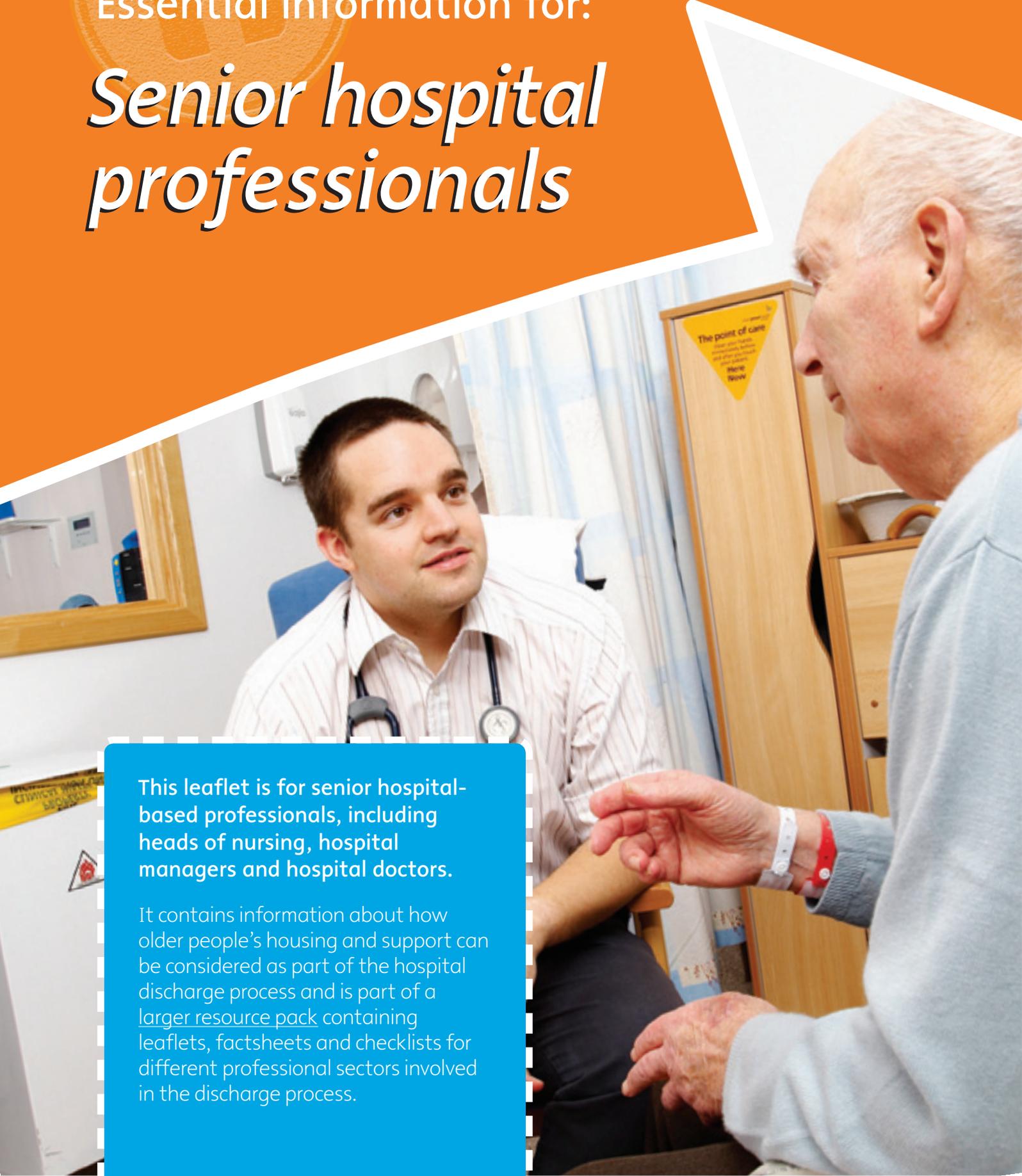


Hospital Home



Essential information for:
*Senior hospital
professionals*



This leaflet is for senior hospital-based professionals, including heads of nursing, hospital managers and hospital doctors.

