Research and evidence session

Co-ordinating hospital discharge for people who are homeless

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Delivering person-centred care in hospital discharge? The role of intermediate care.

QNI Homeless Health Network and Learning Day

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NHS National Institute for Health Research

King's College London University of London · UCL · Plymouth University Peninsula Schools of Medicine & Dentistry · pathway · LSE The London School of Economics and Political Science · University of Liverpool · Barts and The London School of Medicine and Dentistry

Aims of Presentation

To present some preliminary findings from a three year study exploring how can we deliver consistently safe and timely transfers of care for people who are homeless or in housing need.

"Poor practice... Too many hospitals are discharging homeless people back to the streets. Patching a person up and sending them out without a plan makes no sense" (Paul Burstow, Former Secretary of State for Health & Social Care, 201?)

Background

- In 2013, Department of Health released “£10 million cash boost” to improve hospital discharge arrangements, funding 52 specialist homeless hospital discharge (HHD) schemes across England.
- We were commissioned to evaluate these schemes (building on earlier work by Homeless Link). Due to report Spring 2019.

  - Do HHD schemes reduce delayed transfers of care?
  - Which schemes are most effective and cost-effective?
  - Have HHD schemes eradicated the ‘poor practices’ associated with discharging patients to the street?
  - What has happened to the 52 Schemes?

Methods

1) Qualitative fieldwork

- 8 case study sites [6 with specialist care/2 with standard care].
  - ✓ 71 Patient interviews (at discharge then 3 months later)
  - ✓ 77 Stakeholder interviews (practitioners, managers etc.)

2) Data Linkage (NHS Digital)

- Information held in 'safe haven' on 9,000+ service users collected from 16 hospital discharge schemes.
- Looking at a range outcomes including '28 day emergency readmission rates' and 'Time from admission to mortality from causes amenable to healthcare' (Rob Aldridge, UCL)

3) Economic Effectiveness Evaluation

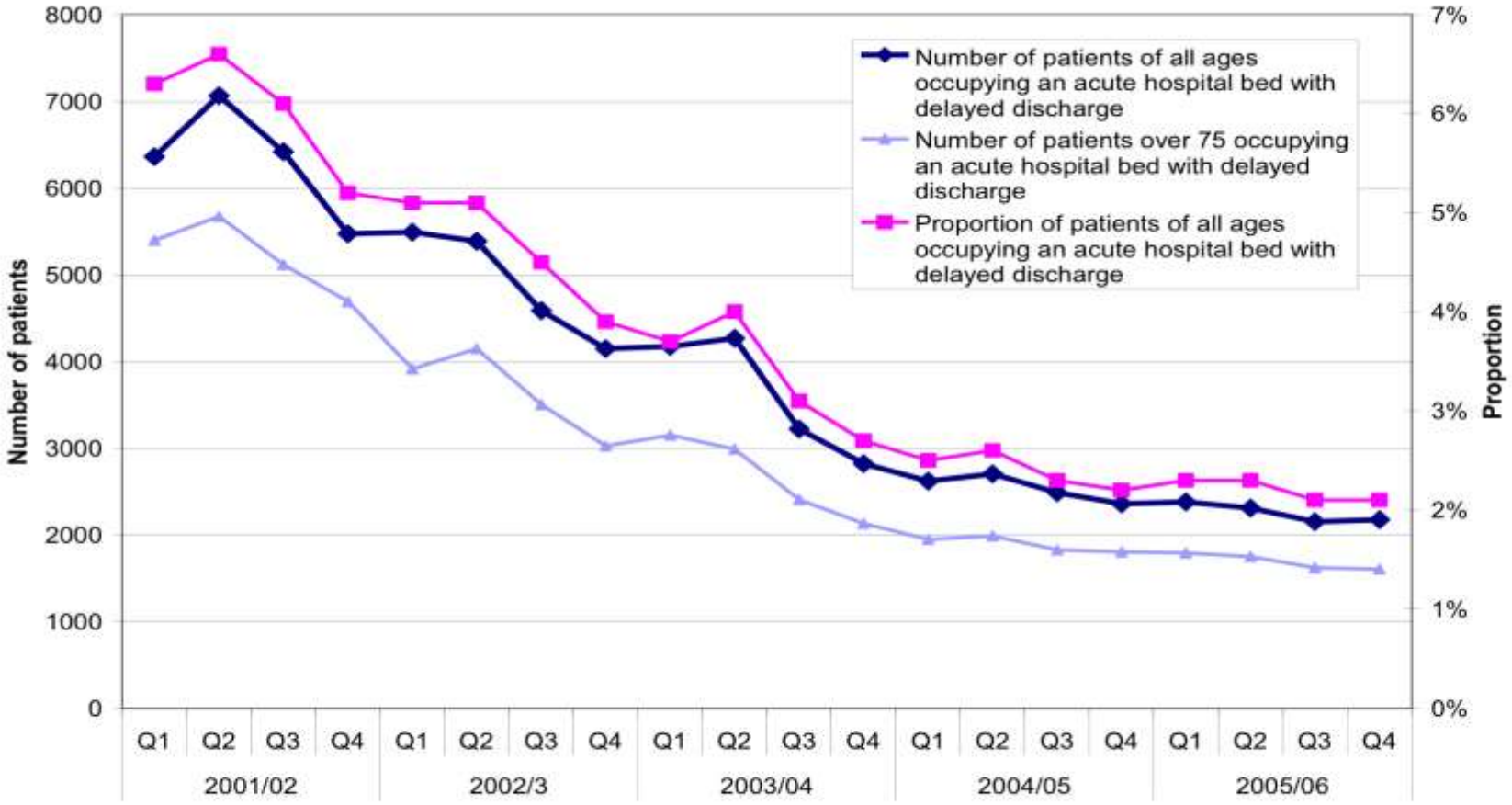
- NICE standards for cost effectiveness. (Michela Tinelli, LSE)

