District Direct Pilot (Evaluation 11th September – 15th December)

1.0 Background

In May 2017 the District Councils agreed to work directly with the integrated hospital discharge hub to investigate reducing delayed transfer of care. An initial meeting was arranged between all Districts and the Norfolk & Norwich University Hospitals (NNUH) staff, this usefully clarified a few misconceptions between the two organisations, for example, Districts preference for referral at point of admission rather than once the patient is deemed medically fit for discharge and statutory and non-statutory services delivered by District Councils that can support patient discharge. The meeting also highlighted significant inconsistencies in adherence to the hospital discharge policy.

We identified and actioned the following; -

- Reviewed the current hospital discharge policy
- Identified and implemented a set of initial triage questions that could help identify potential DTOC/bed blocking patients where Districts could intervene at point of admission
- Reviewed hospital discharge data to identify pinch points
- Established a referral pathway to Districts from the East of England Ambulance Trust for patients who are not transported to NNUH but at risk of admission
- Collectively resourced a district officer presence within the integrated hospital discharge hub for 12 weeks as a pilot

2.0 Pilot delivery

District Direct was initially resourced by five Districts (South Norfolk, North Norfolk, Breckland, Broadland and Norwich) for the duration of a 12-week pilot. This was via 5 officers being seconded one day per week to be located within the NNUH integrated discharge team.

Officers came from a range of backgrounds including those who were experienced in dealing with homelessness, housing adaptations and benefits. It was a conscious decision that the District Direct team would be resourced from different teams to enable us to assess the range of skills required. The analysis identifies the skills required going forward as well as a good knowledge base of District services.

All officers are collocated within the integrated hospital hub and have access to hospital systems.

The hospital discharge coordinators identify patients at point of admission who would have the potential to become a DTOC or bed block via a set of triage questions;

a) Where do you live when you're not in hospital?
b) Do you own your home, or who do you pay your rent to?

c) Do you find it difficult getting into and around your home, in/out of the bath, or up and down the stairs?
d) Do you find it hard to carry out small repairs and odd jobs around the home and garden?
e) Do you have contact with one or more people on a frequent basis?

If the Discharge Coordinators identify an issue, with the permission of the patient, they are then referred to the District Direct officer. DD Officers will visit the patient on the ward, provide assessments, liaise with the patient's home district and put an action plan in place with the patient and the patient's family to support the patient to return home to live independently.

Being co-located within the integrated discharge hub and DD officers attending frequent discharge meetings has meant that the DISCOs and wider discharge team have support at hand to deal with non-medical issues preventing patients from returning home. The officers involved in the project report that the type of referrals coming through have been diverse and have produced a positive outcome for residents, reflected in the performance data.

As well as dealing with specific cases the officers have reported that both within the integrated discharge hub and on the wards across the hospital they have provided general help and advice with cases on an ad hoc basis. This has moved the medical staff to consider the patient's wider needs particularly around housing.

The success of the pilot was very quickly recognised and after sharing initial findings at the NNUH A&E Delivery Board it was agreed that NNUH would fund the extension of the pilot until March 2018 to maintain momentum of the service until more sustainable funding could be secured. Savings from the pilot are shared between the NNUH, Adult Social Care and the CCG.

3.0 Pilot outcomes

<u>Bed days*</u>

Saved 203 bed days over 11 weeks (5-day week) pilot leading to a saving of £40,600

Over the course of a year (7-day week) this could lead to a saving of £262,800

<u>Length of Stay (LoS)*</u>

Halved average LoS in Geriatric medicine beds

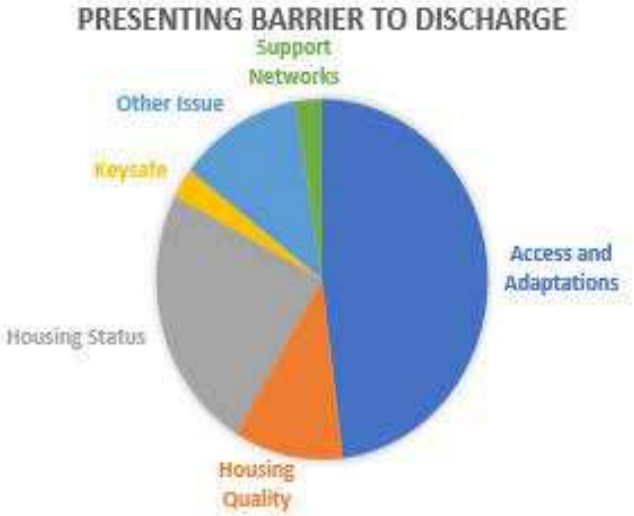
Overall reduced length of stay by 36%

On patients seen between 11th September – 9th November, updated data to be shared at Health Overview & Scrutiny Committee

