REALIST EVALUATION

Evaluation of The Homeless Hospital Discharge Fund
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Aims of Presentation

To present a case study about how to apply realist evaluation in a complex policy area (homelessness) that requires integrated responses from health, housing and social care:

- Provide some background to the programme being evaluated (the 'Homeless Hospital Discharge Fund')
- Explain what realist evaluation is
- Show how we arrived at a tentative programme theory about 'what works'
- Explain how we tested this theory
- Explore how we made sense of the data and reported the findings.

Context – Impact of Austerity

- Since 2010, the number of people who are homeless in England has increased by 160%.
- Homelessness is not just housing issue, but it is characterised by tri-morbidity (the overlap between mental health, drug and alcohol and physical health issues).
  - Access A&E five to seven times more often that the general population
  - Average length of stay in hospital three time the national average.
  - Annual costs of unscheduled care for homeless patient is eight times that of the housed population.
- Average of age of death of someone sleeping rough is 44 years (42 for women)
- Current situation described as a ‘public health disaster’ by the British Medical Association

Homeless Hospital Discharge Fund (HHDF)

- In 2012,it was reported that 70% of homeless patients were being discharged back to the street without having their health and social care needs assessed
- In response, the Department of Health released a ***"£10 million cash boost"*** to improve hospital discharge arrangements
- 52 specialist homeless hospital discharge (HHD) schemes funded across England.
- Kings College & partners commissioned in 2015 to undertake a realist evaluation of the HHDF

What is Realist Evaluation?

'Realist evaluation is a theory-driven approach, based on a realist philosophy of science, that addresses the question 'what works, for whom, under what circumstances and how' (Pawson and Tilley, 1997)

No silver bullets

Nothing works everywhere all of the time

Context + Mechanism = Outcome

Basic or Refined Realist Formula?

(Basic) Context + Mechanism =Outcome

Mechanisms are not the programme service, but the response it triggers from stakeholders

Dalkin *et al. Implementation Science* (2015) 10:49
DOI 10.1186/s13012-015-0237-x

IMPLEMENTATION SCIENCE

DEBATE Open Access

What's in a mechanism? Development of a key concept in realist evaluation

Sonia Michelle Dalkin[1*], Joanne Greenhalgh[1], Diana Jones[2], Bill Cunningham[3] and Monique Lhussier[2]

Mechanism (Intervention-Resources) +

Context > Mechanism (Change in Reasoning)

= Outcome

(Refined) MIR+C>MCIR =O

Why did we select realist evaluation?

‘There is no one model [silver bullet] that will deliver consistently safe timely transfers of care for all patients. What is required is a **complex adaptive system** with **simple rules** rather than rigid inflexible criteria’ (D2A Quick Guide)

- **What are the key components of this complex adaptive system?**
- **Road map of things to consider**

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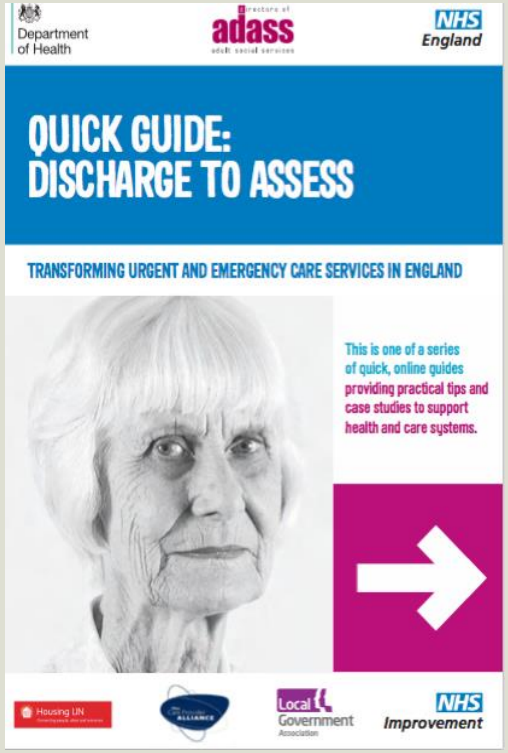


Step 1: Developing Programme Theory

According to RAMESES II Guidelines:

