Hospital 2 Home

Essential information for:

Service commissioners

This leaflet is for those involved in commissioning services for older people living in the community and being discharged from hospital. This includes commissioners of health, social care and housing who may commission a wide range of types of service.

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

Housing and support issues can be overlooked when designing new jointly funded services, yet their potential contribution to preventing further admissions is very significant. The new focus on integrated commissioning involving the new GP-led Clinical Commissioning Groups and local authority commissioners provides a real opportunity to commission housing-related services in the context of patient discharge, in order to both improve patient wellbeing through a personalised approach and deliver more effective service coordination and efficiencies.

CASE STUDY

Preventing 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 discharge, compared with NHS Trust's figures showing a 12% readmission rate within 28 days for the same period[1].

Did you know?

- Enabling older people to return home safely from hospital is not only about efficient transfer of medical and social care; faster discharge and reduced re-admissions may also require changes to older people's housing and living situations in the community.
- Many of the mental health problems and health conditions experienced by older people – such as heart disease, respiratory conditions, arthritis, rheumatism – have a causal link to, or are exacerbated by, particular housing conditions ***(see Factsheet 3)***[2].
- Hospital discharge schemes offering housing help to speed up patient release save local government social care budgets at least £120[3] a day in addition to the cost of an overnight stay in hospital[4]. It can also help prevent emergency readmissions.

Integration and joint commissioning

The NHS, Public Health and Adult Social Care Outcomes Frameworks contain some common elements relating to delaying and reducing the need for care and support and helping people to recover from episodes of ill health or following injury *(see Factsheet 4)*.

Many of these outcomes are more likely to be achieved, and at lower cost, if housing and related services are drawn on and become core elements of an integrated approach to commissioning spanning NHS, social care, housing and voluntary sector services. The recent Care and Support White Paper and Draft Bill reflect this, and will set out new duties on local authorities to ensure that adult social care and housing departments work together (p 27 of White Paper).

Providers and commissioners need to develop cost-effective, community-based services, which can both prevent the need for hospital admission and safely reduce length of stay for older people[5].

Commissioning of housing and support services

Local authorities are in the process of reforming their commissioning frameworks for health and care and these are undergoing a process of 'integration' led by the new Health and Wellbeing Boards. Many are considering how housing and support services can help to prevent acute health treatment and care provision.

Focusing on commissioning related to hospital discharge, in order to deliver appropriate 'preventative' housing and support services at a crucial moment in older people's lives, provides a concrete starting point for redesigning commissioning more widely.

Placing an older person who is having difficulty coping at home in a care home is not always the most appropriate solution. There may be other housing options for older patients and their families to consider that may be more suitable. These include options to enable them to return to their own home ***(see Factsheet 1)*** and options to move to a more suitable home ***(see Factsheet 2)***. Establishing a good selection of housing and support options and services to meet demand from individuals is important, since not all of these options are available in every locality.

Planning to make patients' home situation suitable for their recovery, and where necessary to facilitate the delivery of care and support at home, should become an integral part of the discharge planning process.

"Housing is often an afterthought for health, and needs (specialist) knowledge...it often takes time."

Social services manager[9]

Commissioning for flexible and tailored services:
A study that explored the relationship between provision of equipment and reduction on care and residential care costs found that, over an eight week period, cost savings to care packages through provision of equipment were over £60,000[6].

Housing adaptations can reduce the need for daily visits and reduce or remove costs for home care (savings range from £1,200 to £29,000 a year)[7].

Whilst health services will get patients back home, they do not necessarily ensure patients can get around and use their home, that they can get out of the home again unaided, or that they have some quality contact with someone they know.

"The hospital wanted to discharge me. The hospital matron said 'you have a home to go to'. But it was 6 steps to the front door and on a steep hill and I didn't want to be a prisoner in my own home."

Patient and recent amputee[10]

CASE STUDY

Joint commissioning and shared outcomes produced benefits

Hospital Aftercare Service was developed through a collaboration involving Age UK Rotherham, NHS Rotherham and Rotherham Foundation Trust and included ward staff and hospital managers and ongoing development informed by Age UK Rotherham's experience.

