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Intermediate Care ‘Step Away’ Project Report

Fulfilling Lives
South East Partnership

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COMMUNITY FUND

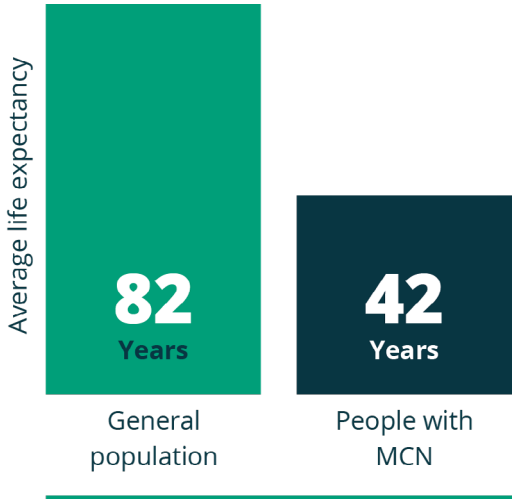
CONTENTS

INTRODUCTION

In 2021, the Department for Levelling Up, Housing and Communities together with local commissioners provided funding to the Homeless Health Inclusion Team at the Sussex Community NHS Foundation Trust to set up an Intermediate Care Step Away project together with partners.

Led by this team, it required a multi-agency approach between medical experts, nursing and other allied health professionals to provide support for homeless and insecurely housed patients in the community after being discharged from hospital. The project included physical, psychological and emotional support by also linking patients into other healthcare pathways for up to 12 weeks in the community post hospital discharge.

Research by Pathway (2020) as well as the King's Fund (2020) indicate that individuals experiencing homelessness have physical functional decline, more commonly associated with a much older age group. These physical functions included mobility issues with associated increase in falls risk, visual impairment, and other indicators such as low grip strength. In addition to physical changes, cognitive impairment was also found to be prevalent in these studies.



Locally, Fulfilling Lives South East's (FLSE) client data shows that 88% of clients in Brighton & Hove have a physical health problem or disability. 23% of FLSE's total caseload have a combination of long-term chronic conditions which contribute to an increase in their frailty scores. The prevalence of frailty in the general population aged 50+ was estimated to be at 8.1%.

The British Medical Journal has come to the conclusion that 'frailty measures have predictive validity in younger populations'. This piqued our interest in frailty scores. The FLSE Impact Report highlights that the average life expectancy for people with multiple and complex needs (MCN) is 51% less than the general population.

THE PARTNERSHIP

Being based in Brighton, Hastings and Eastbourne, FLSE was one of 12 organisations funded by the National Lottery Community Fund to work together to improve the lives of people experiencing MCN.

The programme-wide aims for FLSE are:

1. Providing intensive support for people experiencing multiple disadvantage

2. Involving people with lived experience of multiple disadvantage at all levels

3. Challenging and changing systems that negatively affect people facing multiple disadvantage

The Brighton Homeless Health Inclusion Team's mission is to increase health and wellbeing for the homeless and insecurely housed population by offering an inclusive service. The team comprises of nurses, prescribers, occupational therapists, physiotherapists and assistants. Sussex Community NHS Foundation Trust prides itself on providing excellent care in the heart of the community.

By the time funding was provided for the Intermediate Care Step Away project, FLSE and the Homeless Health Inclusion Team had already established connections and were keen to work together to tackle health inequalities locally. FLSE was keen to use this opportunity to facilitate discussions on health trends as well as providing a space for multi-agency reflections on the healthcare system.

As the eight-year FLSE programme comes to an end in June 2022, both the FLSE and the Homeless Health Inclusion Team are keen to share a summary of our collaboration and learning to support future developments in the local healthcare system.