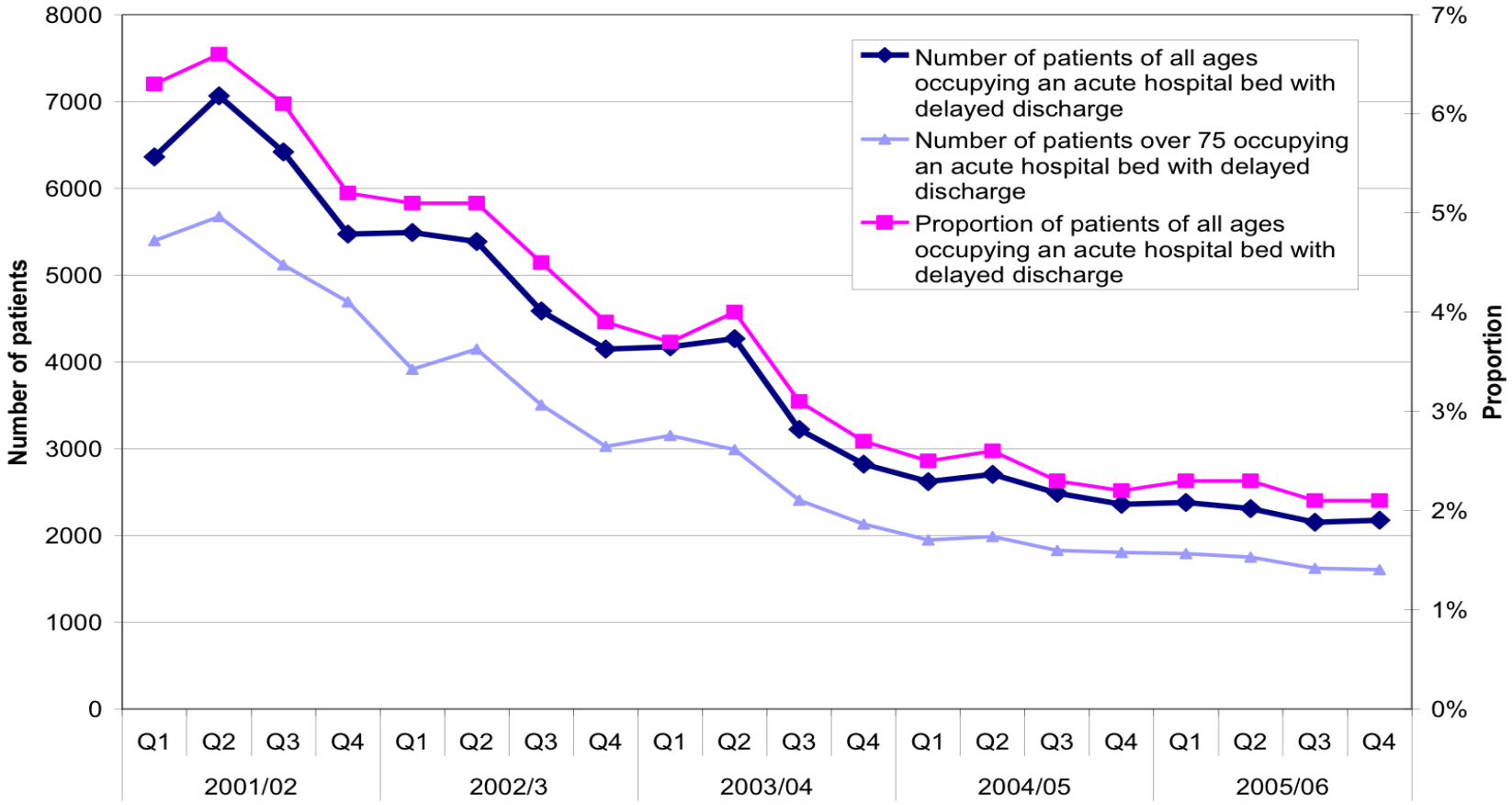
- An initial tentative programme theory should be constructed, setting out how and why an intervention is thought to ‘work’ to generate the outcomes(s)* of interest.
- This initial tentative theory (or theories) are then progressively refined (recast) over the course of the evaluation.

(Wong et al., 2017)

*__In this study main outcome of interest is securing safe, timely transfers of care for people who are homeless - Ending discharge to the street.__

What worked 'back then'?