Patient and Public Involvement (PPI) throughout

'Nothing about us without us'

What worked ‘back then’?

Figure 4 - Delayed Transfers of Care (Discharges) in England 2001-06



Source- Department of Health, SaFFR, LDPR.

The Complete Jigsaw

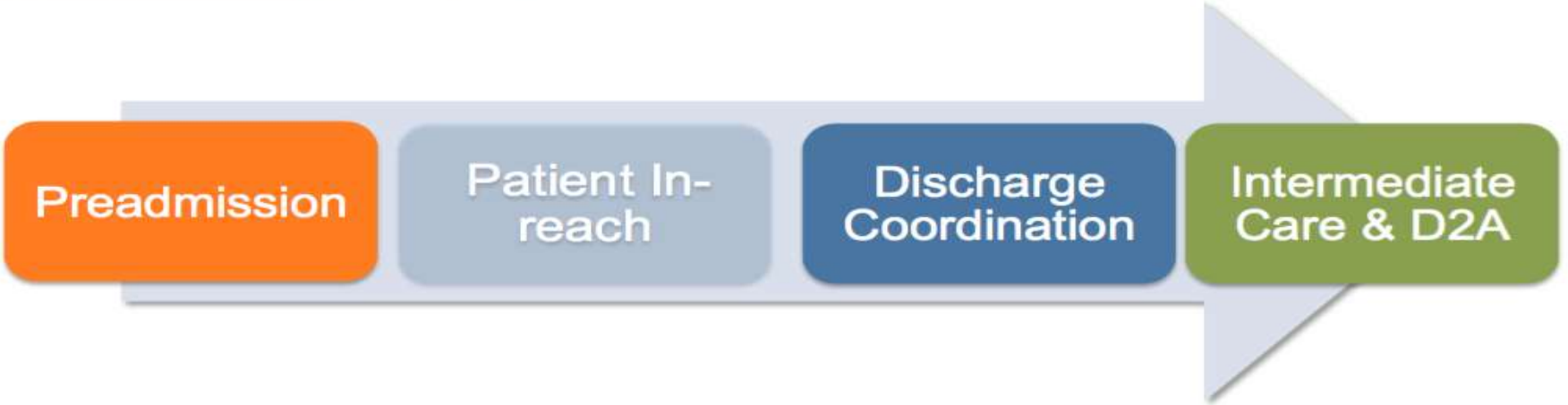
- "Fully coordinated primary and secondary care that provides an integrated service, including specialist primary care, outreach services, **intermediate care beds**, **and in-reach service to acute beds**."
  - Department of Health,
    - Chief Analyst 2010
-

- Snapshot end of 2017, suggests only one place in England has all the jigsaw pieces!

