. There are also a range of public health positive outcomes such as clients finishing antibiotic treatment for strep infections, antibiotic treatment and for MRSA.

Figure 16: Clinical outcomes for MICU service users, Cyrenians hospital in-reach service (March 2020 – March 2021)



Source: Cyrenians / Royal Infirmary Regional Infectious Diseases Unit (RIDU) data
•• Total does not add up to 38 as individual users may have more than one outcome.

Appendix 9

Milestone Intermediary Care Unit (MICU) service information

MICU is a ten-bedded unit providing step-down care for patients who are vulnerable and/or experiencing homelessness on discharge and support to community clients to prevent hospital admissions.

All ten rooms are ensuite, with direct access to outside space. Eight rooms are suitable for wheelchair users. Care staff are onsite 24 hours and all meals are provided.

In addition to the onsite support from Waverley Care, partners include Acute & Primary Care Services, Cyrenians, Housing, Social Work & Recovery Support Services, ensuring residents receive a holistic service to meet their complex care and support needs.

GP & Nursing support is provided by the Edinburgh Access Practice- currently this is not daily so clinical needs including woundcare may require additional DN input. Support with personal care is not currently provided by the onsite care team.

MICU is a registered Care Home Service with the Care Inspectorate, permitted to store and administer medication. Care Home COVID regulations mean all residents must isolate for 14 days on arrival- only visits from professionals or attendance at medical appointments is permitted during this time. Personal visitors after this time must be pre-arranged with staff.

Referral Pathway
Referrals are accepted for vulnerable individuals with ongoing clinical care requirements and a complex range of needs including homelessness, addiction and mental health issues.

Referrals for step-down patients from acute hospital setting are accepted from clinicians in RIE, WGH, SJH and EAP.
Community client referrals are welcomed from all services- please note an additional clinical assessment may be required.

Further assessment may be carried out by Cyrenians Hospital In-reach and/or Milestone GP. All agencies currently supporting the individual will be involved in the assessment process and where applicable the admission plan.

All referrals are considered at the weekly MDT (Wednesday 3.30pm). Referrers will be notified Thursday morning of the outcome of the referral.

Admissions
Initial admissions are agreed for up to 14 days dependant on the clinical needs of the individual.
Arrangements for District Nursing, Physiotherapy, Personal care support etc must be confirmed by the referrer prior to admission.
All residents must be admitted with seven days' supply of all medication.

Appendix 10

Milestone Intermediary Care Unit (MICU) client information

"Everything you need is here- it's warm, cosy, clean and the food is good and the staff are nice, they give so much support. I feel safe and have extra time to recover"

MICU is for hospital patients who are experiencing homelessness are ready to be discharged but need some ongoing medical care before they can return to the community. You may also be referred by your existing support if you have medical needs that cannot be met in the community.

This is a temporary service (usually 1-2 weeks) but this will be reviewed depending on your needs.

What Can You Expect?
- At Milestone, you will have your own room & private bathroom, with access to outdoor space.
- Three full meals a day are provided, and there are Waverly Care staff there at all times to offer support
- Nursing and Medical staff will visit to support you with all your healthcare and prescription needs
- You will be fully involved in all plans for your support and care, treated with respect at all times and your confidentiality will be protected
- Your existing support workers will be able to visit regularly to support you during your stay
- You will be supported to plan for moving on, including accessing accommodation and support in the community

What Is Expected From You?
- Due to COVID-19, communal areas are not in use, for the safety of all residents.
- All residents need to isolate in their room for the first two weeks and you will be tested for COVID before you come
- No alcohol, drugs or weapons are permitted at Milestone
- You are expected to treat all staff and residents with respect.

Appendix 11

Standard operating procedure, Milestone Intermediary Care Unit (MICU)

Governance and Responsibility:

Given the particular circumstances and potential complexities of the care required for those who will be admitted to Milestone, a hybrid model of governance is proposed. This has two streams, the first of which is that although this is a partnership delivery model, each agency involved has agreed to take on responsibility for a particular element of service delivery, as outlined below.

