NATIONAL HOUSING FEDERATION

Home from hospital

How housing services are relieving pressure on the NHS

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Housing LIN
Connecting people, ideas and resources

Contents

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Introduction

This report sets out the impact of delayed transfers of care, the implications for the NHS and the solutions that are offered by housing providers, including the cost benefits these solutions provide to the NHS.

Delayed transfers of care, often referred to as 'bed-blocking', occur when a person is assessed as ready to leave hospital and is still occupying a hospital bed. According to NHS England[1], a patient is ready to depart when:

a) A clinical decision has been made that the patient is ready for transfer

b) A multi-disciplinary team decision has been made that the patient is ready for transfer, and

c) The patient is safe to discharge/transfer.

The main groups affected by delayed transfers of care are older people, people with mental health problems and people experiencing homelessness. The number of recorded delayed transfers of care has increased substantially over the past few years. According to National Audit Office official data[2], between 2013 and 2015 there was a 31% increase in bed days taken up by delayed transfer patients in acute hospitals.

Delayed transfers of care are costly for the NHS. The National Audit Office[3] (NAO) estimates that the NHS spends around £820m a year treating older patients who no longer need to be there. The NAO notes that *"Without radical action to improve local practice and remove national barriers, this problem will get worse and add further strain to the financial sustainability of the NHS."*

Housing providers are ideally placed to relieve pressure on the NHS, and have developed a joined up plan to extend and increase the services they offer to help people out of hospital, into a suitable home with the right support.

There are four key components to this sector-wide offer:

1. An increase in the number of housing step down units or beds nationally which can facilitate efficient discharge from hospital.

2. More housing staff seconded to discharge teams locally to coordinate and speed up transfers of care.

3. Care packages to help prevent people from needing to go into hospital in the first place and to reduce readmissions.

4. A commitment to facilitating robust evaluation of this solution.

This offer will ensure that people are getting the care and support they need, and will free up the NHS to deliver its services to those who need them most.

"Without radical action to improve local practice and remove national barriers, this problem will get worse and add further strain to the financial sustainability of the NHS."