Quick Audit Tool

Transfer of Care Check List for Patients who are Homeless or in Housing Need

Protocol	Is Care Act, 2014 Annex G being implemented? In addition, is there a local 'Homeless Hospital Discharge Protocol?
Preadmission	Are primary and community care services accessible? Are services working together to prevent inappropriate use of A&E?
Patient In-reach	Do ward staff have a good understanding of the needs of patients who may be homeless and who have multiple needs (e.g. an understanding of the issues that commonly lead to early self-discharge)?
Discharge Coordination	Do ward staff have easy access to someone who can advise them about local housing and homelessness services and legislation (e.g. the implications of the new Homeless Reduction Act)?
Intermediate Care & D2A (Discharge to Assess)	Are there beds available in the community where people can stay while undergoing a full assessment of their health, housing and social care and support needs? Are there opportunities for people to have 'breathing space' before making decisions about life changes, including new accommodation and support?
Exit	Is there someone in post who can manage the transfer from 'end to end' - withdrawing support only at the point at which longer term health, care and support services are in place and working well?
WARNING!	*If the D2A pathway extends beyond 6 weeks, this is an indicator that there may be quality or capacity issues in longer term local service provision.*



Integration
The key to seamless 'patient flow'

What is Intermediate Care?

- The primary stated objective of intermediate care is to support anyone with a health related need through periods of transition (DH, 2009 p10).

- Intermediate care is an evidenced based mechanism for managing the tension between the need for fast and efficient 'patient flow' and safe discharge practice **(person-centred care)**

  Reablement
  Crises Response/Rapid Response
  D2A (Discharge to Assess)
  Step-up/Step –down (Can be 'home based' or 'bed based'*)

  **Medical Respite (American Term)*

Hospital Discharge Scheme Typologies

- ‘Clinically-led’ discharge co-ordination schemes with no direct access to step-down intermediate care
- ‘Clinically-led’ discharge coordination schemes with direct access to step-down intermediate care
- ‘Housing-led’ schemes with direct access to ‘step down’ intermediate care

Bradford - Lots of Jigsaw Pieces

A&E and the Hospital Wards

- ✓ Grant Funding
- ✓ Partnership
- ✓ Protocols
- ✓ Discharge Coordination
- ✓ MDT Meetings
- ✓ Residential IC
- X Community IC

Standard Discharge Coordination

Specialist Homeless Discharge Coordination & Patient In-reach

Bradford Pathway Homeless Team
2 FT Nurse Case Managers
1 FT Housing Navigator
8.30-6pm

pathway
Healthcare for homeless people

Adult Social Care Protocols – Care Act

Bradford Council Gateway (Housing Options)

Protocol
(e.g) 'bed blocking forms' trigger 48 hour response

Specialist Residential Intermediate Care
BRICCS
14 beds
1 manager
4 resettlement workers
staffed 24 hours

