



Partnerships with NHS providers to improve hospital discharge and community reablement

Introduction

Joint working between housing and health can reduce pressures on the NHS and improve an individual's overall wellbeing. Housing associations are keen to explore ways of working effectively with the NHS and public health to address unmet health needs among tenants and the communities in which they operate. Some housing associations are also starting to recognise new business opportunities in working with health commissioners and providers in developing integrated models of health, care and support, positioning themselves as healthcare providers or entering into joint ventures with NHS Trusts.

This briefing is one of four documents entitled **Connecting Housing and Health**. These aim to support housing associations in shaping a health offer and providing learning on health commissioning and NHS providers. They sit alongside the **Routes into Health** briefings, which explain the new NHS structures and ways to engage with health.

This briefing provides:

- An overview of the increase in emergency hospital admissions and the resulting pressures on the health system
- Learning on the priorities for health commissioners and NHS providers in improving hospital discharge
- An outline of the different approaches housing associations can take to develop a health offer

Context

Demand on NHS hospital resources has increased dramatically over the past 10 years with a 35% increase in emergency hospital admissions, yet there are a third fewer general and acute beds than there were 25 years ago¹. Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year². Addressing the continuous rise in emergency hospital admissions is not the only challenge facing the NHS. NHS Trusts are consistently dealing with patients who are more acutely ill and with complex needs and who are becoming more resource intensive and expensive to treat.

To try to manage the increasing flow of patients, hospitals have decreased the average length of stay. However, the fall in length has now flattened out and among patients aged over 85, it has started to rise³. Nearly two thirds of people admitted to hospital are aged over 65 years⁴ and an increasing number of these patients are frail, and either exhibit signs of, or have a diagnosis of, dementia.

¹ Imison C, Poteliakhoff E, Thompson J. (2012), Older people and emergency bed use. Exploring variation. London: King's Fund.

² Health and Social Care Information Centre - <http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance>

³ Royal College of Physicians (2012), Hospitals on the edge? The time for action.

⁴ Cornwell J et al. (2012), Continuity of care for older hospital patients: a call for action. King's Fund.



Older patients are also more likely to be readmitted to hospital within a short time of discharge and to be moved around within the hospital⁵. The homeless hospital discharge fund was set up by Government to seek solutions to increasing number of readmissions for people who are homeless. More than 70% of homeless people are being discharged from hospital back onto the streets, damaging their health and resulting in significant levels of readmission⁶. Hospitals are simply not equipped to deal with this rapid rise in complex and multiple needs.

One of the biggest areas of clinical and cost pressure for the NHS is infections, including urinary tract, cranial and chest infections which are a significant burden on primary and secondary care resources. Frequently patients are admitted back to hospital or have their hospital stay prolonged solely to receive intravenous drugs. Other key areas for delayed discharge include: a need for rehabilitation or physiotherapy; care procedures such as dressing and cleaning wounds; medication error; injections, and infusions⁷. These can all be delivered in the community, but the lack of appropriate services often result in care delivery in a hospital setting, which is expensive and distressing for the individual⁸.

The NHS has been slow to develop effective alternatives to admission that are available seven days a week and to which even the most complex cases can be transferred for further care. Commissioners and providers need to design integrated services, providing individuals with the care and support they require, in the most appropriate care settings, and at the right time. This last point is particularly relevant as we know that up to 40% of patients who die in hospital – could have potentially been cared for elsewhere (including their own homes)⁹.

The NHS perspective

As a result of the Health and Social Care Act 2012, NHS England and Monitor have overall responsibility for the NHS Payment system which is based on an agreed national tariff for different types of inpatient, out-patient and primary care¹⁰. NHS Trusts are funded through a payment by results system, which rewards efficiency and quality. There is a nationally set price or tariff for each procedure based on an average of all hospital costs for that procedure. There are separate tariffs for elective and emergency care.

