



Care & Repair

Hospital to a Healthier Home

Linking health and housing: Better outcomes for older people

Evaluation of a winter pressures pilot service | January - March 2019



Contents

Introduction	3
Executive Summary	4
Evaluation of Care & Repair Hospital to a Healthier Home Winter Pressures Pilots	6
Policy Context	8
The Cost of Poor Housing to the NHS in Wales	10
Care Closer to Home - Redressing the Balance	11
Care & Repair Cymru Evaluation work	12
Hospital to a Healthier Home Service Delivery Model	13
Cost Benefits	14
Hospital to a Healthier Home Pilot Evaluation	15
Qualitative Evaluation	17
Learning Sets	18
Patient Stories	16
Thank you	34
Watch our two digital stories	35

Introduction

We are very pleased to present our evaluation of Hospital to a Healthier Home. The evaluation describes how the service started, what type of support has been provided to patients and hospital staff, costs, benefits and the difference it has made to patient well-being, patient flow, quicker safe discharges of care, and preventing re-admissions.

The Winter pilot period was short, ranging from just five to eight weeks. It needed us to deploy our resources and skills quickly. Over a short period of time, we worked closely with Welsh Government and local hospital teams to get to the heart of the best ways to support patient flow and save bed days, by making patients' homes safer, warmer and more accessible.

We think our impact has been immediate and significant for both patients and NHS staff. 626 patients were referred during the pilot period. 508 were helped with quicker safe discharge. Importantly, all were provided with home improvements and support that helped them live independently at home and reduced the risk of them being re-admitted after discharge. Patient stories and NHS staff testimonials help paint the picture of our impact.

We are grateful for the opportunity to help patients and the NHS in Wales, and believe Hospital to a Healthier Home will help deliver on many of the aims of *A Healthier Wales*:

- Services that support people to stay well. Not just treat them when they become ill, but supporting them to live safely and independently at home.
- Joining up services- housing and third sector, as well as health and social care. Working together, pulling in the same direction.



- Working with people and their loved ones through a person centred approach.
- More community based services, outside of hospitals, closer to home or at home. Helping take pressure off hospitals, reducing the time they spend in hospital when they have to go there.

We hope this evaluation demonstrates how well aligned Hospital to a Healthier Home is with A Healthier Wales, and helps support a sustained partnership and long term relationship between the NHS and Care & Repair.

Chris Jones
Chief Executive
Care & Repair Cymru

Executive Summary

Numerous research reports and other publications highlight how poor housing adversely affects health and increases pressure on the NHS. Conversely, investing in healthier housing and good advice services assists the NHS in tackling unscheduled care pressures.

Research commissioned by the BRE Trust, Public Health Wales (PHW) and Welsh Government (WG) using 2017 Welsh Housing Conditions Survey (WHCS) data and the revised NHS treatment cost methodology from the BRE Trust report on the 'The Full Cost of Poor Housing' estimated that there would be a benefit to the NHS of some £95 million per year from treatment costs, following an accident or illness related to housing. The annual treatment cost to the NHS represents around 10% of the full economic cost to society of leaving people in unhealthy housing in Wales, which is estimated at £1bn per year.

The research highlights that improving the poorest housing could lead to 39 per cent fewer hospital admissions, that every £1 spent on making homes warmer could lead to a £4 return on investment, and every £1 spent on adaptations to support quicker hospital discharge generates £7.50 saving for health and social care.

Amongst those at greatest risk from cold, damp, unsafe and unfit housing are older people, who are particularly vulnerable to health impacts from falls, respiratory problems, cancers, circulatory and cardiovascular disease.

Welsh Government key policy drivers - *A Healthier Wales, Well-being of Future Generations Act*, and *Social Services and Well-being Act* recognise that whole system approaches, collaboration, and highly preventative approaches are needed to support long term well-being and better health and social care across Wales.

For Care & Repair's Hospital to a Healthier Home (H2HH) service, fieldwork, data analysis, and desktop study enabled us to link the low cost of H2HH to strong, targeted outcomes, speedy delivery and high impact derived from the investment. A basic, prudent calculation gave a return on investment from the pilot of £2.80 for every £1 invested.

The strongest evaluation findings, however, came from the qualitative research. Often, true costs and benefits are better assessed from understanding day-to-day challenges, process-generated waste, pressures and frustration felt on the ground. NHS staff testimonials, along with patient stories and quality of life impacts give a strong narrative about the non cost related benefits, with H2HH significantly impacting on better patient flow, quicker safe discharges, as well as reducing re-admissions.

Achievements should be understood in the context of short timescales for set up, developing working relationships in hospitals, and adapting internal Care & Repair organisational practices to meet the needs of a quick, agile, can-do approach. Over time, as the new service becomes established and integrates more closely with hospital teams, outcomes are expected to increase.

Hospital site visits and our varied interviews with NHS staff sought to identify benefits and good practice, but also what didn't work so well, and what we can learn and improve upon during the extended time period following the initial pilot. The majority of feedback was extremely positive, with H2HH being warmly welcomed because of day to day benefits, perceived efficiency and effectiveness, assisting positive patient experience, and directly influencing better patient flow and freeing up hospital beds.

From Care & Repair Hospital to a Healthier Home Caseworkers, we encountered huge positivity and excitement, around being enabled to work in a focussed and valued way. The ease with which Care & Repair staff had been assimilated into multi disciplinary teams in hospitals was a strong example of collaboration and multi-agency working.

From our interviews with NHS and Care & Repair staff, along with patient stories, and NHS staff testimonials, we concluded that the best operating model, and strongest returns on investment from both a practical service delivery and financial sense, are from a Care & Repair caseworker being co-located with NHS staff in hospitals.

Finally, from the qualitative evaluation and learning, again based on interviewing NHS and Care & Repair staff, our recommendations are:

Recommendations:

- Long-term funding to sustain and expand the co-located model of Hospital to a Healthier Home, as an All-Wales programme.
- Routine 'offer' of a Healthy Home Assessment to all frail older patients being discharged from hospital as a preventative intervention.
- Care & Repair Cymru to develop a Hospital to a Healthier Home good practice guide to drive effectiveness, efficiency and consistency across hospital sites.
- A more formal link between Hospital to a Healthier Home to NHS discharge planning policy.
- Greater understanding of the 'housing offer' from Hospital to a Healthier Home, potentially linked to NHS workforce development (awareness training).
- Feed-back loops embedded, to ensure Hospital to a Healthier Home post-discharge reports are provided to key professionals in the multi disciplinary team for discharge co-ordination.

Evaluation of Care & Repair Hospital to a Healthier Home Winter Pressures Pilots

In late Summer 2018, Welsh Government published a consultation document on developing a policy framework for unscheduled care: “When something unexpected happens to me”.

Care & Repair Cymru submitted a response to the consultation. As a result, we were contacted and met with the Head of Emergency Care Policy and Performance in Welsh Government. We were subsequently invited to submit proposals for delivering hospital to home pilots in a number of hospitals. Our proposal was based on the practical experience of Bridgend County Care & Repair’s ‘Hospital to Home’ service in Princess of Wales Hospital, in operation since 2014, project work undertaken by Conwy & Denbighshire Care & Repair in Ysbyty Glan Clwyd more recently, and our national capital funding available across the whole of Wales for Rapid Response Adaptations (RRAP) to support works in patient’s homes to enable quicker safe transfers of care.