Key areas of responsibility [YK1]:

- Staff rota and management – Waverley Care
- Day to day support and care – Waverley Care and clinical colleagues
- Care Inspectorate and other regulatory bodies – Waverley Care
- Building maintenance and care – Waverley Care
- Clinical care – NHS/EAP
- Admissions and Discharge – MDT
- Housing and Social Care needs –TAP Cyrenians
- Recovery Support- TPS/CGL – including peer support from Cyrenians

The second strand relates to overall governance. The Steering Group brings together all key partners on a monthly basis to focus on strategy, objective setting and future funding. The MDT meets weekly and any operational issues are highlighted and addressed in this forum. Where this is not possible or appropriate these are referred to the steering group.

The Team
The Waverley Care team have overall responsibility for day-to-day management of the service, supported by-

The Cyrenians hospital in-reach team will be responsible for co-ordinating assessment and discharge planning for all admissions.

Likely Clinical and Care Needs

- Little or no sources of social support on discharge – vulnerable individuals
- Complex range of needs
- Needs around drug and alcohol use and OST
- Mental health issues
- Some ongoing clinical care requirements, which can be supported by NHS Clinical colleagues, EAP and WC staff (where appropriate). Examples of this could include provision of antibiotics; wound care/dressings; daily temp/BP checks
- The OPAT service at WGH will be able to provide ongoing support if needed (in particular with any IV/PICC line needs)

Referral Criteria – Acute Step-Down

All referrals will be for vulnerable, patients experiencing homelessness or those at high risk of homelessness with multiple complex needs discharging from hospital and one or more of the following criteria:

- Confirmed/suspected COVID19 disease requiring hospitalisation and clinically well enough for step down care- min 14 days after onset of symptoms.
- Otherwise ready for discharge but with no access to safe or secure accommodation in the community
- Other complex and vulnerable individuals admitted to inpatient acute settings. Could include:
    - Those requiring ongoing antibiotic therapy (via IV or PICC line)
    - Those with trauma related injuries, e.g. ongoing wounds care
    - Those awaiting social work input where there is no safe discharge pathway
    - Those at high risk of drug related death- history of multiple NFOs
    - Homeless people who are unable to return to their accommodation to self-isolate following inpatient COVID contact.
- Referrals accepted from clinical staff in RIE/WGH/SJH/EAP

Referral Criteria- Community
All referrals will be for vulnerable, patients experiencing homelessness or those at high risk of homelessness with multiple complex needs- those who have self-discharged from hospital, at high risk of repeat admissions or whose clinical needs cannot be met in the community-following clinical assessment of level of need-

- Those who require a period of stabilisation from chaotic drug/alcohol/mental health issues
- Those who require assessment and treatment for significant physical and mental health issues or monitoring of ongoing health issues where this cannot be managed in the community
- Those requiring support to access end of life care
- Those requiring support to access and engage with existing health, social care and housing services or access further support services

Re-admissions can be agreed as part of a planned support plan if agreed at MDT.
Community referral pathway- referral enquiries welcomed from all services. Referral forms will be provided and should be completed and returned to Milestone for discussion at the MDT on a weekly basis.

Process:
Covid 19 testing requirements prior to admission to Milestone:
Admission of COVID-19 patients from hospital
Two negative PCR results are only required in COVID positive patients if they are being discharged within 14 days from symptom onset or first positive test.

Further details can be found in Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.

Admission of non-COVID-19 patients from hospital
No testing required for non-COVID patients

Note: an admission to hospital is considered to include only those patients who are admitted to a ward. An attendance at A&E that didn't result in an admission would not constitute an admission.

Admissions from the community
No testing requirements for community admissions

All residents are required to isolate for two weeks on admission.

LFTs for all residents will be carried out weekly, or immediately on development of symptoms whilst awaiting PCR.

Requirements will be reviewed regularly based on changes to Care Home guidance.

- Secondary Care staff identify patients who could be suitable for Milestone as per agreed criteria
- Secondary Care staff complete the Clinical referral form and Consent form pre-discharge- clinical staff are required to send to NHS email address, currently only Liz Marr has this- In-reach team addresses to be followed up, request for further Waverley care addresses to be allocated
- Wherever possible, potential patients to be flagged to Cyrenians Hospital In-reach Team prior to referral to enable liaison with clinical staff and other agencies to start the housing/support needs assessment immediately (and support discharge)
- Community agencies to send referral to Waverley Care/Cyrenians
- Cyrenians complete assessment of all potential residents- with individual/existing support and GP input where required
- All other paperwork completed by Waverley Care staff upon arrival- to include updated service user agreement.