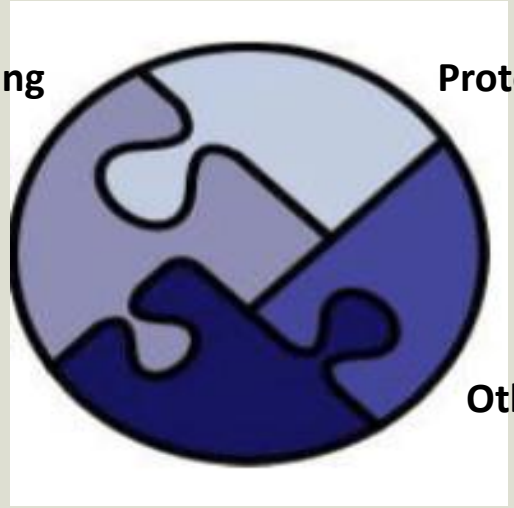
Figure 4 - Delayed Transfers of Care (Discharges) in England 2001-06



Source- Department of Health, SaFFR, LDPR.

Key Components (MIRs) of Effective out-of-hospital care systems for Older People

Multi-disciplinary Team Working & Discharge Coordination



Protocols for Managing System Flow

Other e.g. Trusted Assessment

Step-down Intermediate Care –
short term recovery support – bridge between hospital and home

Initial Tentative Programme Theory: Achieving consistently safe and timely transfers of care for patients who are homeless will depend on localities developing complex adaptive systems that are underpinned by: [MIR 1] **clear protocols** for patient flow and early discharge planning**;** [MIR3] **multi-disciplinary discharge coordination**; and [MIR4] **step-down intermediate care**.

Step 2 Realist Synthesis of the Literature

Literature highlights the need to tackle early self-discharge through clinically-led patient in-reach & advocacy

REVISED Programme Theory: Achieving consistently safe and timely transfers of care for patients who are homeless (improved outcomes) will depend on localities developing complex adaptive systems that are underpinned by: [MIR 1] **clear protocols** for patient flow and early discharge planning**;** [MIR2] Patient In-reach and advocacy [MIR3] **multi-disciplinary discharge coordination**; and [MIR4] **step-down intermediate care**

Step 3: Documentary Analysis of 52 Schemes

- This highlights that some areas/ schemes have more of the jigsaw pieces than others (lots of heterogeneity)
- To make data collection manageable we focussed on two main typologies (versus **Standard Care** - Areas with no scheme/no MIRs):

Typology 1: (no step-down)

Protocol [MIR1] + Patient In-reach [MIR2] + Multidisciplinary discharge coordination [MR3] = (support ends at exit from acute sector)

Typology 2: (with step-down)

Protocol [MIR1] + Patient In-reach [MIR2] + Multidisciplinary discharge coordination [MR3] + Step-down [MIR4] = (support continues for 6+ weeks).

If our hypothesis correct then Typology 2 should be deliver the best outcomes.

Lots of Codes/Nodes: MIR4res/MIR4ft/MIR2up/MIR2mdt

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

Step 4: Testing Programme Theory

WP1) 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.)

"What works for whom, under what circumstances and why"

(Martin Whiteford, Mike Clark, Jo Neale, Richard Byng and Nigel Hewett)

WP 2) Economic Effectiveness Evaluation

- NICE standards for cost effectiveness. EQ5D Multiple Modelling (e.g costs invested per bed day saved) (Michela Tinelli, LSE)

WP 3) Data Linkage (Hospital Episode Statistics/Civil Death Registration)

- Information held in 'safe haven' on 3,882 service users collected from 17 hospital discharge schemes (2013-2016)
- Looking at a range outcomes including '28 day emergency readmission rates' and 'time from admission to mortality from causes amenable to healthcare'