Our proposal was accepted, and during early January 2019, Care & Repair Cymru met with Welsh Government, local Care & Repair Chief Officers, and local hospital managers to discuss how Hospital to a Healthier Home would operate. We explored ideas for the best ways of supporting different hospitals, and discussed our services in more detail at each site. The pilot areas were agreed, with Caseworkers from nine Care & Repair Agencies working out of eleven hospitals. Care & Repair Caseworkers worked in a variety of ways - on ward rounds, clinics, discharge hubs and A&E, having early

conversations directly with patients, nurses, doctors and other clinical staff about housing adaptations and improvements needed to facilitate quicker safe hospital discharges, free up bed-spaces, and help with patient flow. The pilot was operational from 14th January at 3 hospitals, 28th January at 2 hospitals, and 4th February at 6 hospitals.

The hospitals and Agencies involved were as follows:

- **Morriston and Neath Port Talbot hospitals** - Care & Repair Western Bay
- **Llandough hospital** - Care & Repair in Cardiff and the Vale
- **Royal Gwent hospital** - Care & Repair Newport
- **Wrexham Maelor hospital** - North East Wales Care & Repair
- **Prince Charles and Royal Glamorgan hospitals** - Cwm Taf Care & Repair
- **Ysbyty Glan Clwyd** - Conwy and Denbighshire Care & Repair
- **Ysbyty Gwynedd** - Gofal a Thrwsio Gwynedd a Môn
- **Prince Philip hospital** - Care & Repair Carmarthenshire
- **Princess of Wales hospital** - Bridgend County Care & Repair

To support Agencies with an expected high level of take up, and increased numbers needing capital works to facilitate quicker hospital discharge, Care & Repair Cymru met with colleagues in the Housing Directorate of Welsh Government to request additional capital funds to support the pilots, and to join up Health and Housing funds in delivering improved unscheduled care services. An additional £195,000 funding for RRAP was approved.

Working with Welsh Government, Care & Repair Cymru developed a national Service Level Agreement for delivery of the pilots, that LHBs could utilise for future Hospital to a Healthier Home services. The SLA includes agreed data collection, evaluation and information on outcomes. Regular reports have been provided to WG officials, and through the National Programme for Unscheduled Care Delivery Group (NPUC).



The headline data from the January to March pilots were:

Care & Repair Caseworkers working out of 11 hospitals

Actual working days varied between 35 and 55 days

626 patients referred through Hospital to a Healthier Home service

357 patients homes visited and a Healthy Homes Check undertaken

320 patients received a service to ensure they were claiming all the benefits they were entitled, resulting in £120,472 of benefits being accessed, with numerous more cases still being processed

508 patients received work, costing a total of £141,472 through RRAP, that facilitated quicker safe discharge

By self-assessment survey, 266 patients who responded said that work at their home helped them return and live more independently there

Policy Context

Welsh Government have adopted various key policy drivers, which increasingly integrate policy across Health, Social Care and Housing.

Care & Repair's Hospital to a Healthier Home service supports the aspirations of ensuring that vulnerable older people's housing is safe, warm and accessible, enabling independent living and reducing dependency. This fits perfectly with Welsh Government's landmark policy ambitions.

Care & Repair has a proven track record of working in strong partnerships. We are a trusted third sector organisation that works with speed and agility to provide home improvements, adaptations and addresses housing problems that improve daily living, health and well-being.

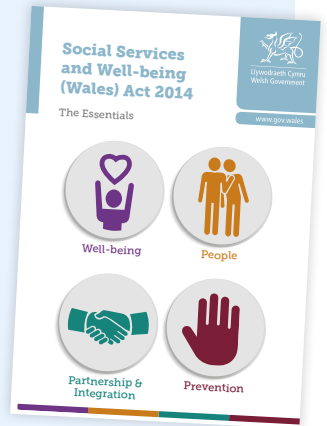


Public health approaches that support Prudent Healthcare and Promoting Wellness are cornerstones of **A Healthier Wales: our Plan for Health and Social Care (2018)**. **A Healthier Wales** also aspires to:

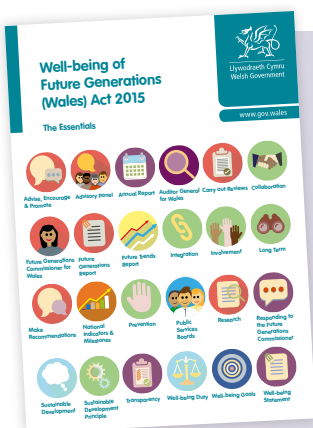


- A whole system approach to health and social care;
- A 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health;
- An equitable system which achieves equal health outcomes for all;
- Services which are seamless, and delivered as close to home as possible.

The **Social Services and Wellbeing (Wales) Act (2014)** contains clear objectives around:



- Voice and control – putting an individual and their needs at the centre of their care and support, with voice and control over the outcomes that will help them achieve well-being;
- Prevention and early intervention – being able to access advice and support at an early stage, to maintain a good quality of life, and reduce or delay the need for longer term care and support;
- Well-being – supporting individuals to achieve well-being in every part of their lives;
- Co-production – involving people in the design and delivery of support and services, and recognising the knowledge and expertise they can bring;
- Multi agency – strong partnership working between all agencies and organisations is essential to improve the well-being of individuals in need of care and support, and carers in need of support.



The Wellbeing of Future Generations (Wales) Act (2015) refers to: **A Healthier Wales: a society in which people's physical and mental wellbeing is maximised and in which choices and behaviours that benefit future health are understood.**

The Cost of Poor Housing to the NHS in Wales

Poor housing puts huge pressures on to the NHS:



Hospital clinical pressures and patient demand from poor housing:

- £96 million treatment costs per year following accident or illness relate to poor housing
- 2,600 hip replacements every year
- Potential for 43% of hospital beds to be occupied by an older faller over any given month
- 1,300 older people admitted will lose their independence in the first year

Pressures through the system from poor housing:

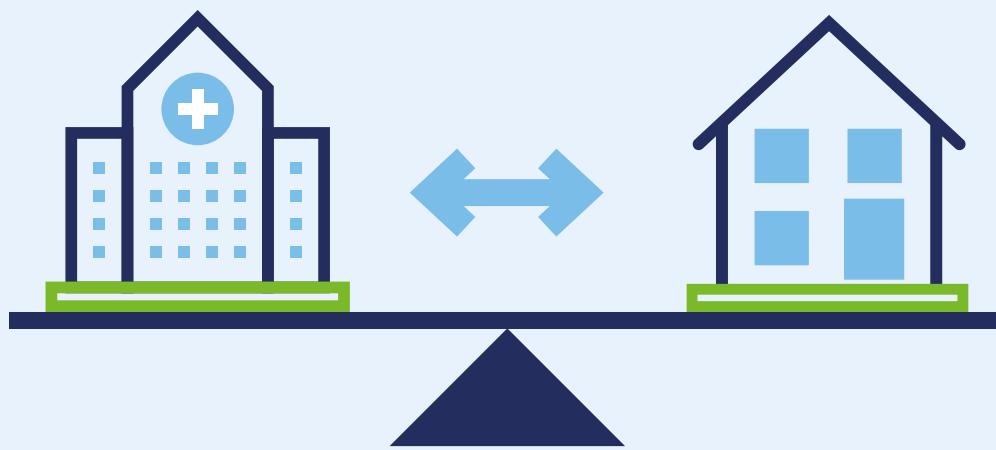
- 18% of homes in Wales pose an unacceptable health risk
- Older people are amongst those at greatest risk from poor housing
- 30% of over 65yrs, 50% over 80 will fall each year
- 122,000 older people will fall more than once in their own home
- Cold damp homes increase circulatory, respiratory and cardiovascular disease
- 4 out of 5 older people live in their own home