(further detail on process described in last two points above along with ongoing support roles/communication to be clarified in additional guidance to follow)

- Daily paperwork will be completed as per current arrangements in Milestone
- All clinical care will be recorded on the TRACK System by clinicians involved in patient care. This will be copied and sent to Milestone management team for their records via NHS email, as per information sharing protocol between NHS Lothian and Waverley Care

- Weekly MDT meetings will be held involving all key staff to discuss cases, this will include discussions on admissions and discharge and be a useful way of ensuring progress on moving people on from Milestone when they are ready and an appropriate support package is in place. Key staff who should be in attendance:

  - Waverley Care management and support staff
  - Dr Laura Aitken, GP
  - Dr Hazel Rae, Associate Specialist, RIDU
  - Cyrenians Hospital In-reach staff
  - Gavin Snape, TAP (Housing)
  - Janet Murray, TAP (Social Work)
  - Claire MacKintosh Clinical Director RIDU

Discharge criteria

Discharge conditions will be discussed on a case by case basis and will be managed and agreed at the weekly operational management meetings with all partners present.

Key partners include:

- *Waverley Care staff team*
- *Linda Smith/Hazel Rae*
- *Edinburgh Access Practice (possibly via HR?)*
- *Cyrenians – in particular on discharge from Milestone (akin to in-reach hospital model)*
- *Social work rep, linked to BBV team*
- *Housing*

The ideal length of stay 2-4 week. Staff from the Single Point of contact site and/or Cyrenians will make immediate contact to plan ongoing care and support. Length of stay will be agreed on a case by case basis and discussed at weekly MDT meetings.

Criteria for discharge will include:

- *The individual is deemed to be clinically well and their medical situation can be managed in the community*
- *There is an appropriate package of support in place to support wider mental health/drug and alcohol/social care needs – lead by Cyrenians and Edinburgh H&SC Partnership via Single Point of Contact staff*
- *Appropriate accommodation is in place for the individual being discharged*

Urgent discharge due to behavioural/management issues: (refer to SU agreement)
Where a resident has been unable to settle in Milestone, or is unable to abide by the code of conduct and behavioural guidelines, it is expected that:

- *Support staff will attempt, wherever possible, to deal with the situation internally and enable the individual to continue their stay until they are ready for discharge*
- *Where this cannot happen, staff will seek advice and support from Edinburgh H&SC Single Point of Contact and/or Cyrenians to put an emergency support package in place to enable the individual to be removed from the premises in a safe and supportive way*

Infection Control [YK2]

PPE will be required to be worn by all staff in all areas of Milestone. Guidance has been provided by Claire Mackintosh, Consultant at RIDU, see below

PPE - HPS guidance for stepdown of infection control precautions would suggest the following:

  - IPC precautions in all health care settings (inpatients, outpatients, residential care settings) should continue for 14 days (minimum) from symptom onset (or first positive test if symptom onset undetermined) with absence of fever for 48 hours (without the use of antipyretics)

  - Adequate and appropriate PPE equipment will be available and supplied to all Milestone staff (including housekeeping).

- Medical equipment – Supplied by EAP
- Catering – can be managed by in-house Milestone catering team, can be enhanced by Cyrenians if required
- Cleaning – Milestone has housekeeping facilities which will operate as normal, possibly with increased hours per week
- Laundry – will operate as per current arrangements

[YK1] To be finalised with all partners but is overview of what was discussed
[YK2] Please note – document has also been sent to colleagues in Infection Control for comment and advice, will update once feedback received.

Appendix 12

Milestone Intermediary Care Unit (MICU) clinical referral form

Information on referral criteria is detailed at the end of the form.

CLIENT DETAILS					
Name:		**Date of Birth:**		**CHI:**	
Address:				**Tel:**	
GP:				**Tel:**	
Has service has been discussed with client/information sheet provided and client agrees				YES:	NO:
ADMISSION DETAILS					
Hospital & ward:		**Telephone:**			
Date of admission:		**Expected discharge date:**			
Reason for admission:					
Treatment received:					
Ongoing treatment required (including duration):					

OPD appointment detail:	
Additional medical conditions:	
Allergies/Dietary requirements:	
Medication:	
Vaccination status (incl. dates):	
WOUNDCARE	
Woundcare requirements:	
District Nursing required Y/N:	
MOBILITY: Y/N –please detail	
Mobility rids required:	
Able to transfer independently:	
Independent in personal care:	
Mobilise in room independently:	
Physiotherapy required:	