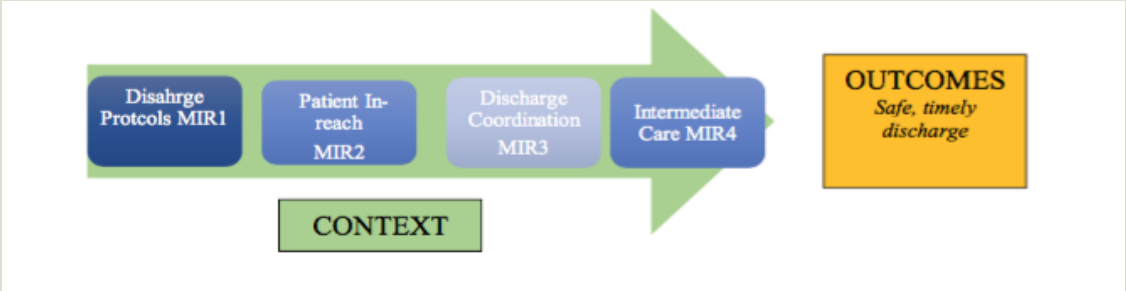
(Rob Aldridge and Andrew Hayward, UCL)

Patient and Public Involvement & Engagement (PPIE) throughout

'Nothing about us without us'

Findings

Overall, there was good evidence from across the three work packages to support our programme theory:

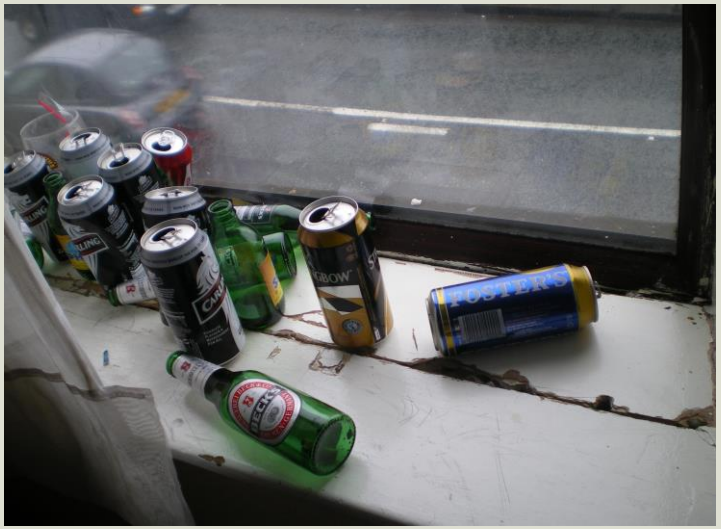


- ✓ Patient experience makes the strongest case for step-down [MIR4], particularly residential intermediate care (WP1).
- ✓ Employing a range of different economic modelling techniques discharge schemes with direct access to step-down [MIR 4] were more effective and cost-effective than schemes that had no direct access to intermediate care (WP2)
- ✓ The data linkage showed that schemes with step-down [MIR 4] were associated with a reduction in subsequent hospital use, with an 18% reduction in A&E visits compared to schemes without step-down (WP3)
- ✓ Discharge schemes increase elective readmissions
- ✓ MI4 in isolation

What troubled programme theory?

Overall outcomes for homeless patients are still very poor:

- **X** 1 in 3 deaths of those in the hospital discharge cohort are from conditions amenable to timely health care.
- **X** Hospital discharge cohort are more likely to be readmitted in an emergency, with five times the rate of unplanned hospital readmission and five times the rate of A&E visits than housed people From deprived neighbourhoods.
- **X** Discharges to the street continue across all areas – especially for those with uncontrolled addiction (hospital discharge schemes work better for some patients than others)