National Audit Office

[1] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf

[2] Discharging older patients from hospital' (2016), National Audit Office

[3] ibid

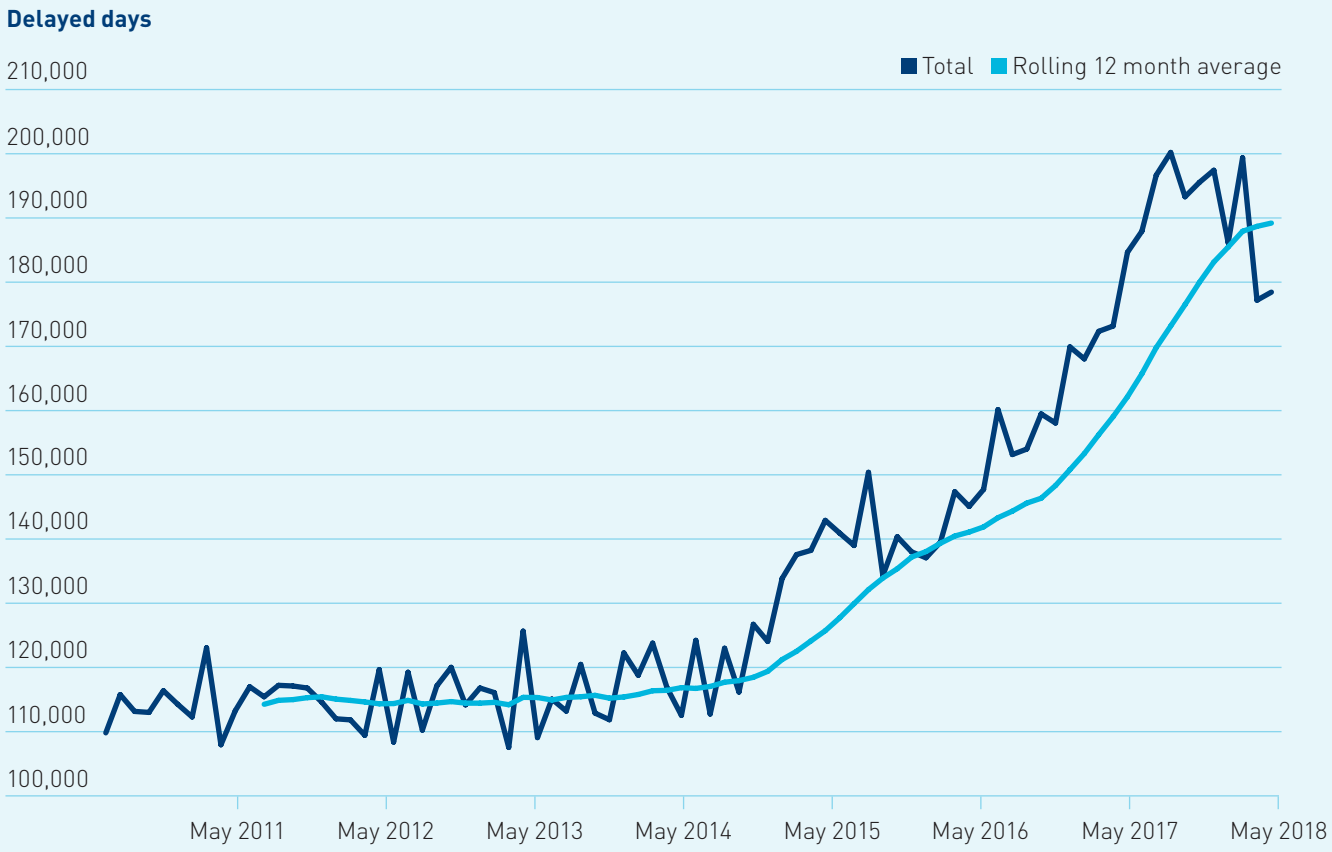
At least a fifth of NHS costs are thought to be spent on end of life care[4], highlighting the financial impact of preventing patients being admitted to hospital unnecessarily at the end of life and ensuring the earlier discharge of terminally ill patients who can be better supported at home.

Delayed bed days occur when a patient is delayed after they are medically fit to be transferred/discharged. There were 456,447 delayed days in 2016-17 – this is a huge increase of 45.3% on the previous year which is attributed to "awaiting care package in own home"[5].

The 12 case studies featured in this report highlight examples where housing providers have prevented unnecessary hospital admissions and avoided or reduced delayed transfers of care through early and timely interventions.

From the evidence presented in this report it is clear that there is a strong case, both in terms of the benefits for the people assisted and the cost benefits provided to the NHS, for significantly increasing the scale and scope of the housing offer.

Total number of delayed days



[4] Demos 'Dying for Change' report (2010)

[5] House of Commons library briefing paper 7415, Delayed Transfers of Care in the NHS

The housing offer

It is estimated that over 30% of households in housing association accommodation are aged 60 or over or living with a disability[6].

There is now a growing evidence base[7] and clear policy drive[8] that demonstrates how housing associations and health commissioners can and are working together to avoid or reduce unnecessary hospital admissions, lengths of stay in hospital, delayed transfers of care and readmission rates.

A wide range of examples of services[9] supplied by housing providers are highlighted in this report. These show the cost benefits provided to the NHS, and the positive outcomes for the people who are assisted. It is not just tenants who can benefit from these services – the housing offer also applies to the general public.

These examples demonstrate how housing providers across England are successful in preventing unnecessary hospital admissions and avoiding or reducing delayed transfers of care through early and timely interventions.

They demonstrate a diversity of housing and health services including:

- providing a temporary home, i.e. 'step down', for people coming out of hospital who cannot return to their own home immediately
- enabling timely and appropriate transfers out of hospital and back to patients' existing homes
- providing a new home for people whose existing home or lack of housing mean that they have nowhere suitable to be discharged to, and
- keeping people well at home who would otherwise be at risk of being admitted or readmitted to hospital.

"If one were to scale up this work it would be massive across the UK. Savings of this magnitude would go a long way towards funding 7-day secondary care".

