Hospital 2 Home

Essential information for:

Agencies providing services to support safe hospital discharge

This leaflet contains information about how older people's housing and support can be considered as part of the hospital discharge process.

It is part of a larger resource pack containing leaflets, factsheets and checklists for different professional sectors involved in the discharge process.

Older people often need to draw on housing and community-based services, temporarily or permanently, when they are discharged from hospital. The availability of the right services, and the ability to access them in a timely way, is critical if delayed discharge is to be avoided.

There is growing evidence that the right housing-related support delivered at the right time can speed up hospital discharge and prevent further admissions, saving money and enhancing patient care. The new emphasis on integrated health and care commissioning, and integrated care and support arrangements, provides an opportunity to incorporate housing-related services into hospital discharge and ongoing care at home. Agencies providing this type of service can play their part by raising their profile, targeting their services and working with hospitals and local social care and community health commissioners to develop more integrated and streamlined patient–centred processes.

This leaflet is for:

- Agencies offering hospital discharge support services, for example *Home from Hospital* services run by Age UK and the British Red Cross.
- Agencies offering older people assistance with repairs, adaptations or other housing help to enable them to return to their homes, including Home Improvement Agencies and handyperson services.
- Agencies offering assistive technology, including telecare and telehealth services.

CASE STUDY

Hospital-linked service

Whiston Hospital has formally recognised the importance of the home environment to patients' safety and to timely discharge. In response, the Home Improvement Agency (HIA) at St Helens Council sought to strengthen its presence with the hospital and to offer its services more directly as part of the discharge process.

HIA employees helped to write the hospital's discharge policy and now take part in quarterly discharge meetings. They have committed to carrying out essential adaptations such as grab rails and access ramps within 2 working days of a request being made, so that patients can be discharged in a safe and timely manner.

Did you know?

- Hospital discharge schemes offering housing help to speed up patient release save local government social care budgets at least £120 a day[1] in addition to the cost of an overnight stay in hospital[2]. These schemes can also help prevent emergency readmissions.

- An independent evaluation of one British Red Cross hospital discharge scheme offering personalised, flexible support found that only 3% of service users were readmitted in the six months following their discharge, compared with the NHS Trust's figures for the same period which showed a 12% readmission rate within 28 days[3]. Housing adaptations can reduce the need for input from other services and reduce or remove costs for home care (savings range from £1,200 to £29,000 a year)[4].

- Older people represent the main in-patient group, at any one time occupying more than two-thirds of acute hospital in-patient beds. Many are living with one or more long-term conditions which can be exacerbated by their home situations. Some have mental health problems some of which are developed while they are in hospital[5].

Key messages for agencies providing services to support safe hospital discharge

If you are running a hospital discharge support service, make sure it includes 'housing' – whether this is an offer of advice, support and signposting or a higher level housing service such as improvements, adaptations or access to intermediate housing.

Raise your profile

- If you are already delivering a commissioned hospital discharge support service, or other similar service, make sure that patients and hospitals in your locality have your organisation and your service offer on their radar. Factsheets 1 and 2 provide lists of types of organisations that hospital-based staff are being encouraged to identify within their local area.

"We are not housing experts... It saves us so much time and (the housing options worker) knows things we don't...Social workers can talk about housing options, but once it gets complex there is a gap."

Hospital social worker[6]

- Produce simple information for patients, their families and carers, hospital staff, social workers and occupational therapists. Place it with patients, ward and discharge staff, social workers and occupational therapists in hospitals and with community-based health and social care professionals. Consider offering to provide face-to-face advice about housing and care options to patients, their families and carers on the ward.

- Share successes and make sure that hospitals and relevant community-based professionals in your area, including social workers and occupational therapists, know about them.

"I felt much more confident coming home from hospital knowing that someone was calling in for three days to see how I was doing. The lady was lovely and very helpful."

Mrs D, service user

"The girls were very professional and helpful following my fall. I was so relieved. I didn't have to go into hospital."

Mrs J, service user[7]

Target your services

- Focus on how your service can help the NHS and local authority to deliver on the outcomes that are important to them. These include outcomes in their respective Outcomes Frameworks ***(see Factsheet 4)*** and delivering efficiencies.