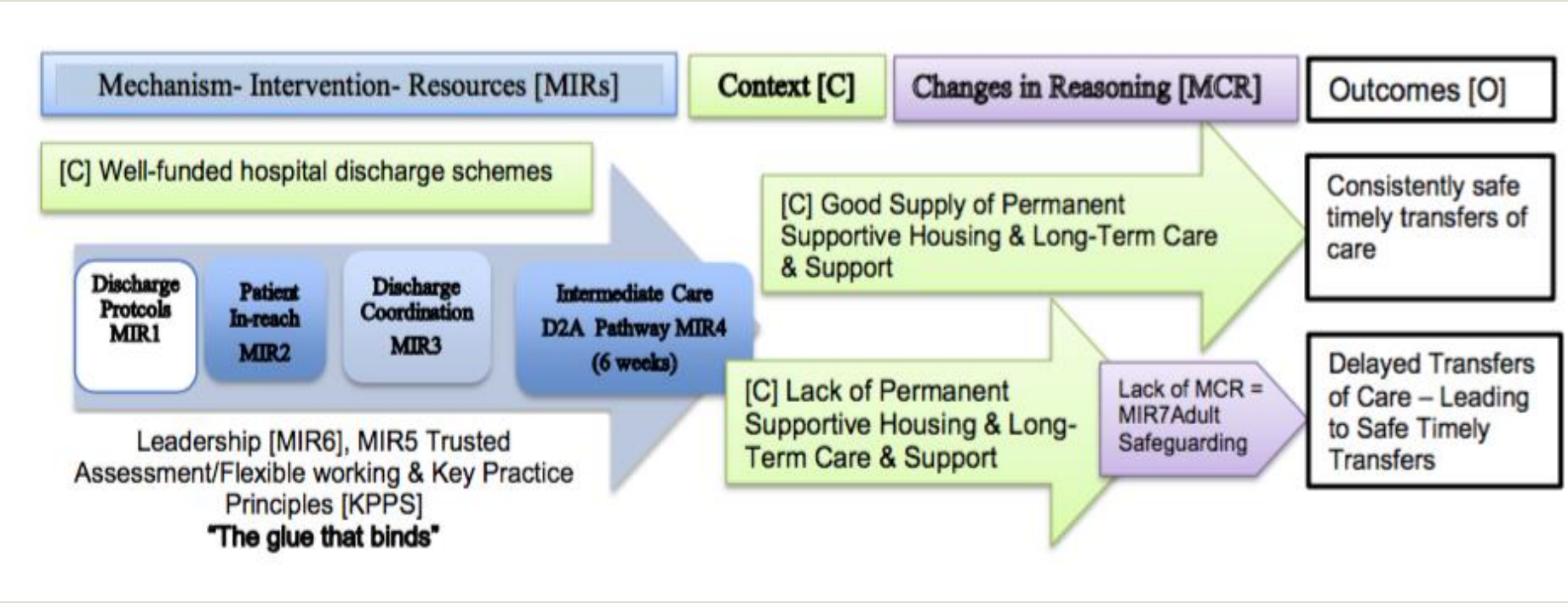


Impact of Context & Failing to Fire

Why are outcomes so poor?

- Underfunding of intermediate care – funding remains stubbornly stuck at a level below the threshold for whole system impact.
- Dimmer switch effect
- Interventions that are shown to work well in areas with well-resourced and efficient community support services have much reduced impact in areas where services are inadequate or lacking.
- No change in reasoning – patients who are homeless still treated differently (stigma and cultural distance)

Road Map



Full Support Tool/Road Map at https://kclpure.kcl.ac.uk/portal/files/119151480/HHD_SUPPORT_TOOL_Briefing_Notes_Nov_2019.pdf

Impact: 2021 DHSC Invests £16 million in out-of-hospital care to implement findings

Guide for doing realist evaluation

Quality and reporting standards, resources, training materials and information for realist evaluation: the RAMESES II project

Wong G, Westhorp G, Greenhalgh J, Manzano A, Jagosh J, Greenhalgh T. Quality and reporting standards, resources, training materials and information for realist evaluation: the RAMESES II project. *Health Serv Deliv Res* 2017;**5**(28).

TABLE 5 Quality standards for peer reviewers of realist evaluation reports

Quality standards for realist evaluation (for evaluators and peer reviewers)				
1. The evaluation purpose				
Realist evaluation is a theory-driven approach, rooted in a realist philosophy of science, which emphasises an understanding of causation and how causal mechanisms are shaped and constrained by context. This makes it particularly suitable for evaluations of certain topics and questions, for example complex interventions and programmes that involve human decisions and actions. A realist evaluation question contains some or all of the elements of 'what works, how, why, for whom, to what extent and in what circumstances, in what respect and over what duration?' and applies a realist logic to address the question(s). Above all, realist evaluation seeks to answer 'how' and 'why?' questions. Realist evaluation always seeks to explain. It assumes that programme effectiveness will always be conditional and is oriented towards improving understanding of the key contexts and mechanisms contributing to how and why programmes work				
Criterion	***Inadequate***	***Adequate***	***Good***	***Excellent***

RAMESES = Realist And Meta-narrative Evidence Syntheses: Evolving Standards

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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