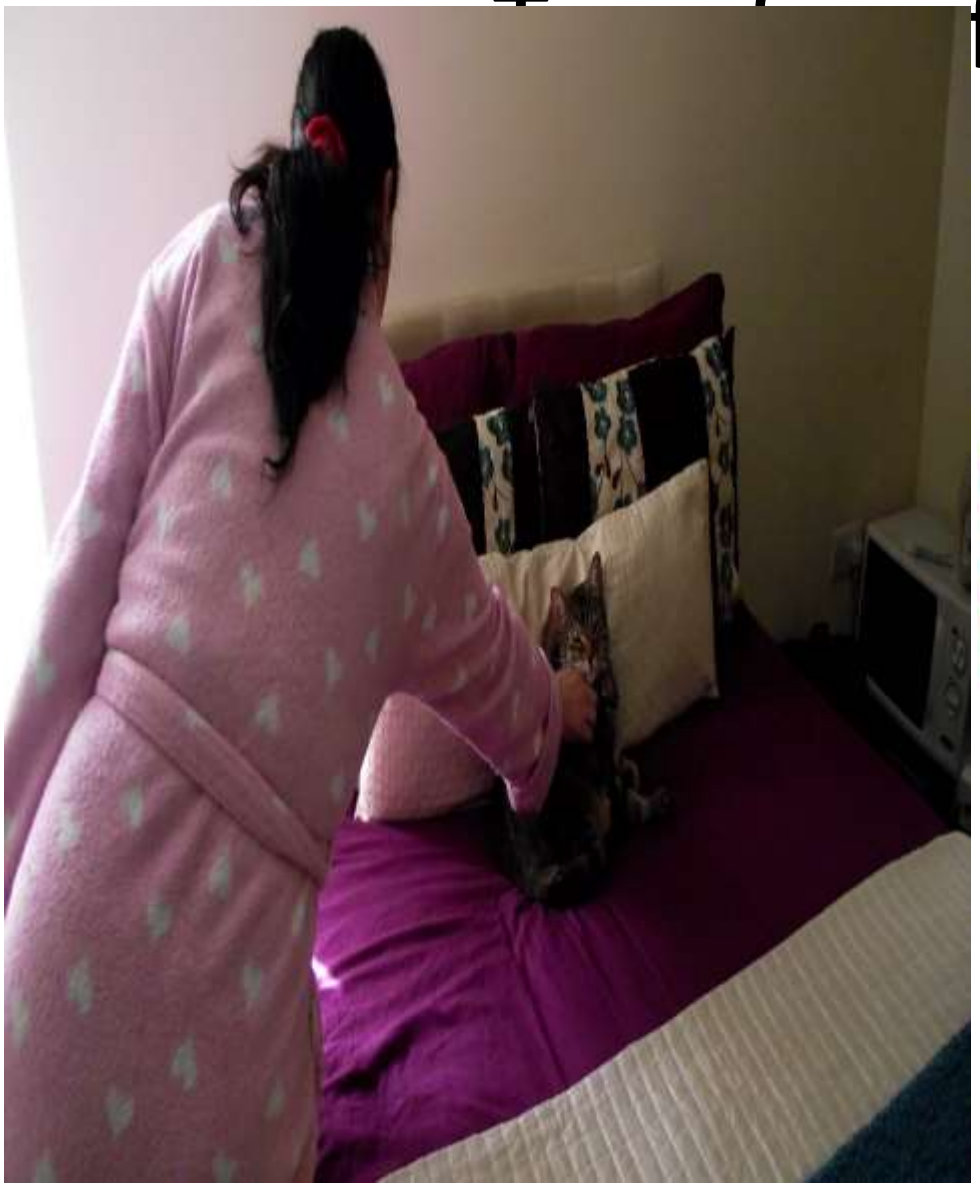
horton housing

Monthly MDTs

Specialist Primary Care (including Street Medicine)
Partnership/Protocol
(e.g) GP led ward rounds in hospital and BRICCS, accompanied by a Mental Health Nurse

Bevan HEALTHCARE

Site 2 – A Safe, Timely, Seamless Transfer of Care



0 miles

4 miles

Tuesday

2pm - Discharged from hospital

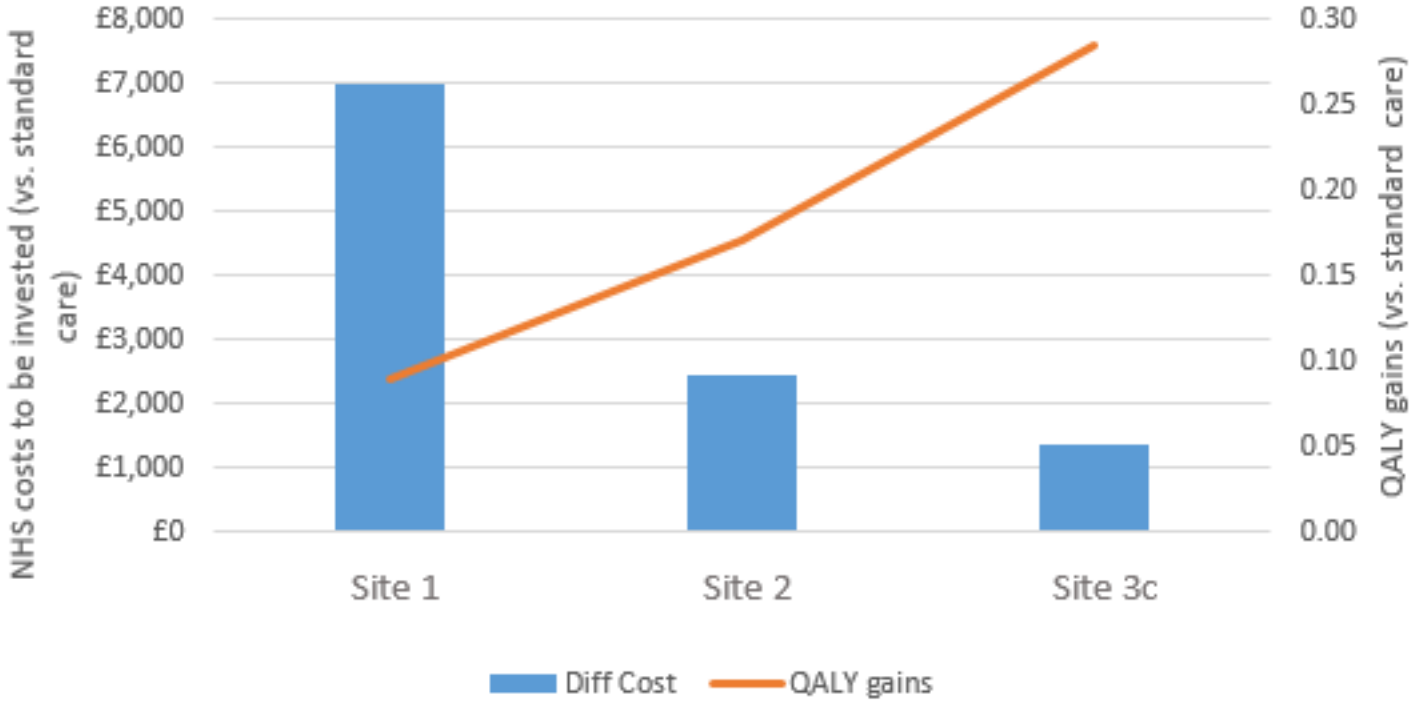
2.30 - Taxi arrives to take Mrs B to STEPPS
(a hostel dedicated to the delivery of intermediate care)