REFERRER DETAILS			
Name:		**Organisation:**	
Role		**Date of referral:**	

Phone Number(s):			
FURTHER INFORMATION			
Are there any known risks for workers or volunteers to see this person?		YES:	NO:
Please give details:			
Please provide any further information in support of the referral:			

Please return by **Email:** Elizabeth.Marr@nhs.scot or karen.hamilton@waverleycare.org or call 0131 4416989

Likely Clinical and Care Needs

- Little or no sources of social support on discharge – vulnerable individuals
- Complex range of needs
- Needs around drug and alcohol use and OST
- Mental health issues
- Some ongoing clinical care requirements, which can be supported by NHS Clinical colleagues, EAP and WC staff (where appropriate). Examples of this could include provision of antibiotics; wound care/dressings; daily temp/BP checks
- The OPAT service at WGH will be able to provide ongoing support if needed (in particular with any IV/PICC line needs)

Referral Criteria – Acute Step-Down

All referrals will be for vulnerable, homeless patients or those at high risk of homelessness with multiple complex needs discharging from hospital and one or more of the following criteria:

- Confirmed/suspected COVID19 disease requiring hospitalisation and clinically well enough for step down care- min 14 days after onset of symptoms.

- Otherwise ready for discharge but with no access to safe or secure accommodation in the community
- Other complex and vulnerable individuals admitted to inpatient acute settings. Could include:
  - Those requiring ongoing antibiotic therapy (via IV or PICC line)
  - Those with trauma related injuries, e.g. ongoing wounds care
  - Those awaiting social work input where there is no safe discharge pathway
  - Those at high risk of drug related death- history of multiple NFOs
  - People experiencing homelessness who are unable to return to their accommodation to self-isolate following inpatient COVID contact.
- Referrals accepted from clinical staff in RIE/WGH/SJH/EAP

Referral Criteria- Community

All referrals will be for vulnerable, patients experiencing homelessness or those at high risk of homelessness with multiple complex needs- those who have self-discharged from hospital, at high risk of repeat admissions or whose clinical needs cannot be met in the community-following clinical assessment of level of need-

- Those who require a period of stabilisation from chaotic drug/alcohol/mental health issues
- Those who require assessment and treatment for significant physical and mental health issues or monitoring of ongoing health issues where this cannot be managed in the community
- Those requiring support to access end of life care
- Those requiring support to access and engage with existing health, social care and housing services or access further support services

Re-admissions can be agreed as part of a planned support plan if agreed at MDT.

Community referral pathway- referral enquires welcomed from all services. Referral forms will be provided and should completed and returned to Milestone for discussion at the MDT on a weekly basis.

Appendix 13

Milestone Intermediary Care Unit (MICU) referral form

CLIENT CONTACT DETAILS			
Name:		**Date of Birth:**	
Current/last Address: Please state which			
Phone Number(s):		**Other contact?**	
Has service been discussed with client/information sheet provided and client agrees		**YES:**	**NO:**
Is the client currently working with any other relevant agency/organisation(s)?		**YES:**	**NO:**
Please give details:			
Consent to contact agency/organisation(s)	**YES:**	**NO:**	
PHYSICAL HEALTH OVERVIEW			
Support needs **Risks identified**			

HOUSING
Support needs **Risks identified**
SUBSTANCE MISUSE OVERVIEW
Support needs **Risks identified**
MENTAL HEALTH NEEDS
Support required **Risks identified**

REFERRER DETAILS			
Name:		**Organisation:**	
Role		**Date of Referral:**	
Phone Number(s):			
FURTHER INFORMATION			
Are there any known risks for workers or volunteers to see this person?		**YES:**	**NO:**
Please give details:			

Please return by Email: Elizabeth.Marr@nhs.scot or karen.hamilton@waverleycare.org or call 0131 4416989

Appendix 14

Waverley Care service user agreement

Waverley Care is committed to providing a safe and supportive environment for all people who access the service, for services users, volunteers, staff and the general public. This is an important part of the Waverley Care ethos.

As someone who uses and accesses services offered by Waverley Care, I agree to adhere to the following conditions:

Confidentiality

The HIV and/or Hepatitis C status of all who may use the service will be kept confidential.

Anti-discrimination Statement

Everyone has a right to be treated with respect and tolerance and we have to be aware of people's differences which include:

- Race/colour
- Nationality
- Religion
- Sexuality
- Disability or illness
- Offending and the offences they have committed
- Causing offence to someone because of one of the above reasons is unacceptable and may jeopardize your ability to access services.