As demand for urgent and emergency care continues to rise, NHS Trusts are concerned about their capacity to maintain and improve quality standards¹¹. They are experiencing such high levels of unplanned admissions that they are unable to take on elective patients, leading to NHS waiting lists reaching a five-year high at 2.9m patients¹². The rise in emergency admissions indicates a higher level of complex need amongst patients and a lack of appropriate care outside the hospital. The tariff carries a marginal rate for emergency admissions, which has transferred a large degree of risk for emergency care onto acute trusts by reducing their income for emergency patients above the baseline. If acute trusts exceed a certain level of unplanned admissions, they get a reduced tariff of up to 30%. Housing associations need to be aware of the implication of the tariff: an offer focused on improving hospital discharge may not be attractive to an NHS provider if they have no way of managing the flow of unplanned admissions. Hospitals will also not receive payment for emergency readmissions within 30 days of discharge following a planned admission, and all other readmissions within 30 days of discharge will be subject to locally agreed thresholds.

⁵ Ibid.

⁶ Homeless Link, St Mungo's and Inclusion Health (2012), Improving Hospital Discharge for Homeless People.

⁷ Bupa (2014), Taking the pressure off: the opportunity for home healthcare in today's NHS.

⁸ Ibid

⁹ Cooper et al. (2009), Caring to the end? A review of the care of patients who died in hospital within four days of admission. NCEPOD.

¹⁰ Monitor (2013), 2014-15 National Tariff Payment System. A Consultation Notice.

¹¹ NHS Confederation (2013), Response to the emergency admissions marginal rate review.

¹² <http://www.theguardian.com/society/2013/aug/15/nhs-hospital-waiting-lists>.



This is to ensure that, wherever possible, hospitals have good discharge arrangements in place to avoid readmissions. Readmissions currently cost the NHS £2bn a year with approximately 14% of patients readmitted within one month of discharge¹³. The vast majority of those readmissions are for older people¹⁴.

Acute trusts are therefore left to deal with more patients, at a lower cost, where the only real way to make investments is to shift resources so as to deliver greater value from the funding available. They feel limited in their ability to curb the fast flow of unplanned admissions. This provides an opportunity to housing associations to offer community-based services to reduce demand for A&E and improve discharge, freeing up the capacity needed in hospitals to deal with more acutely ill patients.

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So far, the way that the funds from the marginal rate have been collected and reinvested hasn't been clear. The 2014-15 National Tariff has recognised this and seeks to improve transparency and collaboration¹⁵. Specifically, they propose to make two important changes to the rule under which NHS trusts are paid 30% of the tariff price for each emergency admission over an agreed baseline, with the remaining 70% being retained by commissioners to invest in keeping patients out of hospital. Firstly, where there have been significant local increases in emergency admissions outside the control of NHS Trusts, commissioners will be required to agree a revised baseline before the marginal rate kicks in. Secondly, NHS England will ensure that the money retained by commissioners through the

application of the rule will be spent transparently and effectively to enable more patients to be treated in community settings.

Clinical Commissioning Groups (CCGs) are struggling to reinvest any savings in community-based health services such as reablement and post-discharge support because the demand for hospital-based secondary care is so great. At the same time, community healthcare trusts have received a lower tariff increase than acute trusts, setting unequal starting points for acute and non-acute care. This makes the process of commissioning whole-service care even more difficult. If housing associations viewed the NHS as business partners, rather than commissioners of healthcare, they could partner up to bid for contracts, providing a strong integrated care package. Care and support commissioners are also looking for ways of making existing resources more sustainable and funding go further. The Better Care Fund¹⁶ does provide some opportunity to address this, particularly when local NHS providers are so keen to explore ways to manage the flow of patients and prevent readmission.

Developing a health offer

Before developing a health offer, housing associations need to assess their current services, understand local health pressures and priorities, and decide which approach fits strategically with the direction of their organisation. Some housing associations will be focused on improving the health needs of their existing tenants, working closely with NHS providers and commissioners to raise awareness of unmet need and how to meet that need. A housing association may need to invest their own resources in a pilot model to demonstrate that the idea has the potential to deliver the desired outcomes in cost-effective ways. Other housing associations will be interested in developing their organisation as an integrated healthcare provider.