3.00pm Settled and comfortable.
Homeless Team nurse pops in to see
if housing staff are happy with the discharge plan.

Thursday

10 am - Homeless Team GP and Nurse undertake 'ward round'
at intermediate care facility and
pop in to see if Mrs B has any concerns.

Economic model 2: Difference in annual NHS costs and QALY outcomes per patient (vs. standard care from Hewett et al 2016



KEY FINDING: HHD Schemes offering **'patient in-reach'** and **'specialist discharge coordination'** are more effective and cost effective when they include **'step down'** intermediate care (as in the case of Sites 2 and 3c above). This reflects the importance of managing the transfer of care not just the 'exit' from the acute sector.

- **The capacity for intermediate care for all patient groups remains stubbornly stuck, and almost certainly stuck at a level below the threshold for whole system impact**
    - **(National Audit of Intermediate Care, Young, 2015)**

Have HHD Schemes Eradicated Discharge to the Street'?

- Our study mirrors the findings of the earlier national evaluations of intermediate care for older people:

'The effectiveness of interventions to improve the speed and quality of discharge will depend to a large extent on the broader service context in which they take place. Interventions that are shown to work well in areas with well-resourced and efficient community support services may have little or no impact where services are inadequate or lacking'

(Barton, et al. 2006)

In sites where housing, care and support is in short supply, it is often assumed that for some individuals there is no option other than discharge to the street…

Site 1 - A Gutter Frame Challenge

0 miles

0.6 miles

1.7 miles

2.3 miles

3.7 miles

4.8 miles

6.4

6.6 miles

6.8 miles

Tuesday

7.30pm - Discharged from hospital to the street

Mrs A has no money and it is a 0.6 mile walk to her usual sleep site.

Wednesday

8.00 - Walk 1.1 mile to the GP surgery – Doors open 9.15

10.30 - See the nurse – assessed as needing intermediate care but assessor not here.

12.30 - See the GP

1.30 - Walk 0.6 miles to the day centre to see if they have an emergency bed for tonight. None are available that have disabled access

3.00 - Walk 1.4 miles back to sleep site.

Thursday

7am - Walk 1.1 mile to 'appointed' chemist to pick up methadone

9.15 - Walk 1.6 mile back to GPs surgery to be assessed for intermediate care

12.30 - Walk 0.2 miles to chemist to get dosset box for medications, wait 2.5 hours until chemist has time to help

3.00 - Walk 0.2 miles back to GP surgery

3.30 - Taxi arrives to take Mrs A to intermediate care bed in a local hostel

Rights to Exercise Choice and Control

- If an older person is 'medically optimized' but needs to wait for care and support to become available in the community or wants to 'exercise choice' about waiting for a specific care home place to become available, then the transfer of care is delayed. This is recorded as a DTOC (Delayed Transfer of Care).

- **Are patients who are homeless are being accorded the same standard of care when it comes to 'rooting out poor practice'?**

- 'Medical optimization is the point at which care and assessment can be safely continued in a non-acute setting… Too often discharge is seen as freeing-up a hospital bed rather than acting in the patient's best interest to move them swiftly to a safer, more familiar environment that will encourage supported self-management, speed recuperation and recovery and have them feel better. **We must make every effort to shift understanding to this reality' (DHSC, 2015).**

Contact Us

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- **For more information about the study**: *"Effectiveness and Cost-effectiveness of 'Usual Care' versus 'Specialist Integrated Care': A Comparative Study of Hospital Discharge Arrangements for Homeless People in England'* visit:
- http://www.kcl.ac.uk/sspp/policy-institute/scwru/res/hrp/hrp-studies/hospitaldischarge.aspx

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