Alcohol policy

Alcohol affects people's behavior and this can cause difficult situations. The consumption of alcohol on Waverley Care premises is not permitted. In addition to this, if you are found to be under the influence of alcohol to the extent where your behavior is disruptive, disinhibited or inappropriate you will be asked to leave. Should you not wish to comply the police will be called.

Drug policy

Waverley Care recognizes that service users may be dealing with very difficult issues and every effort will be made to provide support with this. However, drug misuse will not be tolerated on Waverley Care premises. The use of 'street drugs' or 'extras' (unprescribed medication) is not permitted. Drug dealing and attempted dealing is not permitted. Any breach of this can result in you being asked to leave.

Weapons policy

The aim of this policy is to provide a safe and secure environment for everyone working, visiting or staying in Waverley Care premises. A weapon will be defined as any implement which may be considered by staff (due to its ability to cause harm or intimidate another person) to be dangerous. These items will be removed and, in the case of knives or guns, handed to the police for safe disposal. If service users refuse to comply with this policy they will be asked to leave and the police may be called.

Violence guidelines

Any physical violence or attack upon another service user or member of staff will result in you being asked to leave. If a visitor's behaviour results in an incident they will be asked to leave.

If an incident starts, your main concern is for your own safety and that of your visitors. Try and inform staff so that they are aware of the situation but you should not get involved. Take yourself to a place of safety out with the building or. If in the residential unit, go to your room and stay there until the incident is over. After any incident you will have the opportunity to discuss how you have been affected by the incident and appropriate support will be given.

It is not the role of staff to control the actions of a violent person. This is the responsibility of the police and they will be called.

Assessments and Key workers

When you are first referred to a Waverley Care service you will meet a member of staff from that service who will discuss your needs with you and assist you to make a positive choice about using the service. They may also suggest referrals to other Waverley Care services where appropriate. You may involve a friend, relative or representative to be present at this assessment. We will respect your need for time to make your decision. In some services, e.g. Milestone House residential unit you will be allocated a Keyworker on admission. Your key-worker is responsible for assessing and reviewing your needs. This does not mean that you cannot approach other staff. Please ask if you require any further information.

Computer usage

There are computers available for service users' use on some Waverley Care sites however access to adult sites is not permitted.

Visitors

Service users are expected to take responsibility for friends or visitors they may bring in to Waverley Care premises. In the residential unit overnight stays can be negotiated with the care team staff and 24 hours notice is required. If visitors are staying for meals the kitchen staff must be informed of this in advance (before 10.30am for lunch and 2.30pm for the evening meal. These meals must be paid for. Visitors not staying overnight must leave by 10pm.

Children

Parents are expected to take responsibility for health, safety and welfare of their children while on Waverley Care premises except in the case of children attending the groups run by the Children and Families staff.

Pets

Pets are permitted on Waverley Care premises but owners are responsible for them at all times. This includes ensuring they are well cared for and disposing of any waste materials safely and appropriately. Please negotiate with staff first if you intend to bring your pet with you. Dogs must be kept on a lead at all times in the public spaces.

Buildings and contents

All Waverley Care premises are cleaned on a daily basis and damage or faults to furniture, appliances or buildings are repaired as quickly as possible. Waverley Care expects that all staff, visitors and service users respect the buildings and contents and will not willfully cause damage or mess.

If you are resident in Milestone residential unit, your room will have been cleaned and appliances checked before your arrival. You will be expected to keep your room tidy but should you find this difficult then please speak to your Key Worker. Cups and dishes must be returned to the kitchen after use. If there are any problems with the appliances or other fixtures in the rooms, please inform the staff and we will endeavour to sort it.

Smoking policy

Following legislation in March 2006 smoking is not permitted in any Waverley Care building. If you are resident in Milestone you are only permitted to smoke in the grounds either outside of your room ensuring you are away from the door or in the designated smoking area.

Fire procedures

These are written on a separate sheet and will be explained to you when you first use Waverley Care's services.

Security

For security purposes Milestone residential unit has an alarm system. This is activated by staff between the hours of 2200 hrs and 0600 hrs. External doors must be kept closed at night, however you may open room windows for ventilation.