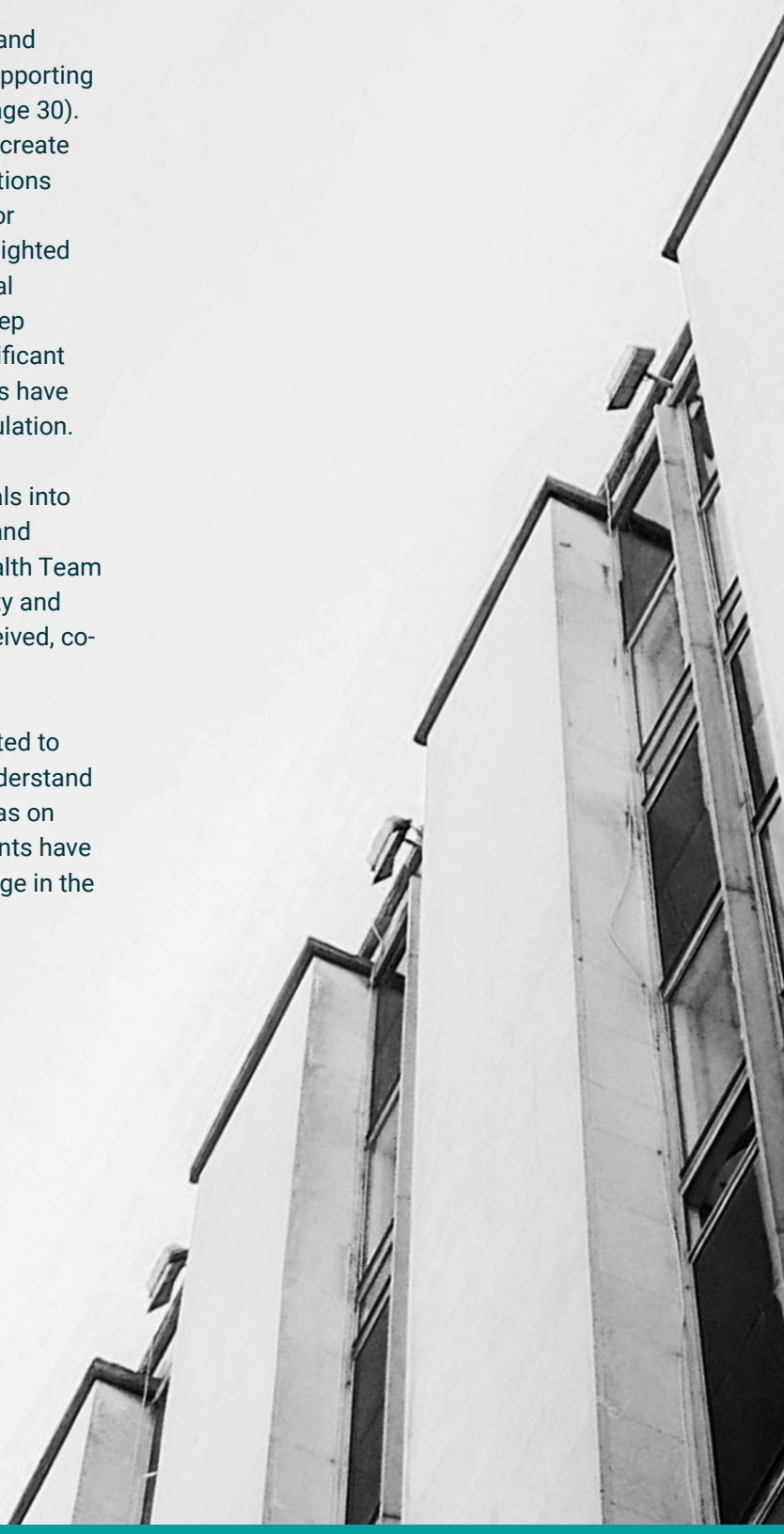
OUR APPROACH

In FLSE's Ripple Effect: The Systems Change Principles and Methods of FLSE Project, the Intermediate Care Step Away project has been spotlighted as a key example of tangible systems change.

We have used a method that we call 'Finding, Naming and Supporting Bright Spots' to provide a framework for supporting positive systems changes during this collaboration (page 30). This method included establishing a steering group to create a safe space for professionals to share ideas, observations and learning on how to improve healthcare provision for patients experiencing MCN. These conversations highlighted the importance of introducing frailty scores as a clinical assessment tool. This was then implemented in the Step Away service and results indicate how frailty is of significant relevance to people experiencing MCN – many patients have high scores usually associated with a much older population.

We decided to focus our data collection on new referrals into the Homeless Inclusion Health Team. FLSE collected and analysed data provided by the Homeless Inclusion Health Team on a monthly basis. This data capture included: equality and diversity data (including age), support offered and received, co-morbidities as well as housing situations.

Our approach to collecting data was two-fold. We wanted to collect quantitative data, such as demographics, to understand the type of patients better. However, our main focus was on evidencing that homeless and insecurely housed patients have a higher frailty score than the general population average in the same age category.