'We will embed change, so that it is better able to meet future challenges and opportunities, and to be sustainable for future generations... Stronger national leadership and direction will support these changes, enabling us to grasp the full potential of our integrated system and our planning approach, but our real test will be in the delivery of services and improved outcomes across Wales'

Andrew Goodall, Chief Executive NHS Wales, A Healthier Wales

Redressing the Balance: A Healthier Wales

Hospital to a Healthier Home helps redress the balance: joining up services, housing and the third sector pulling together; prevention and supporting people to stay independent and well at home; helping take pressure of hospitals and reducing the time patients spend there.



Positive impact of healthier homes:

- Over 38% reduction in hospital visits from 60+yrs who received home improvements;
- 26% reduction in falls requiring medical treatment due to home adaptations;
- 40-50% less respiratory illness in homes that are not damp;
- £7.50 cost avoidance to NHS for every £1 invested in adapting people's homes prior to discharge;
- £4.00 cost avoidance to NHS for every £1 invested in warmer homes for people over 60+yrs;
- Over less than 3 months, Care & Repair's Hospital to a Healthier Homes service provided a service at an average cost of £338 per patient, helping with quicker safe discharge and reducing re-admissions;
- Care & Repair's H2HH helps keep people independent and provides a reality check on how well the transition home from hospital has really gone, and how well older patients are managing after being discharged.

'We want a seamless whole system approach to health and social care. Services from different providers should be seamlessly co-ordinated, and we should go beyond services to make a difference to the social and economic factors which influence health, wellbeing and life chances.'

Vaughan Gething, Minister for Health and Social Services, A Healthier Wales

Care & Repair Cymru Evaluation work

As part of the pilots, Care & Repair Cymru undertook an evaluation, the method for which is as follows:

- Desktop research into the impact of housing interventions on public health and NHS pressures
- An assumption of cost avoidance benefits from local assessment of bed day savings and potential cost avoidance from falls prevention, linked to Public Health Wales epidemiology for falls amongst older people in a community dwelling
- A contrast between service costs and the value achieved from service outcomes
- A qualitative study, based on face-to-face interviews with a range of NHS staff, strategic and operational partners, and Care & Repair Hospital to a Healthier Home Caseworkers; this includes,

An NHS staff digital story

A Care & Repair digital story

The headline findings from the evaluation are:

- Based on the informal local assessment of bed day savings, the service costs are fully substantiated, and return £2.80 for every £1 invested (both revenue and capital)
- Based on modest assumptions and realistic Public Health Wales projections, the potential preventative cost benefits could be as high as £4.50 for every £1 invested
- The average unit cost of a Hospital to a Healthier Home intervention is low, £338 per patient, whilst the impact value could potentially be as high as £1,125,812 cost avoidance
- Practical, needs-led and bespoke interventions in the home helped 626 older patients, with 628 completed works, broken down to 910 individual jobs that supported home safety and independent living



NHS frontline staff interviewed for the evaluation study felt the service was of significant benefit and had the potential to deliver more.

There was a wide appreciation that the service had a strong patient focus, was well regarded by patients, families and carers; and that there was a benefit in terms of improved patient flow and reducing the risks associated with secondary admission rates.

Hospital to a Healthier Home Service Delivery Model

The services provided by Care & Repair for older and vulnerable patients were:

- Working closely with NHS staff in hospitals, identify at the earliest opportunity, patients who required community and housing support to facilitate a timely and safe discharge
- Develop protocols that improved awareness of housing/home environment as a key preventative issue in health promotion
- Improved NHS morale and ability to support positive transitions
- Improved patient flow and cost avoidance based on bed days
- A Healthy Home Assessment
- Links to Care & Repair professional technical/surveyor services
- Links to Care & Repair in-house practical (Handyperson) services
- Links to Care & Repair's specialist Managing Better service (delivered in partnership with RNIB Cymru and Action on Hearing Loss Cymru), if there are significant challenges from sensory loss
- Access to funding for minor/medium repairs/adaptations that are held by the Care & Repair Agency (for example ICF capital, RRAP, Enable)
- Welfare Benefit checks and applications to increase entitled income
- Benevolent/charitable income sourced by Care & Repair where applicable
- Prudent healthcare advice, including falls risk assessment
- Support for access to Local Authority housing grants and Community Occupational Therapy services
- Referral to local statutory and third sector providers for assistance with care needs, loneliness, disabled rights, financial advice etc.
- Winter-proofing and fuel poverty advice

Cost Benefits

The context for the evaluation of Hospital to a Healthier Home is the relative low cost of investment against the diverse impact of the service, providing direct cost benefits from ‘bed days’ saved, and indirect cost savings related to preventing readmissions, social care and primary care costs.

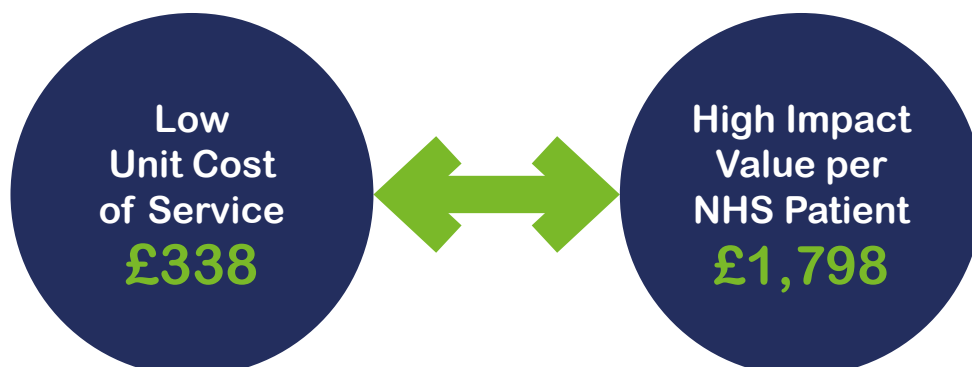
Assisting with home safety, personal safety (assistive technology), addressing cold homes and fuel poverty all have immense impact, not only on health and well-being but on reducing care costs linked to poor housing.

For the pilot, the total revenue sum invested was £70,053. A significant part of the success of the pilots was the additional RRAP capital funding for improvements or adaptations needed in the home to support quicker discharge. At the end of March reporting period, a total of £141,231 was spent to support Hospital to a Healthier Home, although due to timing issues, work on site etc, this will increase. Working purely on the pilot data at March 31st 2019, the unit cost is £338 per patient, including assessments and works completed.

