Rough Sleeper Paramedic Derby City – Case for Ongoing Funding

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Summary

In March 2020 Derby City after three years of multi-agency problem solving, joint funding, system improvements and support from the Ministry of Housing, Communities and Local Government, the City of Derby has a much tighter grip on the issues around rough sleeping and the associated street behaviours. Through the work of a local Partnership (The Safe Space Partnership), linked with the Strategic Homeless Board, Derby City has seen significant reduction in terms of numbers rough sleeping, and the volume of ambulance call outs and A&E attendances relating to the street community & rough sleepers.

Key to this has been the role of the Rough Sleeper Paramedic, funded until the end March 2021 by the Ministry of Housing, Communities and Local Government. (MHCLG) This paper outlines the evidence of impact of the role since April 2018, and proposes that the CCG supports the request for funding for

a) Match funding for half time of an emergency care assistant required to support the work of the Rough Sleeper Paramedic £6,600 for remainder of 2020. (7 months)
b) Ongoing funding for Paramedic Role from April 2021 c £65K pa
c) If successful in increasing impact of paramedic role - ongoing funding for ECA role £28K pa from April 2021

Background

In early 2017 it became apparent that the prohibition of synthetic cannabinoid receptor antagonist (SCRAs - through the Misuse of Drugs Act 1971) had resulted in the transformation of the local new psychoactive substances problem. More problematic and highly visible SCRA use emerged in Derby City centre with associated aggressive begging, antisocial behaviour and acquisitive crime. However, by far the most visual and disruptive effect to the public, businesses and the local economy was the use of the drug in public which resulted in users presenting in a “zombie” like state or being violent/ committing ASB.

On a seven-day period in August 2017, there were 82 calls for service to the police relating to on street drug intoxication incidents and 132 calls for service for an ambulance for the same.

At its height (summer 2017), 'Mamba' drug-related ambulance call outs to the city centre (to deal with what be-came known as 'Mamba attacks') peaked at 23 in a single day (corresponding to 52 client episodes).

This activity was mainly but not exclusively most visible in the homeless community in around the hostels and visible within the centre of the City.

In addition, individual drug related co-morbidity/injection related acute infections/ notable incidence of sepsis, were largely delayed before reaching the attention of health care services, leading to increased complications/ more invasive and sustained treatment and poorer prognosis.

Hospital discharges around Those with No Fixed Abode, proved problematic, often ending with inadequate plans or self-discharge, as pathways either were difficult to navigate or non-existent in practice. Frequently discharges lead to re-admissions.

Late in 2017, a successful bid to Ministry of Housing, Communities and Local Government (MHCLG) funded a Paramedic post to work directly with rough sleepers in Derby City. **The funding for this ends in March 2021.**

Paramedic Data

	Oct-19	July 20	Change	Positive Outcome
Health & Safeguarding data				
Average health interventions completed by Paramedic per month	133	115	↓	TBA
Average number of individuals having at least one intervention each month	49	48	↓	TBA
Average ED attendance/999 avoidance per month	75	83	↑	↑
Average direct hospital admissions (avoiding ED)	9	7	↓	↑
Average Calls for Service per month to Safe Space - EMAS	4	2	↓	↓
Number of deaths	2	5	↑	↔
Number of individuals with an active Safeguarding referral in place		16	New	TBA
Number of individuals on Safe Space "watch list" i.e. concerns		C32	New	TBA

The Paramedic role is recognised as having a significant impact on

- Reducing the number of ambulance call outs in the City to rough sleepers/street community
- Reducing the number of ambulance conveyance to A&E of rough sleepers

- Effectiveness of pathways to and from health care services including hospital admissions/community services (wound care) and primary care.
- The health and life expectancy of rough sleepers and members of the street community in Derby City.
- The reduction of DNA rates with primary care appointments.
- The safe delivery of two babies born to chaotic and complex rough sleepers refusing to engage with maternity services.

To date 142 unique single individuals have accessed rough sleeper/homeless provided by Safe Space, the Partnership Project.

COVID-19 Recovery Plan for Rough Sleepers & development of a Multi-Agency Support Hub for Rough Sleepers.

During the peak of COVID-19, local authorities were charged with getting "Everyone In" to accommodation from the streets, and took over the Holiday Inn Express in Pride Park as a single location where individuals could be accommodated and be supported to stay safe. The Paramedic worked out of this site as well as conducting regular "sweeps" of known locations of rough sleepers who felt unable to remain at the hotel. 143 individuals were accommodated between 23d March and 19th June 2020.