Signed (Service User):

Date:

Signed (Staff):

Date:

References

Aldridge R.W., Menezes D., Lewer D. et al. “Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England.” [version 1; peer review: 2 approved]. Wellcome Open Res 2019, 4:49 (https://doi.org/10.12688/wellcomeopenres.15151.1)

Aitken, E., (2021) “Covid-19: opportunity to improve crisis responses to homelessness?” Journal of Royal College of Physicians, 51 (S1): S53-62.

Blackburn, RM., et al. (2017) “Outcomes of specialist discharge coordination and intermediate care schemes for patients who are homeless: analysis protocol for a population-based historical cohort,” British Medical Journal Open 7: 3019282. Doi: 10.1136/bmjopen-2017-019282

Bramley, G., Fitzpatrick, S., Wood, J., Sosenko, F., Blenkinsopp, J., Littlewood, M., Frew, C., Bashar, T., McIntyre, J. and Johnsen, S. (2019) Hard Edges Scotland; Connected, New conversations about severe and multiple disadvantage. Heriot Watt, I-Sphere, Lankelly Chase and the Robertson Trust.

Cornes M., Aldridge R., Biswell E., Byng R., Clark M., Foster G., et al. (2021) “Improving care transfers for homeless patients after hospital discharge: a realist evaluation.” Health Serv Deliv Res 9(17). Available at [accessed at 30 September 2021]: https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr09170/#/abstract

Davies, N. (2021) International Overdose Awareness Day: “Benzodiazepines implicated in 73% of Scottish drug deaths.’” Available at [accessed at 30 September 2021]: https://www.addiction-ssa.org/international-overdose-awareness-day-benzodiazepines-implicated-in-73-of-scottish-drug-deaths/.

Edinburgh Poverty Commission (2020) A Just Capital: Actions to end Poverty in Edinburgh. Edinburgh Poverty Commission. Available at [accessed at 30 September 2021]: https://edinburghpovertycommission.org.uk/wp-content/uploads/2020/09/20200930_EPC_FinalReport_AJustCapital.pdf

Field, H., Hudson, B., Hewett, N. et al. “Secondary care usage and characteristics of hospital inpatients referred to a UK homeless health team: a retrospective service evaluation.” BMC Health Serv Res 19, 857 (2019). Available at [accessed at 30 September 2021]: https://doi.org/10.1186/s12913-019-4620-1

Gibson, L. (2021) Covid 19 Pandemic- The Edinburgh Response by Homelessness & Drug & Alcohol Services Partnership Working at its Best, Drug Death Task Force Service Development Blog. Available at [accessed at 30 September 2021]: https://docs.google.com/document/d/1CoeMqqjpQVckoxvN2ASnXvyV36d8I-_tlhYRy2-Wgao/edit

Healthcare Improvement Scotland (2021) NHS Fife and Shelter Scotland approach to supporting homeless patients attending hospital. Evidence and Evaluation for Improvement Team (EEVIT), NHS Scotland. Available at [accessed at 30 September 2021]: https://ihub.scot/media/8194/supporting-homeless-patients-attending-hospital-health-economics-report.pdf

Healthcare Improvement Scotland (2020) Homelessness, Access to services and Covid-19: Learning during the pandemic to inform our future, Healthcare Improvement Scotland. Available at [accessed at 30 September 2021]: https://drive.google.com/drive/folders/1XIpiLk18tYp-QI7Orsozkw2sTKXlH9Eg?lfhs=2

Homeless Link, Inclusion Health and St Mungo’s (2011) Improving hospital admission and discharge for people who are homeless, London: Homeless Link/St Mungo’s. Available at [accessed at 30 September 2021]: https://www.homeless.org.uk/sites/default/files/site-attachments/HOSPITAL_ADMISSION_AND_DISCHARGE._REPORTdoc.pdf

McCormick, J. (2020) A Just Capital: Actions to End Poverty in Edinburgh. Available at [accessed at 30 September 2021]: https://edinburghpovertycommission.org.uk/2020/09/30/a-just-capital-actions-to-end-poverty-in-edinburgh/

Morrison, D. (2009) “Homelessness as an independent risk factor mortality: results from a retrospective cohort study.” Internal Journal of Epidemiology, 38: 877-883.