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 and their recovery promoted. There are some common areas where planning for housing-related needs or support frequently breaks down.

Nurses, occupational therapists, discharge co-ordinators and social workers need to know about their older patients' housing and home situation well ahead of their discharge date. They need to know who to approach, to make a patient's home safe for them to return to and to arrange the support they need following discharge. Solutions need to be included within their care plan and discharge process.



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 period¹.

As well as causing patients distress, emergency readmissions represent a growing loss of income to NHS trusts as new rules on non-reimbursement take effect. Emergency admissions account for 35% of all admissions to hospital but take over two-thirds of in-patient beds as people admitted in an emergency tend to stay for longer. More older people are admitted in an emergency than any other group².

Did you know?

- ② The NHS spends an estimated £600 million treating people every year because of poor housing³.
- ② 40% of the NHS budget is spent on caring for people over 65 years of age, with two thirds of acute beds occupied by people over 65⁴.
- ② The current financial cost of dementia is £23 billion a year to the NHS, local authorities and families and the cost will grow to £27 billion by 2018⁵.
- ② By 2025, almost 1.5 million people aged 75 or over will be unable to manage at least one mobility/daily activity on their own⁶.



Improving your discharge process – aiding your patient's recovery

Improving practice in just three areas can reduce delays in discharge and the likelihood of patient readmission, helping you to avoid associated penalties and any negative impact on your hospital's reputation.

Information about patients' housing circumstances

Action: Task your ward staff with assessing and storing information on patients' housing and home circumstances alongside other assessments such as those relating to medication, ability to wash themselves and how they get a meal.

This will enable you and your colleagues to:

- ② Identify any housing-related issues that may have contributed to hospital admission.
- ② Make early judgements about patients' ability to cope when they return home.
- ② Identify complex housing needs that could seriously impede patients' progress towards their clinical goals.
- ② Assess any risk that may lead to a re-admission.

Ensure there is clarity at ward level about discharge arrangements and key housing-related contacts in the community

Action: Make sure that there is at least one individual at ward level who fully understands local hospital discharge

arrangements and knows who the key housing and support contacts are in the community (*see Factsheet 1*).

Action: Make sure that information on housing options and support services that are available to patients on discharge, including the relevant leaflets and checklists in this resource pack, are shared with ward staff and other key personnel.

A focus on long-stay patients

You may wish to give special attention to the discharge arrangements for 'long-stay' groups.

A [Recent Kings Fund report](#) has found that more than 70% of hospital bed days are occupied by emergency admissions. Of these, only 10% stay in hospital for more than two weeks, but those patients that do account for 55% of bed days – and 80% of them are aged over 65. Typical diagnoses for this group include stroke, hip fracture, pneumonia and urinary disorders. Dementia and delirium are also associated with longer length of stay.

Action: Work with community health, housing, care and support agencies – as well as key hospital discharge staff – to develop pathways for earlier and safe discharge of these long-stay groups.



This will mean establishing discharge pathways that include factors relating to a person's home and social environment as well as their clinical and care management for each of these particular common ailments. This could be achieved through 'Care Closer to Home' or 'Care at Home', for example by using virtual wards to speed up discharge to a safe environment that will promote their recovery.

Fact: *'You need people/individuals who understand the system and how to make it work both inside and outside hospital'*⁷

Whiston Hospital has ward-based discharge coordinators who liaise with community-based professionals and families about discharge arrangements.

REFERENCES:

- 1 Supporting hospital discharge and reducing readmissions: A British Red Cross briefing.
- 2 Age UK report Right care, first time February 2012.
- 3 Care & Repair England (2010) A Perfect Storm An ageing population, low income home ownership, and decay of older housing.
- 4 Living Well at Home Inquiry by All Party Parliamentary Group (Housing & Care) (2011) www.housinglin.org.uk
- 5 Source Dementia 2012, Alzheimer Society.
- 6 Care & Repair England (op cit).
- 7 Delegate at Appreciative Inquiry into effective hospital discharge held at Whiston Hospital in May 2012.



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