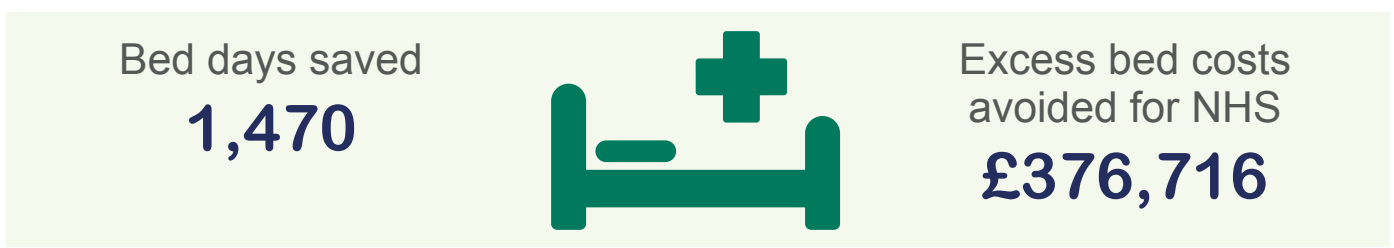
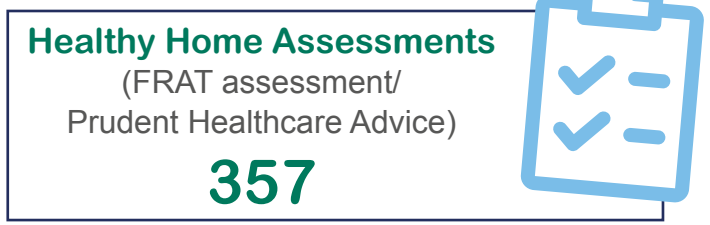
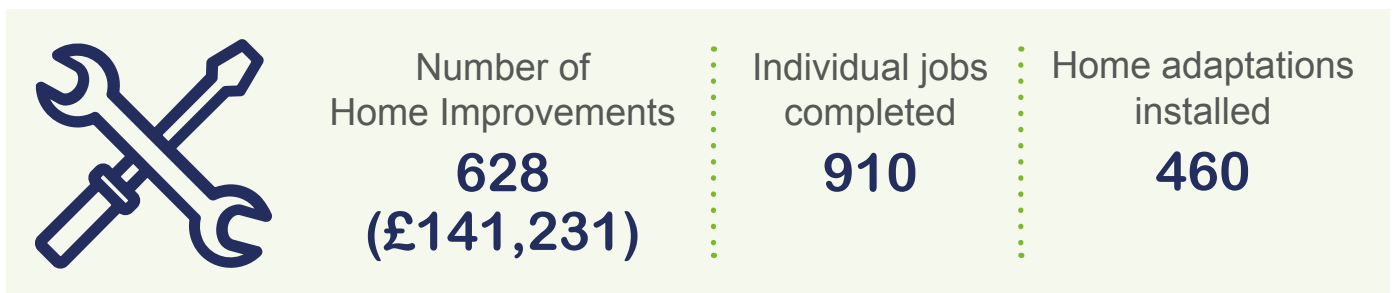
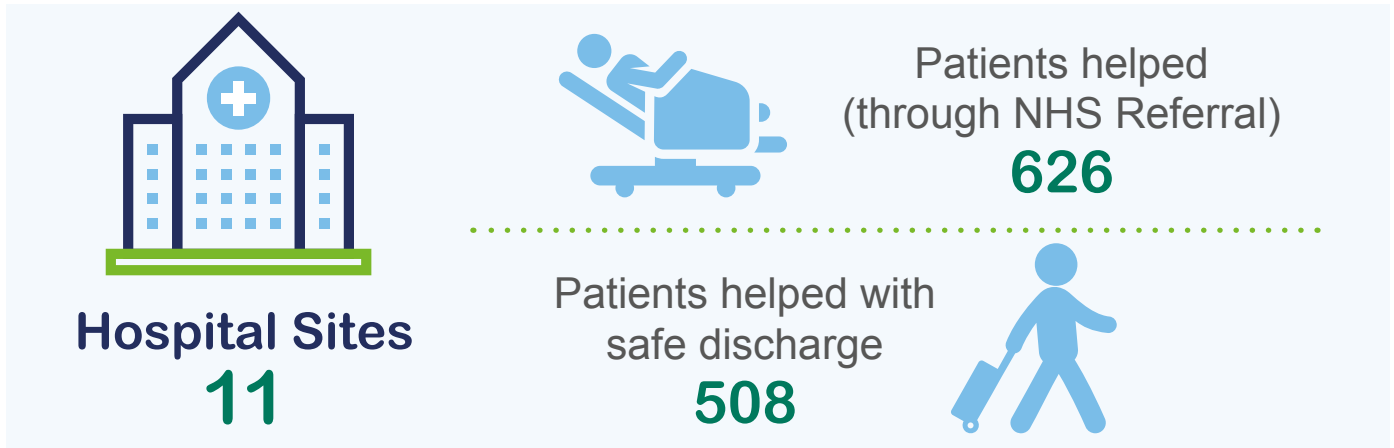
It is important to note, that most of the pilots were initiated very quickly, from a standing start. This involved recruitment, initial service set-up and establishing new partnership relationships. Operational timescales varied across hospitals from commencement on 14th January at 3 hospitals, 28th January at 2 hospitals, and from 4th February at 6 hospitals.

Another challenge was Care & Repair Agencies needing to gear up internally with adjusting practices for in-house Home Maintenance services, sourcing funding and working with trusted external contractors, to deliver to agreed time frames.

The relatively low cost of Hospital to a Healthier Home, needs to be set against potential savings in cost avoidance for NHS bed days, and potential savings for lower risks of readmission and likely transfers into step-down and rehabilitation facilities, or a slide into loss of independence and into residential nursing care. A literature review of the impact of housing and advice services on the NHS is provided separately.



Hospital to a Healthier Home Pilot Evaluation



Improving Patient Flow





Qualitative Evaluation

For the purpose of this evaluation, Care & Repair Cymru visited most of the hospital sites involved in the pilot and interviewed Care & Repair operational staff as well as a range of NHS operational partners. We interviewed some senior/middle NHS managers, but our aspiration was to interview front line operational staff who worked with Care & Repair staff on a day-to-day basis.

Our approach was to get under the skin of the service and tease out any negative views and learning, as well as positive feedback, free from views based on the initial arrangements made between WG and NHS managers.

Our interview approach was one that sought a clear view of benefits, things that worked well, and things that worked less well. For the purpose of the evaluation, it is worth mentioning that we had no direct contact with Cardiff & the Vale NHS staff as the caseworker presence in the hospital was more restricted.

We believe of most value from this evaluation, is the important learning for the future, as set out in the following pages. The voices of both the NHS staff and Care & Repair Caseworkers involved in the pilots will be presented in two digital stories, accessed at the end of this report, and we thank them all for their valuable time and assistance.



Learning Sets

During April 2019, we interviewed several NHS staff and Care & Repair frontline Hospital to a Healthier Home (H2HH) caseworkers to provide qualitative evaluation and key learning points.

The transcript of interviews are themselves instructive and a fuller version is available as a technical report. We have condensed our findings into four learning sets, and these will be complemented by sets of case studies that reflect on this learning.