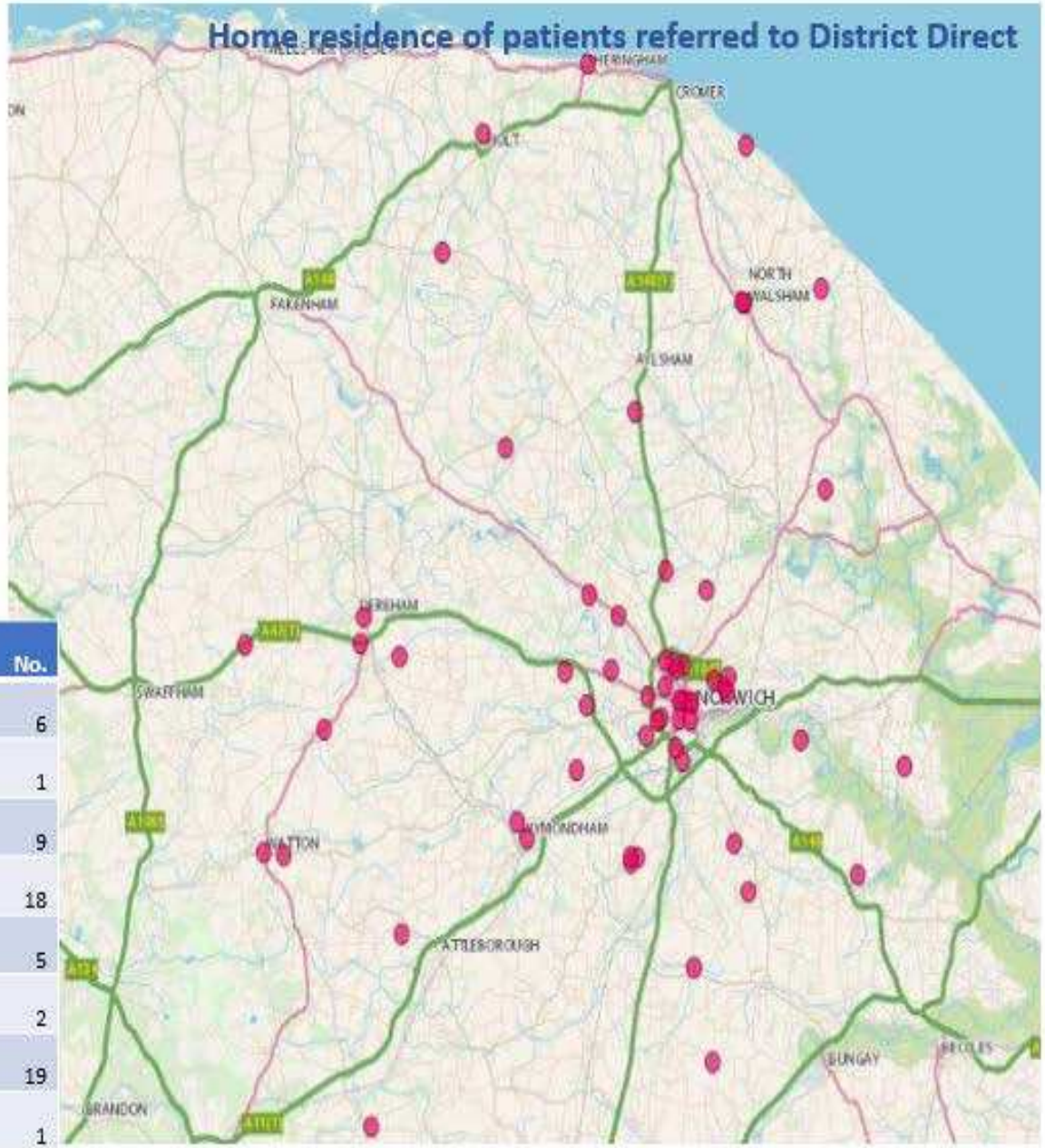
Pilot review

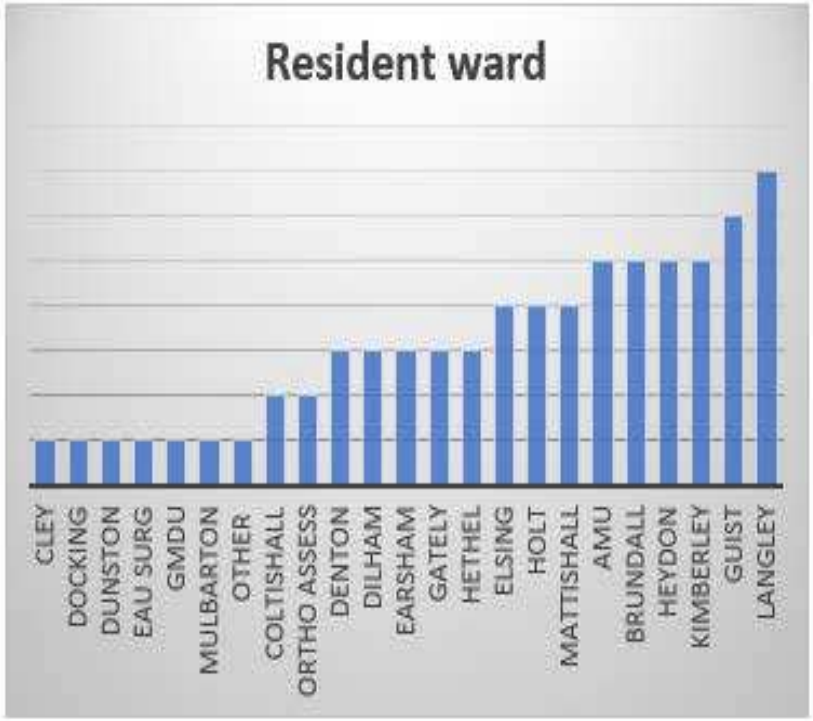
To date the pilot has supported 80 patients, undertaken 132 interventions and provided wider information and advice. Patients have ranged from 31 to 96, with an average age of 71 years.

All but 1 of the patients were emergency admissions.

