Out-of-Hospital Care Services and Homelessness

Making Research Count 7th June 2022

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Aims

To present an overview of the evidence base for “what works” in the safe timely discharge of homeless patients from hospital:

- The experience of being discharged to the street
- What needs to be in place to prevent this
- Impacts of new D2A operating model – focus on Care Act, 2014 assessment
- Economic impacts (Michela)

Pathways to Impact

2012	70% of homeless patients discharged to the street
2013	DHSC allocates £10million to address this – 52 specialist hospital discharge schemes set-up nationally
2015	King’s College, LSE and partners commissioned to evaluate
2021	NICE uses this research to underpin new guideline about specialist intermediate care
2021	DHSC launches ‘Out-of-Hospital Care Models programme £16 million to roll out and scale specialist out-of-hospital care

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Gutter Frame Challenge

0 miles

Tuesday

7.30pm - Discharged from hospital to the street

0.6 miles

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

1.7 miles

Wednesday

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

2.3 miles

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

12.30 - See the GP

3.7 miles

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.

4.8 miles

Thursday

6.4

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

6.6 miles

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

6.8 miles

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

Background

- Homelessness is not just a ‘housing issue’
- Compared to people who are not homeless, homeless people
  - Attend A&E 6 times as often
  - Get admitted 3.2 times as often and stay in hospital 3 times as long
  - Have unscheduled care costs 8 times higher
  - Experience poor care (70% discharged back onto the street)

- In 2013, Department of Health released “£10 million cash boost” to tackle these issues, funding 52 **specialist** homeless hospital discharge projects across England.
- We were commissioned to evaluate these schemes.

Hospital In-reach Schemes

Challenging stigma

Preventing early self-discharge

Duty to refer

Advocacy

More Information see www.Pathway.org.uk

Intermediate care schemes

- Support for anyone with a health related need through a period of transition (DHSC, 2010)
- Early guidance was clear that intermediate care should be accessible to homeless people and prisoners, later guidance has tended to conceptualise this as an older adults service.

“[Prior to hospital admission] I was living in a hostel… it was noisy, doors slamming all night long… There were steps I couldn’t manage... [BRICCS] is completely quieter, nicer, there’s medical care and its just lovely... They’re aboslutely marvelous”

Evaluation Methods

1) Qualitative fieldwork

- 6 case study sites [4 with specialist care/2 with standard care].
  - ✓ 71 Patient interviews (at discharge then 3 months later)
  - ✓ 77 Stakeholder interviews (practitioners, managers etc.)

2) Economic Effectiveness Evaluation

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

3) Data Linkage (NHS Digital)

- Information held in ‘safe haven’ on 3,882 service users collected from 17 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)

Key Findings – You need both in-reach and step-down services

- NHS Trusts with specialist discharge schemes have lower rates of Delayed Transfers of Care (DToCs) linked to 'Housing' than standard care.
- Employing a range of different economic modelling techniques, specialist discharge schemes are consistently more effective and cost effective than standard care.
- Clinical advocacy provided by hospital-based homeless health care teams increases access to planned (elective) follow-up care. This is an especially important outcome as 1 in 3 deaths of people in our homeless hospital discharge cohort were due to common conditions (e.g. heart disease) which are amenable to timely health care.
- Employing a range of different economic modelling techniques specialist discharge schemes with direct access to specialist intermediate care (step-down) are more effective and cost effective than schemes that have no direct access to intermediate care.
- There was evidence that specialist schemes with a step-down service were associated with a reduction in subsequent hospital use, with an 18% reduction in A&E visits compared to schemes without step-down.

New Nice Guideline for Specialist Homeless Intermediate Care Services

https://www.nice.org.uk/guidance/ng214/chapter/Recommendations#intermediate-care

Impact of Covid - Discharge to Assess

- D2A and Home First underpin the new operating model
- Under D2A a period of care is funded to facilitate recovery, rehabilitation and reablement
- An assessment of longer-term care and support needs takes place out-of-hospital once the person has reached a point of recovery
- People should not have to make decisions about long-term care while they are in crises or in an acute hospital bed.
- The new guidance is clear that the needs of people who are homeless need to be considered as part of D2A and that local commissioning plans should include the provision of specialist support
- D2A Pathways

Pathway 0 – No new care and support
Pathway 1 – Home with new support
Pathway 2 – Bedded rehab
Pathway 3 – Care home (likely long term)

Investment & Service Development Across D2A Hubs and Pathways (Step-down from Hospital) 2021/2022

Site	Hospital In-reach *(including posts integrated with D2A discharge hubs)*	0	D2A Pathway 1 – Home First (*Domestic settings/hotels and other accommodation that is not working solely with D2A patients)*	D2A Pathway 2 – Specialist Step-down Facility (*Bed Based/Non-domestic setting working mainly with D2A patients).*	3
Cornwall 2 hospital sites *Project Officer £40,000*	**Housing-led** Hospital In-reach Team covering both acute and mental health hospitals based within the Integrated Safeguarding Services. 1X FTE Homeless Patient Advisor (already in post /not OOHCM funded). £42,000 1X FTE Homeless Patient Advisor OOHCM funded (£42,000) **Total Cost = £84,000**		**Settle-in Support** 2 FTE outreach workers covering different parts of the county, providing 75 hours of settle-in and key work support.* £78,000 £4000 personal budget **Total Cost = £82,000** *There is also access to the Stay at Home CQC reablement/domiciliary care team (see next box for costs).	**8 Units of Step-up/Step-down accommodation** 6 spaces are OHCM funded spaces in newly converted fully accessible house opened January 2022. £157,248 for onsite 24/7 support plus £120,324 to cover rental voids where housing benefit cannot be claimed. **2 step-down beds** also funded through RSI for 2021/22 covering a different geographical area. Cost £23,010 (not OOHCM funded) Residents have access to a **CQC specialist drug and alcohol domiciliary care service** Stay at Home. Cost £76,764 (block contract providing 70 hours per week). Plus £2,400 personal budget. **Total Cost = £379,746**	
Salford (GM) 1 hospital site Evaluation and support £1,250	**Clinically-led** (Pathway Team) GP and Specialist Primary Care Service providing sessional in-reach mainly into A&E and on the wards. £89,905 1 FTE Band 6 Dual Diagnosis Worker £47,085 Housing Options Coordinator based in Single Point of Access Hub (Not OOHCM funded – please provide costs for Y2) ***Total Cost =***		**3 Units of Dispersed Accommodation plus Settle-in Support** Disabled Access: 1 Unit (including a fully accessible bungalow). Housing provider providing tenancy management and sustainment. Costed at £75,840 for 8 units. Support post hospital is provided by two workers who work in the local Rough Sleepers Discharge Team £85,500 Personalisation Fund: No ***Total Cost = 161,340***		