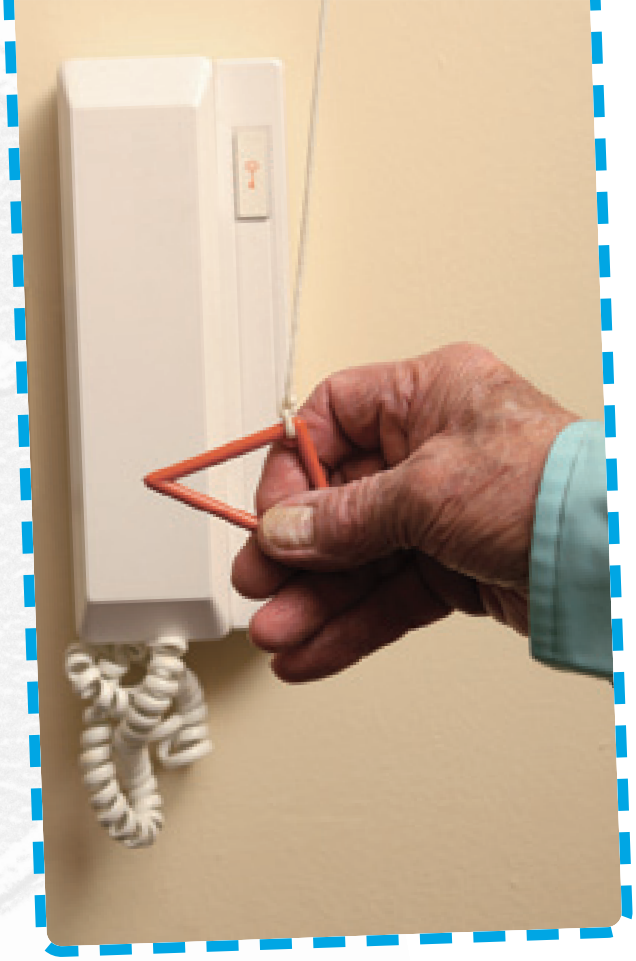
- Work in partnership with local hospitals and service commissioners to ensure that appropriate discharge services are in place for older people who have been admitted in an emergency.
- Show how your service might contribute to pre-admission planning to enable faster return to home e.g. for knee and hip replacements, or to reduce emergency readmissions.

Examples of outcomes that are a focus for all key commissioning partners[8]:

Outcome	Outcomes Framework		
	NHS 2012/13	Public Health 2013/16	Adult Social Care 2012/13
Emergency readmissions within 30 days of discharge from hospital	(3b)	(domain 4)	
Proportion of older people (65 and over) who were still at home 91 days after discharge into (reablement/) rehabilitation	(3.6)		(2b)
Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital	(3.6)		
(Reducing) Permanent admissions to residential and nursing care homes per 1,000 population			(2)
Improving recovery from injuries and trauma and stroke (indicators under development)	(3.3 and 3.4)		
(Preventing) Falls and injuries in the over 65s	(domain 2)		
(Preventing) Hip fractures in the over 65s	(domain 4)		

Work together

2. Consider how you can build partnerships and work together with other agencies offering 'Home from Hospital' services in your locality to present your combined offer to Health and Wellbeing Boards, local hospitals and service commissioners. Having a single conversation with representatives of the housing and support sector will make it easier for health and care based professionals to engage with you.



CASE STUDY

Collaboration between agencies

In North Somerset the Supporting People division of this unitary authority were commissioning a number of housing support services whose remit potentially contributed to closer integration of housing into health provision, particularly concerning hospital discharge for older patients. These services included the local Care & Repair, Age UK, housing associations and others.

The Social Services officer whose remit included brokering better joint working across health and social care was also supportive of integration of housing and helped to make a housing connection with the hospital discharge team and senior management.

The resulting Weston Hospital Partnership now delivers housing related help for older patients within the hospital setting. This has resulted in significant improvements to patient care as well as considerable savings as a result of improved discharge and care arrangements. For detailed description see 'If only I had known' [6] evaluation report .

Checklist

	YES	NO
Have you considered working with all the other agencies offering 'Home from Hospital' related services in your locality to present your combined offer to the hospitals together?	☐	☐
Is your organisation and service offer on local hospitals' radar? Have you identified all the hospitals in your area to target?	☐	☐
Do you have a clear service description and illustrations of how dealing with complex housing needs benefits patients, to share with hospital staff involved in discharge?	☐	☐
Are you able to demonstrate and quantify how your service is helping to meet health and care targets, including reducing patients' length of stay in hospital and readmissions? Hospitals will be looking to save money in this way	☐	☐
Do you or others you are working with have a senior contact within the hospital you are targeting? If not, can you work towards getting a meeting with a senior audience?	☐	☐
Is any information you produce about housing readily available to patients, their families, hospital staff?	☐	☐

REFERENCES:

1 National evaluation of POPPs. Personal Social Sciences Research Unit for Department of Health (2010).

2 NHS Institute Better Care Better Value figures suggest that reducing length of stay by one day saves the NHS £215.

3 Dr F. Zinovieff & Dr C. Robinson, The Role of the Voluntary Sector in Delayed Transfer of Care. (DToC)/ Hospital Discharge and Prevention of Readmission, Bangor University, October 2009.

4 Heywood et al.2007.

5 Age UK report Right care, first time, February 2012.

6 Care & Repair report 'If only I had known...' Published 2012.

7 Home from Hospital Service – Age UK South Staffordshire.

8 A full read-across can be found in Factsheet 4.

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