Dr Mark Holland,
President of the Society for Acute Medicine

[6] In our Lifetime, National Housing Federation (2010)

[7] The Quick Guide: Health and Housing, produced by NHS England's Better Use of Care at Home working group, is a reflection of both the latest in policy development around delayed discharge and the difference that housing can make, as well as providing a range of examples

[8] As part of the drive for more integrated approaches, the Health and Housing Memorandum of Understanding to support joint action on improving health through the home (MoU) was agreed between government departments, agencies such as ADASS, NHS England, Public Health England, and the Homes and Communities Agency, and other housing and health sector organisations in 2014, including the NHF and the Housing LIN. https://www.gov.uk/government/publications/joint-action-on-improving-health-through-the-home-memorandum-of-understanding

[9] The case studies have been identified from NHF members; NHS organisations including CCGs and NHS Trusts; local authorities; the Housing LIN

Case study

Curo – Step down scheme

The Curo Step Down scheme in Bath, North East Somerset provides accommodation for vulnerable adults who are ready to be discharged from hospital but cannot return home.

The service offers six self-contained flats or bungalows with dedicated support and access to 24-hour care teams, allowing people to see how they manage with a care and support package in a place like their home. Step down units are provided by Curo, within or adjacent to extra care hubs. The service is provided on a 'free at the point of delivery' basis and is available seven days a week for periods of time agreed at the point of discharge.

Curo's step down service can offer transport from hospital, avoiding delays in access to non-emergency ambulance services. The emphasis is on relearning skills to improve future independence, supporting people to move into appropriate or adapted homes and reducing the risk of re-admission.

Outcomes

- The service commenced at the beginning of 2014. In 2016/17, 84.6% of clients were discharged to somewhere other than residential care.
- Every year, between 20-30 people are discharged from hospital and enabled to live independently as a result of six step down units.
- In 2016/17 the service saved 1,854 excess bed days.
- The six step down units provided a cost benefit of £561,762 for the NHS in 2016/17 by enabling discharge of patients.

The **six step down units** provided a cost benefit of **£561,762** for the **NHS** in 2016/17.

Case study

Mansfield District Council

Mansfield District Council's Advocacy, Sustainment, Supporting Independence and Safeguarding Team (ASSIST) service has received a National Institute for Health and Care Excellence (NICE) Shared Learning Award. The organisation has recently been awarded a National Institute for Health and Care Excellence (NICE) Shared Learning Award for its ASSIST early discharge scheme. This service aims to expedite discharges from the Kings Mill Hospital in Mansfield, from residential care and to reduce or prevent avoidable admissions to hospital or residential care.

ASSIST provides a 360-degree service to improve the transition of patients from hospital to home. Housing staff work on the wards at King's Mill Hospital to provide a triage service for people who are medically well enough to go home but need extra help to do so. The team also works on the emergency admissions wards to identify those with social needs to free up medical staff time. Interventions range from simple adaptations to complex rehousing cases.

This project is regarded as one of the top four projects in the country for supporting the NICE NG27 1.5 guidance[10] on reducing delayed transfers of care and improving discharge rates.

Outcomes

An independent evaluation by Nottingham Trent University of the ASSIST scheme concluded that:

- There was clear evidence that the scheme benefits the efficiency of hospital discharge and reduces the burden on hospital and social services staff.
- Between July 2015 and April 2016, of 1129 admissions, 5078 excess bed days were saved across Mansfield, Ashfield and Newark.
- On average, for each admission, 4.5 bed days were saved with an average saving of £936 per admission.
- Total savings in terms of the reduction of acute bed days was £1,371,060.