OUR ANALYSIS & KEY STATISTICS

The following data summarises key learning during the period between May 2021 and January 2022:

HEADLINE FACTS

- 33 referrals received
- 93 treatment sessions offered of which 83 sessions have been completed
- Average contact hours per patient was more than 1 hour per day
- 12 admissions to A&E

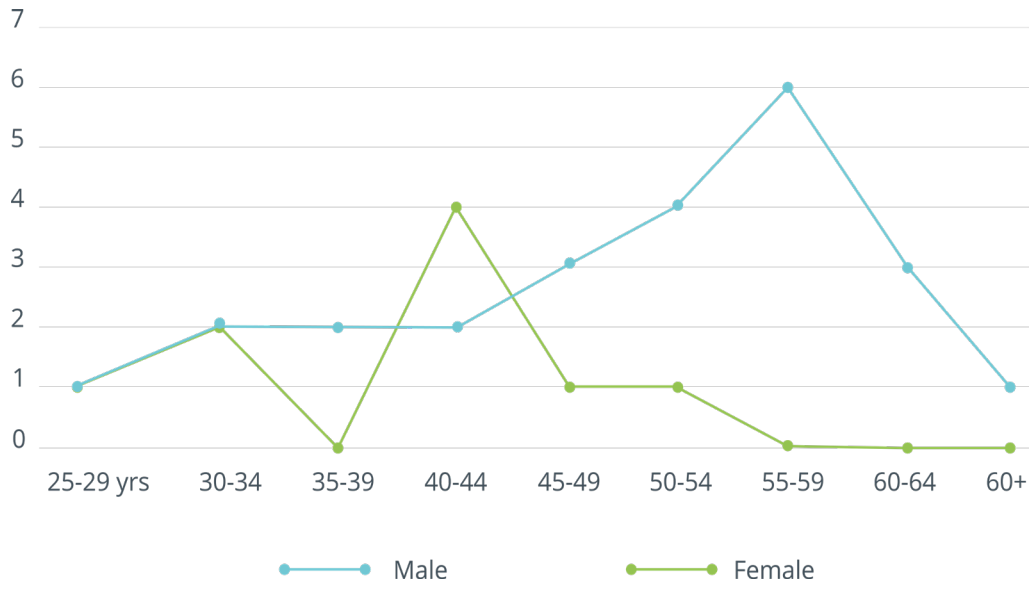
In addition to homelessness and physical health conditions:

- 18 patients had alcohol and drug dependency
- 17 patients had mental health needs
- 14 had 'other' additional support needs

FL Housing situation (in order of prevalence):

- Hostel - 13 people
- Temporary accommodation - 2 people
- Sleeping rough - 1 person (for 27 days)
- Emergency accommodation - 1 person
- Hotel - 1 person

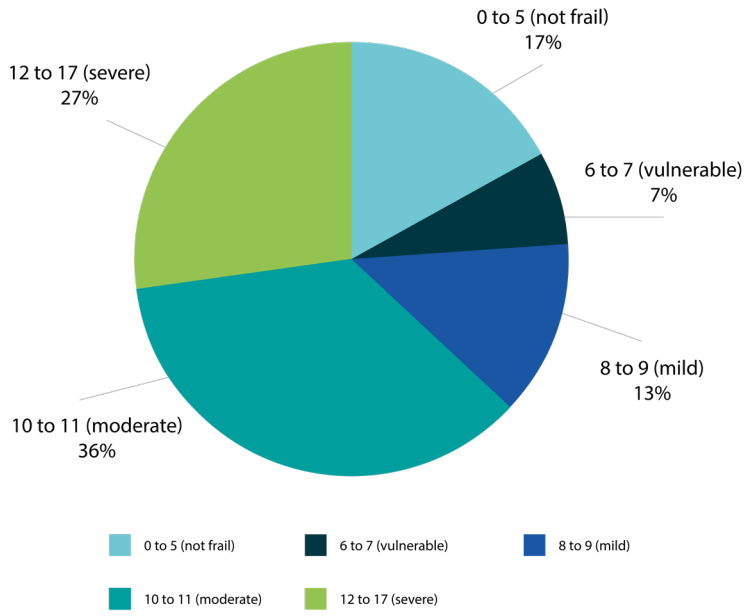
NUMBER OF PATIENTS BY AGE AND GENDER



In addition to this data, the Homeless Inclusion Health Team used the Edmonton Frail Scale as an assessment tool. The scale identifies deterioration or stabilisation of patients over time in a holistic way because it covers topics such as cognition, general health status, functional independence, social support, medical use, nutrition, mood, continence and functional performance.