A Recovery Plan was prepared as part of the transition from the hotel – drawing from the learning during that period. A key part of the lessons learnt was around effective multi system pathways and working, and how, with necessity, previous "blockages" were removed and communication and appropriate and timely information flow and action achieved.

As a result – a new Multi-Agency Support Hub for Rough Sleepers (MARSH) has been agreed by the City Council's Corporate Leadership team and resources identified from within statutory systems. These include a new rough sleeper CPN (band 6), and two dedicated drug & alcohol treatment workers to work with the rough sleeping cohort. Safeguarding teams and a Police Inspector leading on vulnerability and rough sleepers are also joining the team, along with resource from primary care, probation, employment and benefits services (DWP) and Housing. The Paramedic will play a key role in the MARSH going forward, but the funding for this role is unsecured after March 2021, with no indication from MHCLG of the likelihood of future funding.

Since March 2020, and COVID-19, the Paramedic has completed in excess of 1192 COVID checks, with only three requiring self-isolation, and no positive cases. During this period, the Paramedic also worked creatively with existing pathways, primary care and the hospital to support medicines management/ongoing wound care and maternity care of highly vulnerable individuals from within the rough sleeping community. The Paramedic has also played a significant safeguarding role, identifying otherwise hidden risks and vulnerabilities requiring a multi-agency response.

The volume of work that the Paramedic deals with is significant, even before COVID-19, and has relied upon her commitment and professionalism to maintain excellent records of all activity and

outcomes of interventions. However, this "volume" pressure is apparent, and threatens to reduce her ability to respond as required to emergencies as they occur. Reviews of activity with the Paramedic and of her activity, indicate that additional support would release her to work with the more acute/higher risks cases and protect the professionalism required of this complex, multi-faceted role. Discussions around this support with the Paramedic and EMAS suggest that the role of Emergency Care Assistant (band 3) is an appropriate level of support for full time hours. The Partnership asked MHCLG for funding for this role, and **MHCLG have provided funding for 0.5WTE of this role until then end of March 2021. This** role is as yet appointed to as a) COVID-19 delayed recruitment and, b) in order to recruit internally, to avoid shift complications it would need to be full time. There is no other funding in place for this role.

Rough Sleeping and Health Service Impact

- Health outcomes for rough sleepers are poor; for example, the average age of death of a homeless person is between 40 and 42 years, and a homeless drug user admitted to hospital is seven times more likely to die over the next five years than a housed drug user admitted with the same medical problem. [1]
- There is a growing understanding, supported by international research, that chronic homelessness is an associated but probably non-causative marker for tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill health with mental ill health and drug or alcohol misuse. This complexity is often associated with advanced illness at presentation, in the context of a person lacking social support who often feels ambivalent both about accessing care and their own self-worth. Simply housing long-term homeless people (although an essential first step) does not, of itself, resolve the underlying problems. When homeless people die they do not commonly die as a result of exposure or other direct effects of homelessness, they die of treatable medical problems, HIV, liver and other gastro-intestinal disease, respiratory disease, acute and chronic consequences of drug and alcohol dependence.
- In patient care costs of those with "no fixed abode" are approximately eight times greater than those of similarly aged adults; they have almost three times the average length of stay. [2]

Proposal for consideration

In light of the above, we ask that the CCG consider the positive impact of the role of Rough Sleeper Paramedic on both the health care system and the rough sleeping individual, and conversely the impact post March 2021 if funding is removed from this position, with a view to agreeing ongoing funding for the role from April 2021 onwards. **The cost implication is 65K pa inclusive of on costs.**

In addition, we would ask that the CCG considers testing the impact of the ECA role through funding the additional 0.5WTE until the end of March 2021, with a view, if effective, of ongoing funding of this role. **The cost implication is 28K inclusive of on costs**.

