Suggested Quality Framework for Homeless Hospital Discharge Teams

(developed by homeless hospital discharge nurses through Burdett funded 'Strengthening Leadership' programme 2018-2019)

Key Performances Indicators

It is important to note that these are suggestions, and would need to be adapted and moulded to any pre-existing local contexts, but are meant to be suggestions for key performance indicators that deliver better care for patients, rather than cost reduction per se.

1. To increase the number of people currently experiencing homelessness that are identified as homeless during their hospital stay **– to enable equitable access to care**

2. To increase the number of currently homeless people referred to and seen by the homeless team **– to enable equitable access to care**

3. To deliver timely, holistic assessment, treatment and discharge plans to people experiencing homelessness that improves health and housing outcomes **– to deliver best quality care and improve health outcomes**

4. To provide a homeless hospital discharge experience that patients value highly **– to deliver value-based healthcare**

5. To reduce delayed discharges / delayed transfers of care **– to improve hospital efficiency**

6. To reduce the number of people that rough sleep on leaving hospital **– to reduce reattendances and improve health**

7. To increase the number of people engaged with a GP on discharge **– to reduce reattendances and improve health**

8. To increase the number of people with accurate follow-up details recorded in hospital **– to reduce reattendances and improve health**

Key objectives	Team Activities	Measurement / monitoring method
1. To increase the number of people currently experiencing homelessness that are identified as homeless during their hospital stay **– to enable equitable access to care** 2. To increase the number of currently homeless people referred to and seen by the homeless team **– to enable equitable access to care**	Education of hospital staff Ongoing work with hospital services and systems to improve identification of homelessness at admission Tracking of background homelessness trends in the community to understand what might be expected Development of an open, responsive referral system Open dialogue with referrers	Recording the of number of referrals Recording of the time of admission and referral time and establishment of median[1] time to referral (should go down over time as hospital staff became aware of team and importance of referral) Recording of the number of rejected referrals (should go down over time as referrals would be increasingly appropriate) Review of feedback on the nurse / team from partner services in hospital - to be sought and collected at least once a year Regular review of referral system
3. To deliver timely, holistic assessment, treatment and discharge plans to people experiencing homelessness that improves health and housing outcomes **– to deliver best quality care and improve health outcomes** N.B. For suggestions for what should be included in assessment and treatment plans based on	Referrals are seen within a target timeline (? 2 days) Patients receive a holistic assessment (see guidance below), treatment and discharge plan that aims to improve health and housing outcomes Nurse / team works with partner services and agencies to deliver planned activities successfully	Recording of time of referral and time of assessment and establishment of mean time from referral to assessment (should be within target time – nurse / teams not achieving this could be seen to be in need of review or extra capacity) Care Plan audit: practice review of random selection of patients' notes to assess whether best practice was delivered – to be undertaken once annually Service user feedback to be obtained

observations of practice see box below.	Nurse / team runs effective MDT meetings or similar to facilitate this process	Regular review of MDT / case conference minutes or similar to review effectiveness Complaints monitoring and review Incident monitoring and review
4. To provide a homeless hospital discharge experience that patients value highly **– to deliver value-based healthcare**	Nurse / team communicates in a way that improves the patient experience Nurse / team provides a clinical service that improves the patient outcomes and experience Nurse / team provides subsistence support that improves the patient experience (optional)	Service user feedback questionnaires to be obtained Complaints monitoring and review Incident monitoring and review
5. To reduce delayed discharges / delayed transfers of care **– to improve hospital efficiency**	Nurse / team works with hospital managers to prioritise patients who are delayed, and prioritises work to expedite discharge where this is relevant Nurse / team works with partner services and agencies to deliver planned activities successfully	Delayed Discharge audit: practice review audit of notes of patients who had a considerably delayed discharge to assess whether best practice was delivered – to be undertaken once annually Review of feedback on the nurse / team from partner services in hospital - to be sought and collected at least once a year
6. To reduce the number of people that rough sleep on leaving hospital **– to reduce reattendances and improve health**	Nurse / team works to get patients into appropriate housing on discharge wherever this is possible Nurse / team works to safeguard vulnerable adults that have no housing options and need safeguarding	Record of number of referrals discharged to the street Discharged to Rough Sleeping audit: Practice review of notes of patients who returned to the street after their hospital admission

		Record of no of accepted referrals that self-discharge (hopefully this would always be low, but it would prompt a review of the reasons if self-discharge increased)
7. To increase the number of people engaged with a GP on discharge [2] **– to reduce reattendances and improve health** 8. To increase the number of people with accurate follow-up details recorded in hospital [2] **– to reduce reattendances and improve health**	Nurse / team checks GP registration during assessment Nurse / team undertakes activity focused on achieving GP registration Nurse / team undertakes check of follow-up details on discharge	No of people accepted as service patients who have no GP on their hospital records is recorded. No of patients assisted to register with a GP is recorded No of people accepted as service patients who have the wrong contact details on their hospital and service notes is recorded. No of people with the wrong contact details who have had action taken to rectify this is recorded Service user feedback questionnaires to be obtained

Notes:

1. Median time is used here, because it is noted that there will always be a patient that is referred after e.g. 6 months of being in intensive care, so this data point is effectively removing extreme outliers.

2. As well as ensuring a patient is registered with a GP, and that contact details are correct this will also over time ensure that future discharge notes go to the correct GP, and that future attendances and admissions are charged to the correct CCG. This may be cost saving for some hospitals – patients who have NFA and no GP recorded on their records are automatically charged to the CCG in which the hospital is in.

Assessment and treatment plans should cover:	
ESSENTIAL • Physical health (not just the condition admitted for) • Mental health • Addictions and Smoking • Cognition / mental capacity • Language / literacy challenges • Understanding of current medications • Safeguarding concerns / safety • Current housing status and needs • Support in the community • Rights to healthcare – GP registration / HC2 • Benefits / debts / financial concerns – including need for sick note	**DESIRABLE** • Nutritional status • Dental • Eye care • Missed screening / vaccinations

RECOMMENDED PRACTICE INTERVENTIONS:

Referral into service

- Pro-active identification of cases within hospital system (may require comprehensive teaching programme in hospital and/or proactive identification processes to be put in place)
- Homeless link nurses are identified on wards to support specialist nurse / team
- Homeless link nurses / other staff know what to do out-of-hours
- Team has readily available leaflets about community services, which are also readily available to all staff
- Every contact with staff is seen as a teaching opportunity
- Team takes a system change approach that fits into a hospital strategy

Clinical Intervention

- Plenty of time available for comprehensive assessment
- Assessments and plans equally consider both health and housing outcomes
- Harm reduction work takes place routinely
- Opportunistic public health interventions take place as routine practice, even if this is just reminders e.g. about vaccinations / screening
- Team is able to fulfil subsistence needs as required
- Discharge checklist is used to check safe discharge for all patients
- Clients are followed up routinely in the community to check health and housing outcomes

Working within a multi-agency setting

- Nursing role sits within a multidisciplinary team
- Team is integrated or clearly networked with specialist community health services
- Regular case reviews or multidisciplinary meetings take place
- Hospital discharge protocol is in place with Local Authority
- Integrated clinical records with community services are in place

Peer Involvement

- Team has peer involvement e.g. through care navigators
- Service user feedback is gained routinely

Follow Up Care

- Step-down 'medical respite' care is available, or being worked towards
- Patients are followed up after discharge

Learning and improving practice

- Reflective practice takes place regularly