1. Maximising Opportunities for Independent Living and Speeding Up Safe Discharge

Our fieldwork gained perspective from both patients (case studies) and NHS staff (interviews) to help demonstrate impact. Patient stories provided later clearly indicate how older, often frail and vulnerable people, received services that addressed key issues that prevented a safe discharge home. Staying in a bed is often not the best place to recuperate from illness. The reality of living independently in an unfit home means that anxiety, environmental determinants of poor health and hazards such as falls, damp and cold, often leads to readmissions. Our Healthy Home Assessment provides added support for independent living, keeping older patients home for longer, and providing a safe environment for virtual ward clinical interventions. It helps support patient well-being and reduces dependency.

From an NHS perspective, once patients are medically fit for discharge, busy wards are provided with a window of opportunity to safely free up a hospital bed. Unfortunately, the 'safe' discharge planning process is often complex, and there is ample evidence of opportunities being missed.

“We talk about acute wards, because of how busy they are. They 100% do not understand how complicated a discharge can be. So they tend to have a view that there are people elsewhere seeing to those issues but they are not always clear who they are. Since we’ve had your colleagues (Care & Repair) involved, there’s suddenly, ohh, so there is a little angel in place who’s going to help me sort out those things to make that speedy discharge.”
(Pauline Dobson – Discharge flow lead for Wrexham Maelor Hospital)

“An analogy we use within Health is, in an emergency department you are working in seconds, in admissions you are working in minutes maybe, perhaps an hour tops, you go to a ward and you are working in days. Now, if other systems are working in months, you get to a blockage point, because you can’t sort things out as quickly as you need, so that a patient who’s been with us, and we know what their average length of stay is in hospital, and the frail older population, the longer they stay the more deconditioned they became. Actually, if we don’t hit that sweet spot and get them out in a timely way, we are going to require a

much bigger package, more adaptations, more input, because they have actually deteriorated while they have been in our care.”

(Susan Jones – Head of Operational Services, Neath Port Talbot Hospital)

The consequence of delaying discharge is that stays in a hospital for the frail can be overly protracted. The impact of secondary illness and infections, as well as the difficulty of sorting out non-medical issues, are often significantly onerous, with measures sliding from weeks into months. A ‘lean’ approach to process and enhanced Multi Disciplinary Team partnerships (bringing targeted resources and new skills) can assist a better outcome. There is direct evidence from the pilot to support this.

“And most importantly, to be honest, it was having the money to pay for the works, because although we have RRAP it’s the other works I think that OT’s struggle with. There are also other works, stairlifts, bathrooms, big ramping jobs which again can take (time)... I really wouldn’t like to say, you are looking at months and months, because it would have to go down a Disabled Facility Grant (DFG) route.”

(Beatrice Roberts – Care & Repair in Cardiff & the Vale)

The learning we gained from our interviews indicated how the discharge planning process could positively benefit from approaches introduced through the pilot. Firstly, having wider, face-to-face discussions earlier in the patient journey, resolves issues prior to the ‘discharge bottleneck’, or time the patient is ‘medically fit’. The richness of this approach is that they involve awareness of new skills, and are both formal and informal, often iterative: the best products of good team working.



Secondly, they produce better trust and buy-in from the patient, as focusing on how prepared patients are for a difficult transition home, is often not possible to achieve in a busy ward. Thirdly, smaller but no less significant problems are brought to light early and can be solved with a flexible, can-do approach. Fourthly, liaison with family and carers, and with other relevant professionals/ services can be removed from NHS time-pressures. Lastly, there is more immediate and direct access to home adaptations, where clients are helped with bureaucracy and referral forms are completed for busy NHS staff on electronic tablets. The evidence of process time saving was significant.

Recommendations:

- Routine ‘offer’ of a Healthy Home Assessment to all frail older patients being discharged from hospital as a preventative intervention
- Care & Repair Cymru to develop a Hospital to a Healthier Home good practice guide to drive effectiveness, efficiency and consistency across hospital sites

2. Providing Added-Value and Reducing Risks of Readmission

During nearly every interview, we found an improvement in NHS staff awareness of what Care & Repair services provide. Sometimes it was a comprehensive re-understanding with Care & Repair becoming recognised as a critical independent living service rather than just a 'grab rail' service.

"We would just run day to day with the limited knowledge we had at the time, and it predominantly involved small aids or small adaptations for example like a grab rail. It didn't involve any of the advice or even the links that it could allow us to have with other agencies as well."

(Sarah Collins, Occupational Therapist, Prince Philip Hospital)

Far and above the minor adaptations and basic works relating to discharge, Care & Repair provided outcomes more fundamental to patients' longer-term well-being. These included improvements in welfare income, energy advice, improvements to heating, electrical & gas safety and falls prudent healthcare advice. NHS staff were not aware of our Casework Healthy Home Assessment or our Technical Services providing supervised building work. Nor were they aware of our Managing Better service, delivered in partnership with RNIB Cymru and Action on Hearing Loss Cymru, that targets specialist support to vulnerable older people with a sensory loss. Further, they came to understand our problem-solving approach, assisting with moving furniture, delivering aids, external safety, white goods, utilities, cleaning & de-cluttering, and housing options.

"I've had a lady here on the ward, very, very poor, no money, wasn't sleeping in a bed, they helped me to get her home with a bed. And that was fantastic, that woman has stayed out in the community, no ulcers on her legs, no swelling on her legs, because of that bed. I didn't know they did that, that was good."

(Jenny Jones – Social Worker based at Wrexham Maelor Hospital)

"The other clear benefit and refreshing way of working is the diversity of the support offered by Care & Repair, and rather than being told 'we don't do that', the Caseworker has negotiated and navigated through organisational boundaries and systems to ensure an issue is dealt with. This has prevented numerous 'hand offs' to others and has been extremely solution focused."

(Jayne Sankey, Interim Assistant Director of Nursing, Wrexham Maelor Hospital)





In a busy clinical setting, and without Hospital to a Healthier Home, much of this would have either been ‘invisible’ to comprehensive discharge decisions or something that was ‘delayed’ or ‘forgotten’ within a complex array of issues required to help older patients go home safely. More importantly, resolving these challenges were most impactful in terms of reducing the risks of further admissions to hospital.

“Because obviously that is the main aim, you want people to go home and be safe. If they go home and they fall then it’s another admission, whereas if we can prevent that then it’s like preventative measures, to make sure people are safer longer term. It’s definitely needed. If it stops now we’ll definitely miss it.”

**(Jenna Mulholland – Band 5 Physiotherapist
Royal Gwent & Saint Woolos Hospital)**

Recommendations:

- A more formal link between Hospital to a Healthier Home to NHS discharge planning policy
- Greater understanding of the ‘housing offer’ from Hospital to a Healthier Home, potentially linked to NHS workforce development (awareness training)

3. Co-Location and NHS Systems Enhancement

Most pilots involved Care & Repair Caseworkers being co-located at hospitals with NHS staff. Two of the pilots however had Care & Repair Caseworkers less integrated with hospital staff. It was clear that the stronger model was Care & Repair being based at the hospital and having closer day to day connections and conversations with patients, their families and a range of hospital staff.