¹³ NHS Institute for Innovation and Improvement, http://www.institute.nhs.uk/scenariogenerator/tools/reduce_readmissions.html

¹⁴ Cornwell J et al. (2012), Continuity of care for older hospital patients: a call for action. King's Fund

¹⁵ <http://www.monitor.gov.uk/NT>.

¹⁶ Go to: <https://www.gov.uk/government/publications/better-care-fund>



Either way, this is about developing a new service offer to meet health outcomes frameworks. Housing associations should ensure that there is a clear service offer that is measurable, marketable and tradable to NHS providers. The organisation should be clear about whether it is looking to be a sub-contractor, to be a partner in the redesign of a particular pathway or whether they have the skills and balance sheet strength to be part of a joint venture.

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Health commissioners do not have the solutions to achieve preventative, integrated care, and large scale transformation of the health system will take years to achieve. An NHS trust will want to see greater efficiencies in the delivery of care to ensure they maintain a steady flow of patients, regain a focus on elected admissions and, for some, retain an acute footprint in their local area in an attempt to assert more control over the types of patients they see arrive in hospital. With this in mind, it is important that housing associations look more towards the providers of NHS services, than to the commissioners. Reconfiguring the supply chain is important, and only the suppliers can come forward with new and innovative solutions. NHS Trusts are the major providers of healthcare in this country. Housing associations should recognise this as an opportunity to demonstrate to NHS providers not only their skills and expertise, but also their capital and access to finance that can enable NHS trusts to transform existing services. Housing associations may need to be prepared for a long-term investment of time and effort to build engagement plans and relationships with health. It may take years of investment and evaluation to demonstrate measurable impact on the causes of health inequality and poor health outcomes.

This briefing sets out the following approaches to health:

- 1. Integrated care and support at home following discharge**
- 2. Intermediate care in the community following a hospital stay**
- 3. Reablement in the community to manage a new condition and support self-care**

1. Integrated care and support at home following discharge

Traditionally, housing associations have developed models of hospital discharge support, which sit alongside hospital reablement teams or operate independently to provide care and support to enable someone to return home quickly after time in hospital. Housing associations know that 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. Furthermore, many of the health conditions experienced by older people – such as heart disease, respiratory conditions, arthritis, rheumatism – are linked to particular housing conditions¹⁷. Hospital discharge support has focused on ensuring the home is ready for the patient to return home, and that the support is there for them to get back to living independently as quickly as possible.

However, the main causes of delayed discharge are infection, physiotherapy, injections and ongoing medical care procedures, which can all be delivered in the community¹⁸. By drawing in services from a local NHS provider of community healthcare, housing associations could deliver a model of integrated care, potentially saving the NHS £390m in a year¹⁹.

¹⁷ Hospital to Home Resource Pack: http://www.housinglin.org.uk/hospital2home_pack/

¹⁸ Bupa (2014), Taking the pressure off: the opportunity for home healthcare in today's NHS

¹⁹ Care and Repair England (2013), Hospital to Home Resource Pack: http://www.housinglin.org.uk/hospital2home_pack/



This would enable them to offer acute trusts a service, including discharge, which encompasses healthcare procedures as well as care and support. To do this, a housing association needs to be able to share risk with the NHS, which will enable them to take on any patient and formalise a partnership agreement. For more details on how to develop the governance structures required for this, visit the Federation's [health partnership hub](#).

2. Intermediate care in the community following a hospital stay

80% of emergency admissions whose length of stay exceeds two weeks are aged over 65 years. By focusing on reducing length of stay for older people, it is possible to reduce use and cost of hospital beds²⁰. If all areas achieved the rate of admission and average length of stay of those in the lowest 25th percentile, 7,000 fewer hospital beds would be needed across England²¹. Housing associations could enter into a joint venture with the NHS, making use of an out-of-use hospital ward or nearby NHS-owned site, to build a virtual care ward to which the Trust can quickly move patients with complex needs to recover and get used to any newly diagnosed conditions (such as dementia) before moving home. For some of these customers, home will not be an option, so an attractive offer for an acute trust is a development which provides a mixture of intermediate care and nursing home accommodation. To develop this model, a housing association needs to develop an integrated service, which combines the trust's clinical expertise with the housing association's housing and support expertise.