Total **savings** in terms of the **reduction** of acute bed days was **£1,371,060.**

[10] https://www.nice.org.uk/guidance/ng27/chapter/recommendations

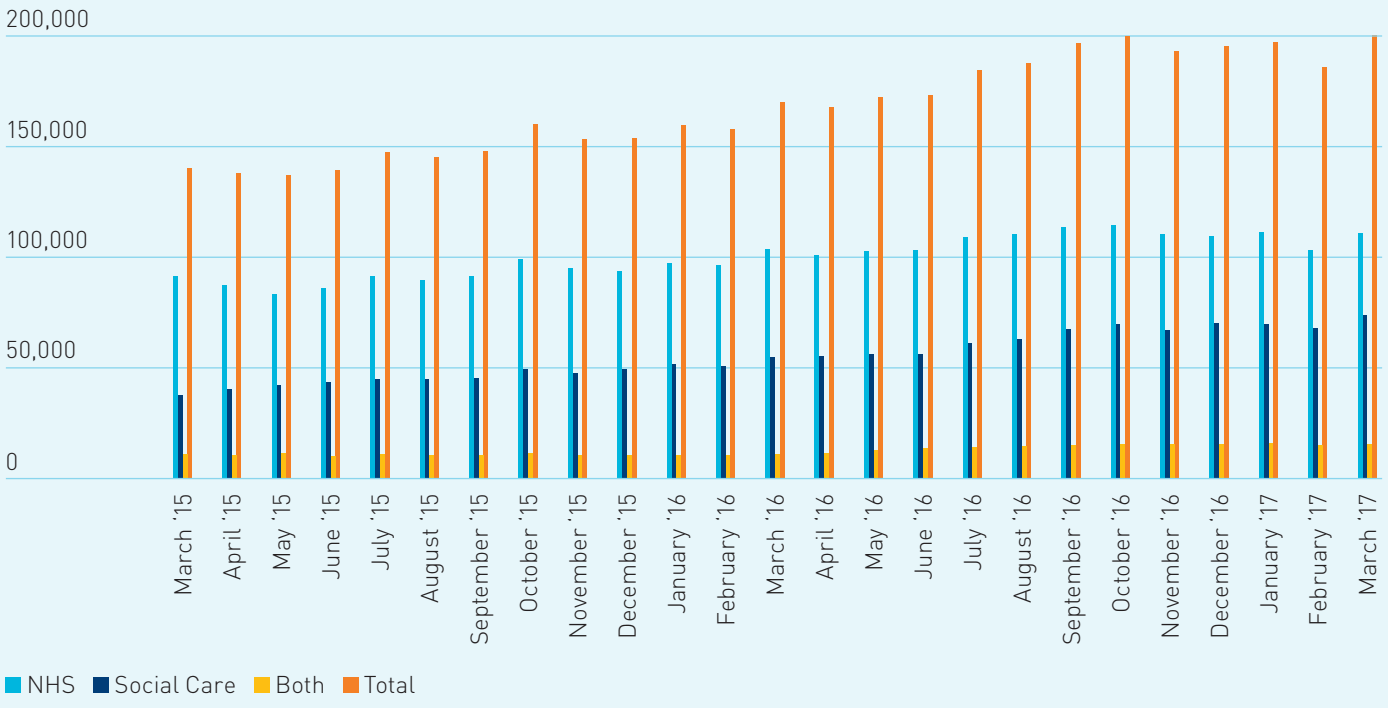
The scale of the problem
How housing providers are helping

Over the period 2013-2015, the number of delayed bed days rose by 31%. In 2014/15 there were 1.6 million total delayed bed days in England, which averages at approximately 4,500 delayed transfers of care per day.

In addition, the National Audit Office estimates[11] that the number of older patients in hospital who are no longer benefitting from acute care is approximately 2.7 times higher than the figure for reported delayed transfers of care. This discrepancy is due to delays in people being assessed by clinicians, delays during treatment and inconsistencies in counting delayed transfers of care.

The table below shows that the overall monthly level of delayed transfers of care has been increasing over the period March 2015-March 2017.