National Records of Scotland (2021) Homeless Deaths 2019. Available at [accessed at 30 September 2021]: https://www.nrscotland.gov.uk/files//statistics/homeless-deaths/19/homeless-deaths-19-report.pdf

New Economy/Greater Manchester Combined Authority (2017) Inspiring Change Manchester: Housing First: Interim Progress Report. Available at [accessed at 30 September 2021]: https://hfe.homeless.org.uk/sites/default/files/attachments/ICM%20Cost%20Effectiveness%20Interim%20Report%202017_0.pdf

National Records of Scotland (2020) The Registrar General’s Annual Review of Demographic Trends 2019. Available at [accessed at 30 September 2021]:https://www.nrscotland.gov.uk/files/statistics/rgar/2019/rgar-2019.pdf

NICE (2017) Intermediate care including reablement, NICE guideline [ng74]. Available at [accessed at 30 September 2021]: https://www.nice.org.uk/guidance/ng74

Office of the Chief Analyst, Department of Health (2010) Healthcare for single homeless people. London: Department of Health.

Partnership for Action on Drugs in Scotland (2017) Recovering Connections: Changing stigma to respect. Edinburgh: PADS. Available at [accessed at 30 September 2021]: https://www.communityjusticeayrshire.org.uk/wp-content/uploads/2018/07/PADS-Recovering-Connectiosn-Changing-Stigma-to-Respect.pdf

Pleace, N and Bretherton, J. (2019) The cost effectiveness of Housing First in England, Homeless Link. Available at [accessed at 30 September 2021]: https://drive.google.com/drive/folders/1CY6xZLTGyq_lXVJtCQ5gaFa9OSc_Np7X?lfhs=2

Public Health Scotland (2020) Inclusion health principles and practice: An equalities and human rights approach to social and systems recovery and mitigating the impact of COVID-19 for marginalised and excluded people. Edinburgh: Public Health Scotland. Available at [accessed at 30 September 2021]: https://publichealthscotland.scot/media/2832/inclusion-health-principles-and-practice.pdf

Public Health Scotland (2020) Core COVID-19 Sectoral Information and Guidance for Homelessness Settings. Edinburgh: Public Health Scotland. Available at [accessed at 30 September 2021]: https://publichealthscotland.scot/media/3395/1_covid-19-homelessness-sector-guidance.pdf

Public Health Scotland (2021) Scottish Burden of Disease Study 2019: Summary of health loss in City of Edinburgh. Available at [accessed at 30 September 2021]: https://www.scotpho.org.uk/media/2075/2021-09-21-scottishburdenofdisease-city-of-edinburgh.pdf

Public Service Commission (2011) Commission on the Future Delivery of Public Services, Scotland: Scottish Government. Available at [accessed 30 September 2021]: https://www.gov.scot/binaries/content/documents/govscot/publications/independent-report/2011/06/commission-future-delivery-public-services/documents/0118638-pdf/0118638-pdf/govscot%3Adocument/0118638.pdf

Rees, S. (2009) Mental Ill Health in the Adult Single Homeless Population: A review of the literature, Public Health Resource Unit, London: Crisis. Available at [accessed at 30 September 2021]: https://www.crisis.org.uk/media/20611/crisis_mental_ill_health_2009.pdf

Royal College of Physicians of Edinburgh, Drug Deaths in Scotland: an increasingly medical problem. Available at [accessed 30 September 2021]: https://www.rcpe.ac.uk/sites/default/files/drugs_deaths_in_scotland_report_final_0.pdf

Scottish Drug Deaths Taskforce (2020) A Strategy to Address the Stigmatisation of People and Communities Affected by Drug Use - We all have a part to play. Available at [accessed at 30 September 2021]: https://drugdeathstaskforce.scot/media/1111/stigma-strategy-for-ddtf-final-290720.pdf

Scottish Drugs Forum (2021) MAT Standards Informed Response for Benzodiazepine Harm Reduction, Interim Guidance, August 2021. Available at [accessed at 30 September 2021]: MAT Standards Informed Response for Benzodiazepine Harm Reduction.