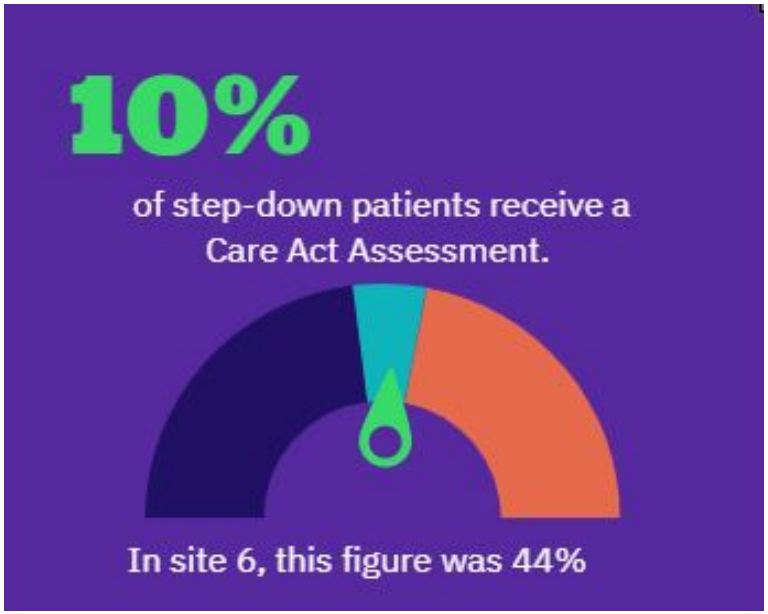
DHSC Out-of-Hospital Care Models Programme – £16m 17 test sites across England

Out-of-Hospital Care Models Programme – Leeds Discharge to Assess Case Study (Extract)

Assessments Completed	Care and Support Plan (HIB Team Acts as Case Manager coordinating a single care/support plan)	Review (HIB Team undertakes continuous monitoring and review of care and support plan).
Nursing Assessment		**Outcomes Achieved**
Systemic Lupus Erythematosus (SLE) - R had significant skin lesions caused by her Lupus but exacerbated by her drug use. She was experiencing joint pain and inflammation and was not engaging in any health service to manage her Lupus.	*Goal: To improve management of long-term health conditions (physical health)* *Plan:* Referral to Rheumatology. Support staff facilitate engagement with GP and accompany to appointments.	R's skin is clear Fully immunised against Covid.
Mental Health Assessment		**Outcomes Achieved**
Coexisting mental health and substance use (Paranoid Schizophrenia, Dissocial personality disorder, Heroin, Crack, Amphetamines, Pregabalin, Spice, Diazepam).	*Goal: To improve management of long-term health conditions (mental health/addictions)* *Plan:* HIB staff coordinated, accompanied and advocated for R to engage with mental health services. A mental health assessment was carried out and R was stabilised on a depot injection. HIB staff referred and accompanied R to drug and alcohol service	R's mental health and presentation have been far more stable since being at the HIB. R has stabilized on OST scrip, drug testing has shown she is testing negative for Heroin, crack, amphetamines and diazepam.
Care Act Assessment, 2014 ***NB: An initial assessment of care and support needs is undertaken by the specialist HIB Team social worker. Assessment under Care Act takes place toward end of stay in HIB bed if still required following period of reablement.***	**Settle-in/Reablement/Resettlement Plan**	**Outcomes Achieved**
Unable to maintain personal hygiene Not appropriately clothed R - was unkempt and self-neglecting.	Support worker to prompt R to maintain personal hygiene/be appropriately clothed.	Good self-care, always clean and smartly dressed, wears make up, takes pleasure in her appearance.

Total Number of Assessments Completed = 2 (with plans for a Care Act, assessment).

What is the “assessment” in Discharge to Assess?



- Aim of D2A is to build an accurate picture of likely need and options following a period of recovery after discharge
- Seeing a post code lottery around access to Care Act assessment
- Care Act is being interpreted narrowly as being about care not care and support
- People waiting 4 months in some areas, coupled with housing shortages means services are silting-up

9 Test Sites returning some monitoring data for Q1/2 [Number of Patients In-reach n= 622 Pathway 1 n= 121 Pathway 2 n=45]

Length of stay

50%

of service users on Pathway 1 stay longer than 6 weeks

40%

of service users on Pathway 2 stay longer than 6 weeks

KCL LSE Expert Focus

9 Test Sites returning some monitoring data for Q1/2 [Number of Patients In-reach n= 622 Pathway 1 n= 121 Pathway 2 n=45]

86% of service users on Pathway 1 did NOT return to rough sleeping

80% of service users on Pathway 2 did NOT return to rough sleeping

62% of those seen by a hospital based in-reach team did NOT return to sleeping rough