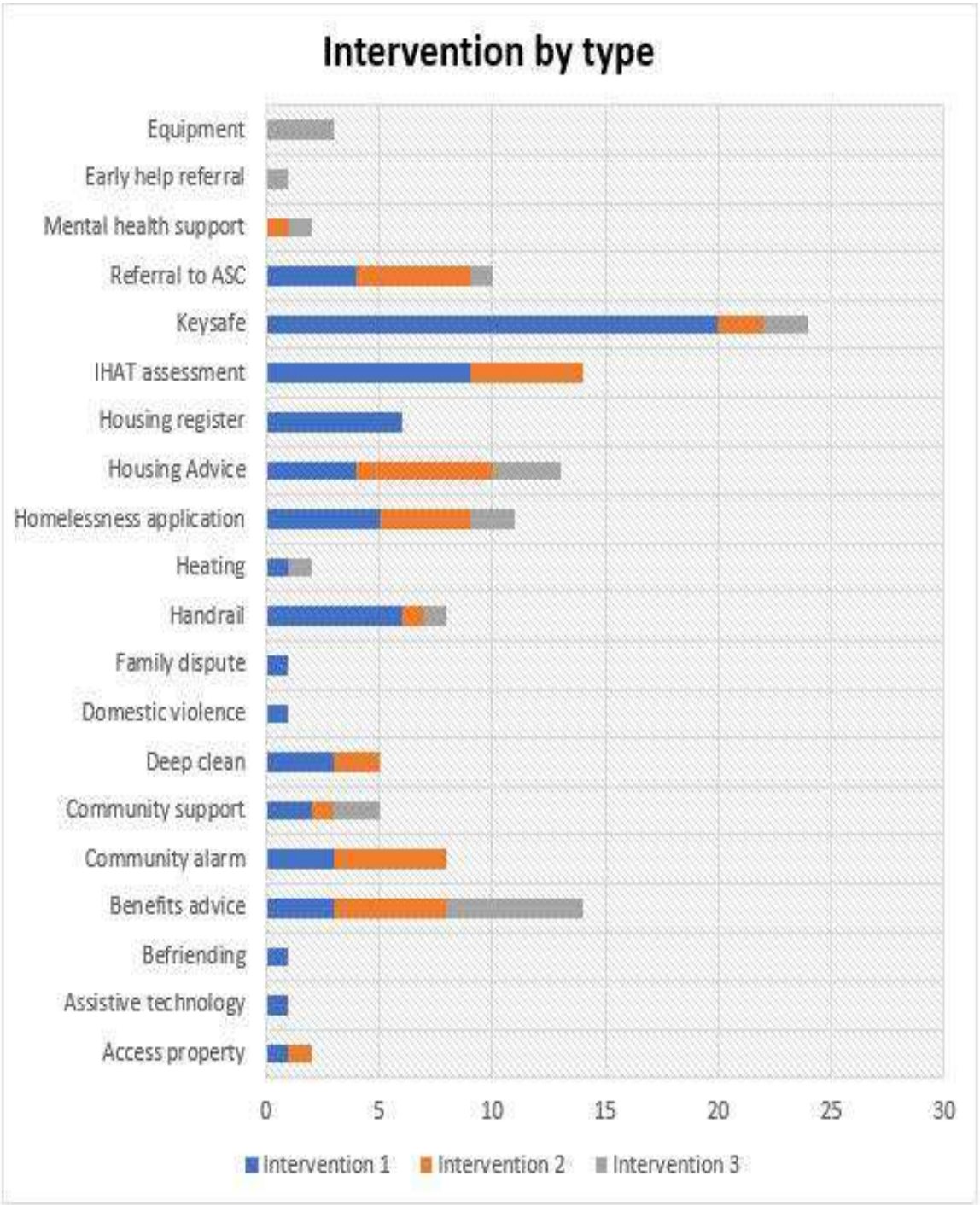


District	No.
Broadland	6
West Norfolk	1
North Norfolk	9
Norwich	18
Norwich City	5
Out of Area	2
South Norfolk	19
Unknown	1




Resident ward
CLEY
DOCKING
DUNSTON
EAU SURG
GMDU
MULBARTON
OTHER
COLTISHALL
ORTHO ASSESS
DENTON
DILHAM
EARSHAM
GATELY
HETHEL
ELSING
HOLT
MATTISHALL
AMU
BRUNDALL
HEYDON
KIMBERLEY
GUIST
LANGLEY


Resident Tenure
NFA
Other
Owner Occupier
Private Rented
Social Housing
Temporary
Unknown


Intervention by type
Equipment
Early help referral
Mental health support
Referral to ASC
Keysafe
IHAT assessment
Housing register
Housing Advice
Homelessness application
Heating
Handrail
Family dispute
Domestic violence
Deep clean
Community support
Community alarm
Benefits advice
Befriending
Assistive technology
Access property
0
5
10
15
20
25
30
Intervention 1
Intervention 2
Intervention 3

4.0 Case Studies

Case Study 1

Referral received for a very vulnerable man with some MH issues. He was admitted to hospital following a very dangerous self-harming incident. He reported to staff that he has been staying in a tent. The patient was referred to District Direct, further investigations identified he had his own home (NCC tenant) but was worried about going back there because he thought he was going to be evicted. He was under-occupying his home, accruing rent arrears and had just lost his job. The District Direct Officer was able to notify the right people (housing officer) and reassure him that going back to his home, not his tent, was the best thing for him and that he wasn't being evicted. He was linked with specialist support services to deal with benefit claims, budgeting and moving to smaller more affordable home, and a home visit was arranged the day after he was discharged.

Case Study 2