The service was reconfigured in the first year to respond differently to two categories of older people that emerged: those who had little requirement for follow-on support and those who needed greater input. This replaced a system where all older people using the service were offered seven follow-up visits after discharge, whether they needed it or not. This allowed a flexible response from Age UK Rotherham.

Annual audits and independent evaluation by Sheffield Hallam University[8] demonstrated:

- That the service was effective when measured against key outcomes for service users (including independence, motivation, mobility, financial and confidence), all measured using a mental health resource called the 'outcomes star' process.
- Value for money and efficiency savings for public sector organisations and the wider community. Currently around ten bed days per week are saved and there are cost-savings relating to transport costs and other economic impacts, such as welfare benefits.
- Improved discharge experience of older people because of the reduced waiting time.

CASE STUDY

Housing expertise in hospitals

In North Somerset, the Care & Repair housing options adviser and a number of other housing related support staff now provide housing advice and help for older patients in Weston hospital everyday of the week. A housing element has been introduced into internal hospital training and older patients' housing issues are much more likely to be identified by hospital-based staff and referred for help.

Payment process for equipment and adaptations

Disagreements about who will pay for equipment and adaptations can delay discharge. As a health or a care commissioner, you could put in place a mechanism for up-front payment of equipment and adaptations. This would make it possible to prepare a home in a timely way and before a patient is discharged.

There are a number of ways you could achieve this, including:

- Having pooled or dedicated budgets – you could justify redirecting money that might otherwise be spent on fines for readmission.
- Providing a loan facility for patients, allowing them to repay the cost of repairs or adaptations over a 12 or 24 month period.
- Providing clear information for patients, families and carers, about their liability.
- Signposting patients, families and carers to an expert or agency who can advise and assist them to make arrangements for payment.

Checklist

Checklist	YES	NO
Are you developing joint commissioning arrangements for hospital discharge across health, care and housing? And across the hospital-community boundary?	☐	☐
Are you aware of the range of housing and community services that already exist in your locality, from which you could commission relevant services?	☐	☐
Are you engaging agencies that provide housing and support services in order to improve patient care and save you money?	☐	☐
Are you working with occupational therapists and social workers to explore the range of services that can help older people live well at home following discharge and to better match local services with patient's requirements? Do you make use of any predictive modelling tools?	☐	☐
Have you identified gaps in 'home from hospital' service provision in your locality? Are you acting to fill those gaps?	☐	☐
Are you requiring service providers to work together, where appropriate, as a condition of contract?	☐	☐
Do you have a pooled or dedicated budget to pay for equipment and adaptations for those leaving hospital, to speed up discharge?	☐	☐
Do you know how long it takes to get an adaptation made or equipment fitted? Does your commissioning process allow sufficient planning time ahead of discharge?	☐	☐
Are you aware of local housing authorities' policies relating to Disabled Facilities Grants (which pay for some home adaptations)? Are you involved in shaping delivery of home adaptations and related grant policies?	☐	☐
Do you know where you can refer patients on for information and advice on housing and support services in your area?	☐	☐

CASE STUDY

Low cost, high impact services

Sometimes, very small housing-related interventions can improve independence and quality of life in the short and longer term. In one instance, the immediate provision of oil filled radiators to create a warmer home made it possible for a patient with cancer to be discharged home promptly. Longer term repairs to the central heating system and a leaking roof were arranged by Care and Repair, with a grant obtained from the Royal British Legion.

REFERENCES:

1 Supporting hospital discharge and reducing readmissions: A British Red Cross briefing.

2 Care & Repair England (2012) If only I had known; integration of housing help into a hospital setting.

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

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

5 Age UK (2012) Right care, first time

6 Hill S (2007) Independent living: equipment cost savings. Chelmsford: Essex Learning and Social Care

7 Heywood F, Turner L (2007) Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence. London: Her Majesty's Stationery Office.

8 Age UK (2012) Right care, first time

9 Care & Repair England (2012) If only I had known: Integration of housing help into a hospital setting

10 see 11

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