With training, this tool can be used by anyone, not just healthcare professionals. It can help open referral pathways into social care and is a tool to help inform robust support and care packages.

The Intermediate Care Step Away team discovered that the majority of their patients fell into the moderate and severe frailty score.



OUR LEARNING

The Homeless Inclusion Health Team and wider Steering Group members recognised quickly that younger patients experiencing homelessness have a higher frailty score compared to the average in their age group. It also became clear that this assessment tool could become key in supporting people experiencing MCN.

THE INTERMEDIATE CARE STEP AWAY PROJECT HAS SHOWN THAT FRAILTY SCORE CAN:

- Act as an assessment tool: The frailty score is a key tool to recognise deterioration or stabilisation in patients and can act as a 'red flag'.
- Open up referral pathways: The frailty score assessment is a holistic tool that can bring together Adult Social Care, Housing and third sector organisations to collaborate more closely and in a person-centred way.
- Create robust care and support packages: Focussing on the frailty score creates the same language across services and anyone trained can use the frailty score to fast-track support. The closer support services work together and share information, the easier it is to recognise frailty risks, such as poli-pharmacy (especially for patients with a history of long-term addiction).

These findings have been shared at the national Pathways from Homelessness conference in March 2022. The full programme can be found here and the presentation has been uploaded to the conference's google drive for everyone to download.

FLSE also wrote and published a blog about this collaboration.

Caterina Speight, Clinical Services Manager and Nurse Lead for the Homeless and Inclusion Health Team fed into our report called: How can we avoid treatable or preventable deaths of people facing multiple disadvantage? and highlighted the Edmonton Frail Scale as a tool to help professionals in and outside the healthcare system to recognise patterns of deterioration.

RECOMMENDATIONS

Since the start of the Step Away Project, it was clear that people experiencing MCN have difficulties in accessing primary healthcare services and that due to the nature of complexity, it is not always easy for healthcare services to link in with other organisations.

The frailty scores are a tried and tested method in geriatrics which could be extended to MCN and hence provide better support.

That is why we hope the following steps will be integrated into support systems for people experiencing MCN as a way to address health inequalities:

1. Frailty scores need to be integrated into further assessment processes in the support system, particularly in housing options assessment tools to help allocate care and support.

2. Investment in a one-stop-shop clinic to respond to the moderate and severe frailty scores for patients with MCN – this will improve accessibility to services and lead to better diagnosis and clinical investigations.

3. Long-term substance use to be seen as a chronic health condition – this impacts on frailty of patients. We support the recent Dame Carol Black review where she called on the government and society to recognise addiction as a chronic health condition.

FURTHER READING

Intermediate Care Step Away Model- a holistic community support approach with testing of frailty score-based interventions

How to avoid preventable and treatable deaths of people facing multiple disadvantage?

'Bright Spots'- What enables people with multiple and complex needs to access primary healthcare?

Ripple Effect: The Systems Change Impacts of Fulfilling Lives South East Project

Edmonton Frail Scale

APPENDIX: CLIENT JOURNEY THROUGH THE STEP AWAY SERVICE

The diagram below identifies how patients access the Step Away service, who identifies the patient's needs in the community, which in turn will lead to improved health and wellbeing for the homeless patient.

REFERRAL

- Referral criteria
- People who are or are at risk of rough sleeping
- Frequent users of urgent & emergency care
- Those readmitted
- Patients with a history of rough sleeping who need safe and timely continuity of care from hospital/ reablement

ASSESSMENT/TRIAGE
WEEKLY

- Frailty score
- Needs assessment
- Identify pathways
- Triage meeting (weekly) to get into Step Away
- Safeguarding
- Refer to Adult Social Care for carer assessment

RISK PLANNING
1-2 DAYS

- Identify agencies and staff members who need to be included in the patient's care
- Care planning
- Harm minimisation
- Stabilisation work
- Safeguarding
- Initial therapy assessment
- Person-centred goal planning

IMPLEMENTING
12 WEEKS

- Coordinate and deliver the patient's support and staff members that is needed including reablement approach
- Time limited interventions

ONGOING REVIEW AND EVALUATION
WEEKLY

- Mid and end point review and evaluation
- Signposting and referring to other services such as GP; social prescribers
- MDT review