[1] Public Policy Institute for Wales (2015) Tackling Homelessness A Rapid Evidence Review
[2] London Pathway & College of Medicine (2011) Standards for Commissioners and Service Providers. Faculty for Homeless Health – London Pathway & College of Medicine


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Additional Information

Review of Model and Vision for Rough Sleepers

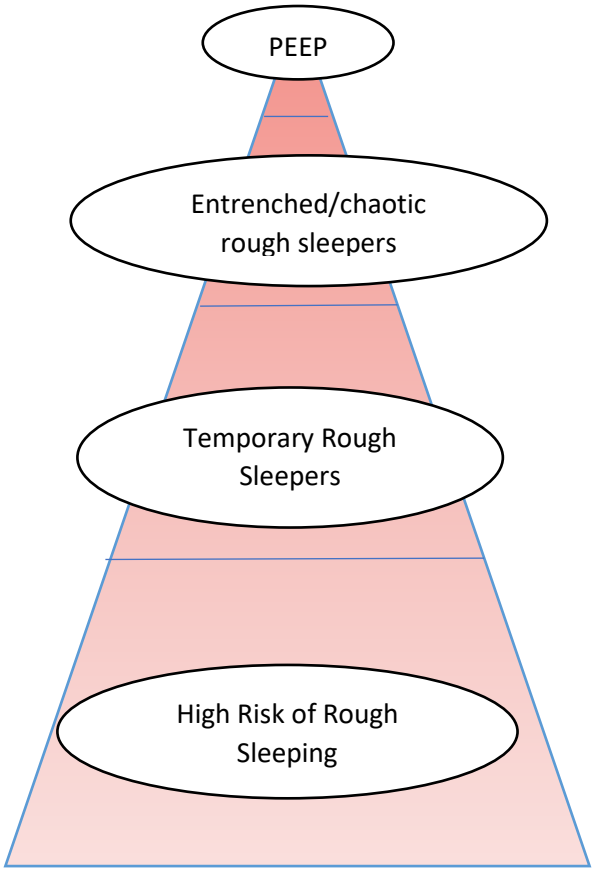
Pre COVID - the Partners had reviewed the evaluation material and outcomes from the project since March 2018, and assessing findings alongside existing and emerging publications (e.g. Marmot Review 2020, The Drug Review Feb 2020 (Caroline Black) and the already cited references). It has been their intention to agree a vision going forward to include both the targeted approach and the pathway that could be further tested ahead of decision making for a future longer-term model of intervention.

The Partners have articulated a model as below which outlines the targeting of resources aligned to rough sleeping:

Overarching Targeted Model of Intervention

Rough Sleepers & Street Community

In Derby, we have found that rough sleepers fall into one of four groups. The diagram below shows these and illustrates the comparative volume of individuals within each group



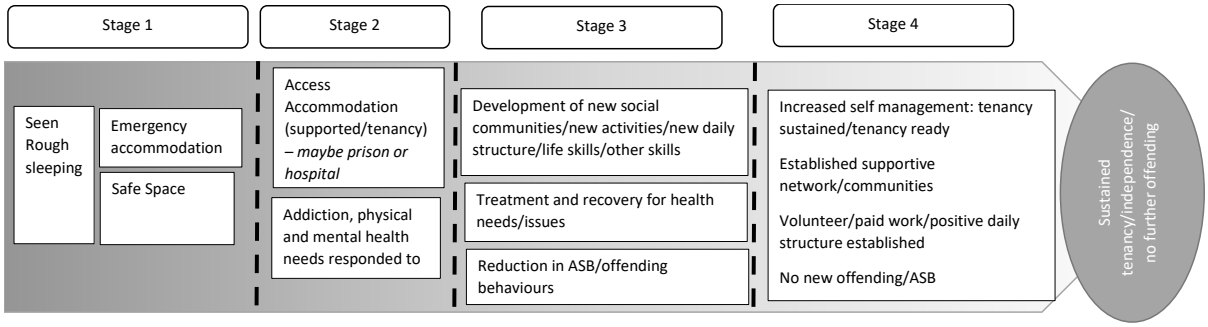
PEEP: Persistent anti-social and criminal behaviours that present an ongoing public safety risk + support, facilitate and enable the illegal supply of substances to categories 2,3,4.

Entrenched Rough Sleepers: Persistent chaotic lifestyle, and unmanaged psychiatric and personality disorder driven behaviours that lead to adult safeguarding concerns + ongoing anti-social behaviour + significant health risks for individuals + pose an economic risk to businesses in the City + repeatedly fail to sustain accommodation offered.

Temporary Rough Sleepers: Individual crisis e.g. trauma /loss/ mental ill health/ eviction/ release from prison without accommodation leading to temporary chaotic and/or anti-social behaviours. Association and engagement with street and rough sleeping community

High Risk of Rough Sleeping: Association with street and rough sleeping community and at risk of eviction from accommodation

The pathway for this intervention is shown as four stages. During stages 1,2,3 there is likely to be moves between the stages until stability is achieved. The Paramedic & ECA roles would focus predominantly on individuals in Stages 1 & 2



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