“In terms of discharging we have instant access, instant feedback. To make sure our estimated discharge can roll more effectively, we’ve got more of a handle on when someone can go home with the adaptations that are needed because we have got someone that we can talk to at hand to see what the options are. Like I said it allows for better teamwork, better communication and that helps. It’s not just sending a referral off to someone and not getting the feedback. It would all sort of work seamlessly.”

(Sarah Collins – Occupational Therapies, Prince Philip Hospital)

With conventional partnership and collaboration, speed is inhibited by the process of outside referral. Referrals are more forthcoming when the service is based at the hospital alongside clinical staff. When services are more arms-length, it is evident that an ‘out of sight out of mind’ mindset occurs. Communication is much stronger in a co-located arrangement (rather than relying only on formal, written communication, there is a benefit in communicating face-to-face, across MDTs, and including informal and iterative approaches, for example, overheard problems and debate). Strengthening MDT with additional resource and skills also tangibly improves staff morale.



“To be honest it has helped my workload as well because now it’s just a case of making a referral by going to speak to somebody, and things are just done without me having to chase and make phone calls and send emails and trying to chase things up, to me it’s been nothing but valuable.”

“How can I put it? There’s no walls up or anything It’s ‘ok, let’s sit down, lets discuss the situation, lets discuss the need’, and then it’s just a case of rolling with it. In one of the instances within a space of 10 days, everything was done and sorted, where that would have probably a month, 2 months without Care & Repair.”

(Kelly Peers – Discharge Coordinator for Wrexham Central District Nurse Team)

In Cwm Taf, the H2HH Caseworkers became integrated/co-located in the follow up to the pilot, having initially been more detached during the pilot period. The Acute Occupational Therapy Team and the Stay Well @ Home service felt that a co-located service provided an immediacy in terms of communication, feed-back loops, patient/family relationships, wider liaison and problem-solving, that could not be derived from telephone, e-mail, or fax. Both commented on waste inherent in a dispersed referral process. Both talked of lost opportunities for accessing the 'discharge window', delays in chasing up conversations, accessing services that would undertake practical interventions, tasks that were postponed and then forgotten about due to extreme pressure.

'.....having Jemma (H2HH Caseworker) here has opened our eyes to a whole new range of services that we can utilise to get patients home. I think it does assist with patient flow especially when the reasons for patients not being discharged is the home environment and are things that traditionally an OT wouldn't do, like issues with heating and boilers, issues with windows, carpets, damp, that type of thing.'

(Joanne Santos Matthews – Team Lead Occupational Therapist at Prince Charles Hospital)

'I think we have come to the realisation that people's homes and their environments are absolutely key in supporting and maintaining them in their own homes.'

(Emma Ralph – Team Manager Stay Well @ Home Service Cwm Taf Morgannwg)

'there wasn't any family with this particular man, so we would have had to liaise directly with social services to do everything so now having Kelly (H2HH Caseworker) as that person to help coordinate things, it's taken a lot of time pressure off us so we are able to see other patients.' ...and..... 'I think being able to go to a family, like this family I was speaking to yesterday, they are a family at crisis point, and to be able to say, I can help,

and I can help with something that will be quite straight forward and easy, you know, you can see the relief on their face straight away.'

(Nicole Jones – Occupational Therapist at Royal Glamorgan Hospital)

There was much to consider in placing key services, not directly related to NHS medical or nursing care, at the heart of service delivery, as this was an easy way of improving MDT approaches. A key barrier to getting something comprehensively achieved in a hospital is understanding how busy and pressurised the work environment is. There is even a dislocated sense of awareness between discharge coordination (multi-factorial and complex) and general ward and ancillary support (care and rehabilitation focussed) as to what the end-to-end approach needs to be. The patient's understanding, emotional transactions and transitions home are understandably often over-looked under the impact of time pressures to 'free up a bed'. It was felt Care & Repair could get important issues considered when we were active members in a team and help to focus on the patient. This was universally valued by our NHS colleagues.

Recommendations:

- Longer-term funding to sustain and expand the co-located model of service delivery of Hospital to a Healthier Home

4. Patients/Clients and Transitions of Care

Our interviews revealed an almost impossible task of balancing the imperatives of NHS resource management (i.e. freeing up beds), with support to the patient for a difficult transition home. It was evident that it is not often fully considered from a patient perspective that going home, as much as it is eagerly sought after, can be a daunting experience. Patients often feel anxiety, feelings of loneliness and the stark realities of recuperating when there is far less support. The realities of managing independently are stark and difficult to determine from a hospital-based assessment, particularly when the issues of living condition and personal circumstance become more real at home. This is when the importance of having the 'property doctor' on your team becomes clearer.

"To give you another example, I had a lady on one of the medical wards, her daughter was quite reluctant for her to go home. There were issues about the house, it was damp and I referred to C&R just to have a look. They had a surveyor I think who went and had a look, we had a good comprehensive written report on the state of the house. She couldn't go back there."

(Beverley Evans – Discharge Support Nurse Wrexham Maelor)

What NHS staff appreciated from Care & Repair services was that the real pressures of living independently were incorporated into an extended care & support model. Many of the bed-side assessments were based on patient replies influenced by the hope that they could go home.

"Years ago, we used to do visits to nearly every patient we saw but we don't anymore we haven't got the time. You may only have a day or two to get things sorted and you can't always do it in that time, and once they are gone, they are gone. And we can't carry them on in the community, perhaps we can do 1 visit but we can't keep on, because there are more patients coming in to replace them, so we don't carry an outpatient list at all."

(Ann Carpanini – OT Team Lead for Cardiac Surgical & Renal Murrison Hospital)

Having an extra pair of professional eyes back in the home that clearly identified challenges with the patient being discharged, and providing an additional day-to-day perspective on how adaptations and independent living aids were being utilised by the patient, proved most beneficial.

"I would anticipate that an in house presence (of Care & Repair) would be effective within those areas where they have an A&E feeding in because the pressure on the staff in these units is so great that I would imagine that they have, overall, less chance and ability to gain an in depth understanding of what is happening within people's homes and situations."

(Steve Seagull – Specialist Discharge Advisor, Prince Philip Hospital)

Recommendations:

- Feed-back loops should be embedded, to ensure Hospital to a Healthier Home post-discharge reports are provided to key professionals in the MDT for discharge co-ordination



Patient Stories

Maximising Opportunities for Independent Living and Reducing Risks of Readmission

Bridgend County C&R Hospital to a Healthier Home Service (Princess of Wales Hospital)

Mrs S (73yrs) was admitted to hospital after suffering a stroke. Just before discharge the Hospital to a Healthier Home (H2HH) caseworker received a referral from a Hospital Occupational Therapist (OT) for a handrail to the steps at the front of her property. This work was completed the following day allowing Mrs S to return home safely.

After discharge the H2HH Caseworker visited Mrs S at home to carry out a Healthy Homes Assessment. The house was in a poor state of disrepair and there was a lot of clutter around. During the visit a FRAT (Falls Risk Assessment Tool) assessment and a WBC (welfare benefit check) were also completed.

Mrs S was in receipt of pension credit but not claiming any disability benefit. A claim for Attendance Allowance was submitted and she was awarded the higher rate of £87.65 per week. A referral was made to Age Connects for their Hospital to Home Discharge Service, who are visiting her for six weeks to help tidy the house to make it a safer environment for her.