Formalising a partnership with the NHS means buying in NHS services – such as care coordination, medical prescription, psychiatric and/or geriatric consultancy – and selling them back to the Trust as a package of integrated care.

²⁰ Poteliakhoff and Thompson (2011), Emergency bed use: what the numbers tell us, King's Fund.

²¹ Imison et al (2012), Older People and Emergency Bed Use, King's Fund.

“Housing associations could enter into a joint venture with the NHS, making use of an out-of-use hospital ward or nearby NHS-owned site, to build a virtual care ward.”

Employing nurse practitioners will reduce costs, increase flexibility and improve the capacity of the team. This may also require the buy-in of social care commissioners to cover the care elements of the services either through individual budgets or self-funders. A formal partnership with an acute trust would also require a shared approach to risk and management of the service through integrated data management systems and clear incident reporting. A close clinical relationship means that the service can accept anyone irrespective of their symptoms or diagnosis. For more detail on how to develop the governance structures required for this, visit the Federation's [health partnership hub](#).

3. Reablement in the community to manage a new condition and support self-care

Intermediate care services, including rehabilitation and reablement, have the potential to reduce length of stay by speeding up hospital discharge, but also by preventing deterioration that could lead to a hospital stay. Community reablement can make it possible for people to stay in their own homes for longer, reduce the need for home care and improve outcomes for service users²².

²² King's Fund (2014), Making best use of the Better Care Fund: Spending to save?



Rehabilitation and reablement provided at home is cheaper than hospital care and in many cases services provided at home are preferred by service users. However, access to rehabilitation and reablement outside acute hospitals varies significantly²³.

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It is vital that there is capacity to offer rapid responses in the community that offer an alternative to a hospital stay. Housing associations could deliver admission prevention schemes or virtual community wards to deliver care, monitor conditions and support in the community, and at home for the management of long term and/or ambulatory care sensitive conditions. To do this, housing associations can offer up existing assets, such as repurposed schemes or current voids in a nearby scheme to take on patients with complex needs. Working in partnership with an acute Trust, they could flex hospital staff across to those sites to deliver a portable accident and emergency service. A teaching hospital may even wish to base medical students in voids to provide informal healthcare in return for free accommodation. In day-to-day practice, housing associations delivering care and support should look to make good use of district nurses to deliver training to their staff in developing low-level healthcare skills to ensure they avoid unnecessary admissions, ensuring, for example, that care staff understand how to prevent pressure ulcers or to manage falls more effectively.

²³ Dr Tony Smith et al. (2013), Exploring Differences between Different Intermediate Care Configurations – A Review of the Literature, NHS Benchmarking.

Useful resources

The National Housing Federation’s report, ***On the Pulse***, explores how health and social care commissioners can work with housing providers to enable older people to manage changes in their health, to maximise independence and reduce the need for costly interventions.

The King’s Fund report, ***Making our health and care systems fit for an ageing population***, sets out a framework for improving care for older people, presenting key evidence about works and giving examples of local innovations.

The King’s Fund briefing on the Better Care Fund, ***Making best use of the Better Care Fund***, offers an evidence-based guide to aid the discussions between clinical commissioning groups, local authorities and health and wellbeing boards on use of the fund.

Improving Hospital Admission and Discharge for People who are Homeless is a joint report from Homeless Link and St Mungos produced to inform the National Inclusion Health Board to identify what more must be done to prevent people at risk of rough sleeping being discharged from hospital without accommodation.

Examples of housing associations developing partnerships with health can be found on the case study section on the National Housing Federation **Health Partnership Hub**.

The Federation has produced a **briefing paper on the creative use of NHS estate** which outlines the disposal process for NHS estate and sets out possible approaches housing associations can take to access land.

The Federation has produced a **briefing paper on quality governance** which explains the key elements of good quality assurance for partnering with NHS providers.