Scottish Drugs Forum (2021) “More than half of homeless deaths in 2019 drug-related.” Available at [accessed at 30 September 2021]:https://www.sdf.org.uk/more-than-half-of-homeless-deaths-in-2019-drug-related/

Scottish Drugs Forum (2017) Older People with Drug Problems in Scotland: Addressing the needs of an ageing population: The Expert Working Group on Older People with a Drug Problem: Final Report.Available at [accessed at 30 September 2021]:https://www.sdf.org.uk/wp-content/uploads/2017/06/Working-group-report-OPDPs-in-2017.pdf

Scottish Government (2021) NHS Recovery Plan 2021-2026. Available at [accessed at 30 September 2021]: https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2021/08/nhs-recovery-plan/documents/nhs-recovery-plan-2021-2026/nhs-recovery-plan-2021-2026/govscot%3Adocument/nhs-recovery-plan-2021-2026.pdf

Scottish Government (2021) Homelessness in Scotland: 2020-21. Available at [accessed at 30 September 2021]:

https://www.gov.scot/publications/homelessness-scotland-2020-2021/documents/

Scottish Government (2021) Homelessness in Scotland: 2020-21; Main tables (June 2021). Available at [accessed at 30 September 2021]:

https://www.gov.scot/publications/homelessness-scotland-2020-2021/documents/

Scottish Government (2021) Medication Assisted Treatment (MAT) Standards for Scotland: Access, Choice, Support. Available at [accessed at 30 September 2021]: https://www.gov.scot/binaries/content/documents/govscot/publications/independent-report/2021/05/medication-assisted-treatment-mat-standards-scotland-access-choice-support/documents/medication-assisted-treatment-mat-standards-scotland-access-choice-support/medication-assisted-treatment-mat-standards-scotland-access-choice-support/govscot%3Adocument/medication-assisted-treatment-mat-standards-scotland-access-choice-support.pdf?forceDownload=true

Scottish Government (2020) Scotland and the Sustainable Development Goals: A national review to drive action. Available at [accessed at 30 September 2021]: https://www.gov.scot/binaries/content/documents/govscot/publications/progress-report/2020/07/scotland-sustainable-development-goals-national-review-drive-action/documents/scotland-sustainable-development-goals-national-review-drive-action/scotland-sustainable-development-goals-national-review-drive-action/govscot%3Adocument/scotland-sustainable-development-goals-national-review-drive-action.pdf?forceDownload=true

Scottish Government (2018) Ending Homelessness Together: High Level Action Plan. Available at [accessed at 30 September 2021]: https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/11/ending-homelessness-together-high-level-action-plan/documents/00543359-pdf/00543359-pdf/govscot%3Adocument/00543359.pdf

Scottish Government (2018) Rights, Respect and Recovery, Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths. Edinburgh: The Scottish Government. Available at [accessed at 30 September 2021]: https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/11/rights-respect-recovery/documents/00543437-pdf/00543437-pdf/govscot%3Adocument/00543437.pdf?forceDownload=true

ScotPHO (2016) The Scottish Burden of Disease Study, Deprivation Report, Scottish Public Health Information for Scotland. Available at [accessed at 30 September 2021]: https://www.scotpho.org.uk/media/1656/sbod2016-deprivation-report-aug18.pdf

Stevenson and Spencer (2002) Developing Intermediate Care: A Guide for Health and Social Services Professionals, London: The King's Fund.

St Mungo's (2015) Homeless Health Matters: Our campaign impact. London: St Mungo's. Available at [accessed at 30 September 2021]: https://www.mungos.org/app/uploads/2017/07/Homeless-Health-Matters-Impact-Report-1.pdf

St Mungo's (2014) Reading Counts: why English and maths skills matter in tackling homelessness. London: St Mungo's. Available at [accessed at 30 September 2021]: https://www.mungos.org/publication/reading-counts-english-maths-skills-matter-tackling-homelessness/

Wadhera, R., Choi, E., Shen, C.,Yeh, R. and Joynt Maddox, K. (2019) "Trends, causes and outcomes of hospitalizations for homeless individuals: A retrospective cohort study." Medical Care, 57:1, pp.21-27.

Waugh, A.; Clarke, A., Knowles, J. and Rowley, D. (2018) Health and Homelessness in Scotland: People, Communities and Places, Scottish Government. Available at [accessed 30 September 2021]: https://www.gov.scot/publications/health-homelessness-scotland/documents/

Zeitler, M., Williamson, A.E, Budd, J., Spencer, R., Queen, A. and Lowrie, R. (2020) "Comparing the Impact of Primary Care Practice Design in Two Inner City UK Homelessness Services." Journal of Primary Care and Community Health, 11: 1-13.

Contact

For more information or questions about this report, please contact:

Esther Currie
Marketing & Stakeholder Affairs at EVOC
E: esther.currie@evoc.org.uk