During the visit it became apparent that Mrs S was struggling to get up the stairs to her bathroom. A referral was made for the Care & Repair Agency's OT to visit and carry out an assessment. This resulted in an application to the Bridgend Stairlift Grant Scheme and a stairlift was fitted within three weeks. A RRAP grant referral was also processed to raise the sofa and provide a raised toilet seat.



Helping Mrs S claim Attendance Allowance increased her household income by £4,558 per year.

When leaving the property after the initial visit, the caseworker noticed the front door handle was broken and dangerous so arranged for the Agency's Home Safety Officer to visit the next day to repair under the Healthy Homes Assistance Grant.

Cwm Taf C&R Hospital to a Healthier Home Service (Prince Charles Hospital)

Mrs D (74yrs) was admitted to hospital following a fall at home resulting in a broken knee. The H2HH caseworker received a referral 5 days prior to Miss D's expected discharge date in February 2019, she had been in hospital for 64 days. The H2HH Caseworker visited Mrs D's home, with her daughter, the same day to complete a Healthy Homes Check and a key-safe was installed at the property that day to allow a safe hospital discharge.

However, the Healthy Homes Assessment identified significant problems at the property which would put Mrs D at high risk of a fall and possibly readmission to hospital. The toilet & wash hand basin were leaking, the light in the toilet was not working and there was no heating at the property. The caseworker arranged for the toilet, wash-hand basin and lighting to be repaired using funding from the Agency's Handyperson service (funded by Rhondda Cynon Taf County Borough Council Private Sector Housing Unit). The caseworker arranged for a gas engineer to visit the property to assess the central heating boiler. He confirmed it was broken and beyond repair. The Agency arranged for temporary heating to be delivered to the property on the same day as receiving the report.

Due to the significant dangers identified at Mrs D home, which would not have been identified unless a home visit by the H2HH caseworker had happened, Mrs D would have been discharged from hospital to an unfit home. Once identified, solutions to

the problems were quickly found and Mrs D returned home just 1 week later than her initial discharge date.

Care & Repair continued to support Mrs D after her hospital discharge to have a replacement central heating boiler installed. Funding applications were submitted to: Care & Repair Cymru's Health Through Warmth and Gas Safe funds (obtained through partnerships with nPower, Gas Safe Charity and Foundations Independent Living Trust), and Cwm Taf Care & Repair's own internal hardship fund.

A total of £1,800 of funding was awarded allowing for a new boiler to be installed two weeks after Mrs D returned home from hospital.



Without a home visit by the H2HH caseworker Mrs D would have been discharged to an unfit home. Once identified, solutions to the problems were quickly found.

Providing Added-Value and Reducing Risks of Readmission

Conwy & Denbighshire C&R Hospital to a Healthier Home Service (Ysbyty Glan Clwyd)

Mr R (83yrs) who lives with his wife (81yrs), was admitted to hospital due to experiencing dizzy spells for 18 months and had extremely high blood pressure. Mr R lives with COPD (Chronic Obstructive Pulmonary Disease) and hearing loss which is corrected by a hearing aid in one ear, but had mastoids removed in the other ear leaving him with no hearing in that ear.

The H2HH caseworker received a referral from the Hospital Admissions, Discharge & Transfer OT in the Emergency Department asking to discuss what services and support Care & Repair could provide. Mr R had been admitted following a dizzy spell and collapsing at home but was hoping to be discharged the same day. The H2HH caseworker visited Mr R in the Emergency Department Observation Unit and discussed what support was needed to facilitate a safe discharge.

The Caseworker used the Healthy Homes Assessment to discuss each room in detail with Mr & Mrs R to assess possible support needed.

Access to the front of the house was identified as a major fall hazard due to nine steps to the front door and a steep driveway. A RRAP referral was completed for rails to be installed the following day.

As both Mr & Mrs R had hearing loss a referral to Care & Repair's Managing Better (MB) service was arranged. This is a specialist housing support service for vulnerable older people, particularly those with sensory loss, frailty, stroke and dementia. Mr and Mrs R had a loop for the TV, but they do not always hear the doorbell and they would not hear the smoke alarm at night.

As neither Mr & Mrs R were claiming Attendance Allowance a referral was made to the DWP's home visiting service. Mr & Mrs R are currently waiting for the outcome of their Attendance Allowance claims.

The MB caseworker visited Mr & Mrs R the following week and completed the Healthy Homes Assessment started by the H2HH caseworker in hospital. This visit resulted in additional grab rails being installed in the bathroom and a referral to the Fire & Rescue service for vibrating alarm pads to alert them in the case of a fire.



Care & Repair are continuing to work with Mr & Mrs R to provide a number of home repairs and identify funding to replace old, and very draughty, windows.

Carmarthenshire C&R Hospital to a Healthier Home Service (Prince Philip Hospital)

Mrs P (72yrs) was referred to the H2HH caseworker by the hospital OT just prior to Mrs P being discharged. Grab rails around the home had already been arranged however, the OT felt a home visit was required to see if there was anything else needed to ensure Mrs P had a warm, safe home environment to return to.

The H2HH caseworker arranged to visit Mrs P the day after she was discharged from hospital to undertake a full Healthy Homes Assessment. The visit identified Mrs P was struggling to get up the stairs so a referral to the Community OT was made for a stairlift assessment.

A welfare benefits check identified neither Mrs P, nor her husband (Mr P is 77yrs.), had applied for Attendance Allowance. Both were helped to make successful Attendance Allowance applications which in turn allowed them to successfully apply for Pension Credit. This ensured the couple were no longer required to pay Council Tax. Mrs & Mr P joint income has increased by £800 per month, or £9,600 per year.

Following the Community OT assessment, a stair lift has been installed for Mrs P paid for by a Disabled Facilities Grant and due to Mrs P now receiving Pension Credit she was not required to contribute towards the cost of the stairlift.



The H2HH caseworker arranged to visit Mrs P the day after she was discharged from hospital to undertake a full Healthy Homes Assessment.

Co-Location and NHS Systems Enhancement

Newport C&R Hospital to a Healthier Home Service (Royal Gwent Hospital)

.....

Mrs R (71yrs) received a visit from the H2HH caseworker on the ward following a referral from the ward's discharge co-ordinator. Mrs R was due to be discharged but needed her bed at home to be taken downstairs.

As Mrs R lives in Torfaen, outside of the Newport C&R area, the caseworker contacted Torfaen & Monmouthshire C&R directly making a referral to their handyman service. Arrangements were made for the bed to be moved the next day, the same day as Mrs R was discharged.

The breadth of work the Care & Repair service can undertake to assist older people to live independently was not known to NHS discharge staff prior to the H2HH caseworker being co-located in the hospital. The cross-county issue in this case would also have been an additional complication.

Co-location of a H2HH caseworker in the hospital highlighted a solution and facilitated its speedy delivery allowing Mrs R to return home quickly.



North East Wales C&R Hospital to a Healthier Home Service (Wrexham Maelor Hospital)

Mrs X (72yrs) was referred to a H2HH caseworker as she was due to be discharged later that week. However, the Discharge OT was concerned as the home had no heating and was cluttered. Prior to our Hospital to a Healthier Home service there was no obvious service to help with discharge.