Appeared no issues to prevent patient from returning home from hospital, however was flagged to District Direct as her Son was struggling to pay bills and maintain the house during her inpatient stay. The DD officer contacted the son, arranged for the district welfare rights and debt adviser and other support services to visit, contacted the energy companies to prevent services being cut off and made sure all benefits were in order. The DD Officer worked with the Integrated Care Coordinators who had concerns around the living arrangements and made sure an appropriate care package was in place for the patient's return home.

Case study 3

A patient required assistive technology and a key safe in order to have a safe discharge. The DD Officer contacted the relevant company to install an alarm and identified funding that would reduce the cost for the patient. The District where the patient lived did not have a handyperson service so the DD officer arranged for another District to provide this service and recharge.

5.0 Future for the pilot

To date the pilot is resourced by officers from each district through existing resource, a more efficient and sustainable option would be to recruit 2 District Direct officers to cover the role on behalf of the districts covering 7 days at a cost of £71,194 per annum. This role would sit with the districts and be governed by the IHAT Strategic Board.

Focus on the pilot to date has been targeting wards, it is felt the number of homelessness cases are fairly represented, which is more likely in A&E (and not being admitted). We will look to target A&E also which should pick up considerably more referrals from this target group.

Keen to roll out the pilot to other acute trusts, community hospitals, mental health inpatients and prison release.

NHS England have chosen to use the District Direct pilot as a case study of best practice and will be sharing details of the pilot nationally.

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