The caseworker visited Mrs X the day after her discharge from hospital and carried out a Healthy Homes Assessment. The home was very cold, and the heating was not working so temporary heaters were immediately provided free of charge. A welfare benefits check was carried out and an application made for Attendance Allowance.

Mrs X is very proud, and reluctant to accept help. The caseworker is visiting her regularly to build trust. The North East Wales C&R

hardship fund has paid for a carpet in her lounge which was bare concrete, so very cold and also provided a high risk of injury due to client having seizures. Other support discussed is Telecare (for heat extreme detector to notify if home drops to low temperature), and central heating (waiting for Mrs X to agree).

The caseworker has identified additional help and support needed with repairs and replacement furniture. The Agency has a stock of donated furniture which can be given free of charge. The caseworker will approach each of these issues sensitively and help Mrs X when she is ready. The Agency will continue to work with Mrs X to identify solutions and funding routes for repairs and adaptations allowing her to live independently in a safe, warm home, and reducing the risk of re-admission.



The Agency will continue to work with Mrs X to identify solutions and funding routes for repairs and adaptations allowing her to live independently in a safe, warm home.

Patients/Clients and Transitions of Care

C&R in Cardiff & the Vale Hospital to a Healthier Home Service (Llandough Hospital)

Mr V (79yrs) was admitted to hospital with leg and hip pain and a referral to the H2HH caseworker was received from an OT during the morning ward round in the hospital. The OT was concerned about the stairs in Mr V's property and requested a joint home visit with the H2HH caseworker.

During the joint visit, the OT identified that Mr V would benefit from a stairlift as there was no space downstairs for a bed and Mr V was in the habit of sleeping in his armchair which was proving detrimental to his health as he couldn't raise his legs. The OT also requested a Keysafe be fitted.

During the visit the caseworker carried out a Healthy Homes Assessment and identified the need for a flashing doorbell, large button telephone and a referral to the fire service for smoke alarms.

The Care & Repair handyperson fitted the flashing doorbell and Keysafe the next day. A contractor fitted a stairlift, funded from the H2HH capital fund, 4 weeks after the home visit and Mr V returned home from hospital the following week after an 8 week stay in hospital.

Without the H2HH capital fund which paid for the stairlift, a DFG (Disabled Facility Grant) application would have been needed to be made to the local authority which would have taken many months to process.

Mr V has been able to return home from hospital in a safe, timely manner. His home is safe and adapted for his needs, hopefully preventing future falls and further hospital admissions.



Gofal a Thrwsio Gwynedd a Môn Hospital to a Healthier Home Service (Ysbyty Gwynedd)

Ms B (68yrs) was admitted to hospital with a broken hip resulting in a replacement hip operation. The hospital OT referred her to the H2HH caseworker as part of the discharge planning.

A home visit was arranged with Ms Bs family to the property to allow the caseworker to conduct a Healthy Homes Assessment, especially the stairs, as Ms B had said they were “quite hard to negotiate to the top”.

On the visit the caseworker met the family, who initially wanted Ms B to remain in hospital to address other issues that they implied she had. The caseworker discussed the matter with them, and the fact that Ms Bs wish was for the work to be carried out so that she could return home. This was eventually agreed, and the Agency arranged for the fitting of a new bannister rail and grab rails to help ensure safe use of the stairs by Ms B who was discharged from hospital a week later.

Having a “what matters” conversation prior to hospital discharge helped Ms B return to a safe and suitably adapted home.



Thank You

We would like to take this opportunity to thank the NHS and Care & Repair staff we interviewed during this evaluation:

Morrison Hospital

- Ann Carpanini, Occupational Therapist Team Lead
- Lucy Anderson, Occupational Therapist

Neath Port Talbot Hospital

- Susan Jones, Head of Operational Services

Royal Gwent and St Woolos Hospitals

- Jenna Mulholland, Physiotherapist
- Sarah Pocock, Discharge Coordinator

Prince Philip Hospital

- Sarah Collins, Occupational Therapist
- Steve Seagull, Specialist Discharge Advisor

Prince Charles Hospital

- Joanne Santos Matthews, Team Lead Occupational Therapist
- Ryan Williams, OT Technician

Royal Glamorgan Hospital

- Karen Williams, Team Lead Occupational Therapist
- Nicole Jones, Occupational Therapist

Stay Well @ Home Service Cwm Taf Morgannwg

- Emma Ralph, Team Manager
- Lisa Tee, Therapy Technician

Wrexham Maelor Hospital

- Beverley Evans, Discharge Support Nurse
- Jenny Jones, Social Worker based in the hospital
- Kelly Peers, Discharge Coordinator for Wrexham Central District Nurse Team
- Pauline Dobson, Discharge flow lead for Wrexham area

Ysbyty Glan Clwyd

- Cate Sheldon, Occupational Therapist ADT Team Glan Clwyd Hospital
- Ceri Jones, Occupational Therapist ADT Team Glan Clwyd Hospital
- Lavinia Tilley, Occupational Therapist Acute Stroke and Rehab Ward Ysbyty Glan Clwyd
- Jessica Hammond, Occupational Therapist Acute Stroke and Rehab Ward Ysbyty Glan Clwyd

Ysbyty Gwynedd

- Julie Jeffries, Hospital Social Worker
- Cally Haines, Complex discharge coordinator
- Sharon Thomas, Discharge Quality Matron for the area West Ysbyty Gwynedd
- Vicky Birc, Complex Discharge Coordinator

Care & Repair Hospital to a Healthier Home Caseworkers

- Lynette Catto, based in Prince Philip Hospital
- Carol Williams, based in Morrison and Neath Port Talbot Hospitals
- Meinir Woodgate and Cath Dixon based in Princess of Wales Hospital
- Julia Burgess, Jemma Lewis and Kelly Gwilym based in Prince Charles and Royal Glamorgan Hospitals
- Beatrice Roberts, based in Llandough Hospital
- Gethyn Pelope, based in Royal Gwent Hospital and St. Woolos
- Kathryn Massie and Jacqui Valentine, based in Wrexham Maelor and Chirk Hospitals
- Danielle Hankey & Daryl Hughes (Technical Officer) based in Ysbyty Glan Clwyd
- Wynn Roberts based in Ysbyty Gwynedd

Watch our two digital stories...

...which feature the experiences of staff directly involved in delivering the Hospital to a Healthier Home pilots.

In this story you'll hear from NHS staff from across Wales who talk about the positive impact Hospital to a Healthier Home has made to their working day.

In this story you'll hear from Care & Repair Caseworkers who talk about how their work has helped older patients return home from hospital safely.



“...having Jemma (H2HH Caseworker) here has opened our eyes to a whole new range of services we can utilise to get patients home.”

“...we've built relationships with hospital staff so they have a better understanding of what we (Care & Repair) are about... we're not just a grab rail service.”



**Care & Repair
Gofal a Thrwsio**

www.careandrepair.org.uk

find us on



To contact your local Care & Repair Agency

0300 111 3333

Care & Repair Cymru

029 2010 7580

Report and digital stories produced by Care & Repair Cymru
June 2019

Every effort has been made to ensure that the information in this document is accurate. However, Care & Repair Cymru does not accept any responsibility for errors or omissions.