Monthly delayed transfers of care figures March 2015-March 2017



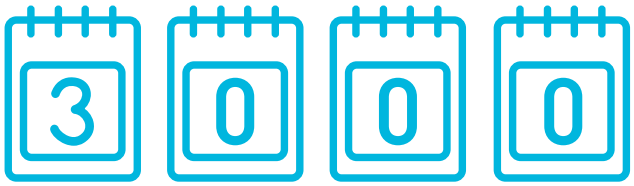
Source: https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/2016-17-data/

[11] ibid

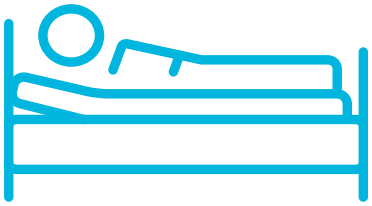
There are a range of reasons why a delayed transfer of care may occur, including when someone is:

- waiting for the completion of an assessment
- awaiting nursing home placement or availability
- awaiting residential home placement or availability
- waiting for a suitable care package to be put in place in their own home
- waiting for further non-acute NHS care
- awaiting community equipment or adaptations to be put in place.

Some of these reasons will be attributable to the NHS and others will be attributable to local authority social care. In 2015/16, 1.1 million delayed days were attributable to the NHS, an average of more than 3,000 per day.



In 2015/16, **1.1 million** delayed days were attributable to the NHS, an average of more than **3,000 per day.**



In **2014/15** there were **1.6 million** total delayed bed days in **England.**

Delayed days occur when a patient has been delayed one day after they were medically fit to be transferred/ discharged. Although the majority of delayed days are attributable to the NHS, delays attributable to local authority social care – for example, people waiting for a suitable home care package to be put in place or for a residential care home place to be found – have risen by 44% over the past two years[12].

NHS England's delayed transfers of care figures for 2015-16 show a marked rise in delays due to 'awaiting a care package in own home', up 62.1% in comparison with the previous year. There have also been increases of over 10% for 'awaiting completion of assessment', 'awaiting nursing home placement or availability', and 'awaiting residential home placement or availability'.

Housing association 'step down' services that utilise older people's housing schemes to enable a person to be discharged, such as in extra care housing, provide a solution to this problem.

[12] Delayed transfers of care in the NHS, House of Commons briefing paper (December 2015).

Case study

Wigan Council

Wigan Council operates a housing hospital discharge service. The purpose of the service is to:

- reduce delayed transfers of care across all wards and be part of a safe discharge planning process, and
- reduce unnecessary attendances and readmissions through Accident & Emergency (A&E) departments.

The service provides a specialist housing advisor to assist people with housing issues on admission to hospital rather than react when a housing problem is identified at the point of discharge from hospital.

The hospital housing advisor:

- has access to temporary accommodation in a crisis
- acts as first point of contact when issues arise where housing is a critical factor, and
- identifies housing solutions that meet the patient's needs.

Outcomes

- The service has delivered savings of £644,300 over a two-year period (2014/15 and 2015/16) based on 800 excess bed days saved. In 2016/17 the service saved £337,150 and 920 bed days.
- The person-centred approach delivered by the service means that the outcomes reflect the needs of specific clients, but with a consistent focus on reducing delayed transfers of care and reducing unnecessary attendances and readmissions through A&E.

The service has delivered **savings** of **£644,300** over a **two-year period based** on **800 excess bed days** saved.

Case study

Nottingham City Homes

Nottingham City Homes (NCH) provides a Hospital to Home (H2H)/Housing Health Coordinators (HHC) scheme which:

- supports people's transition from a reablement bed to self-care/supported living at home
- facilitates earlier discharge from hospital where inappropriate housing is the delaying factor in discharge
- provides early intervention in supporting people affected by poor or inappropriate housing
- improves the uptake of empty social housing properties for older persons in the city, and
- improves the health and wellbeing of people who are negatively affected by poor or inappropriate housing.

The service is funded by Nottingham City Clinical Commissioning Group (CCG).

Outcomes

An evaluation by Nottingham CCG was carried out to assess the outcomes and financial cost benefits of the HHC project. The project was launched as a 12-month pilot in November 2015, which was further extended until March 2017:

- The evaluation for the full period demonstrated that the service had generated savings of over £931,203 (£807,307 net) as compared to the alternative scenario in the absence of the HHC project.
- The evaluation estimated the net financial return on investment to be £6.40 for every £1 spent on the project, as a result of savings generated for local public-sector agencies (NHS, NCH and Nottingham City Council).
- For those people who had used the service, health outcomes and the ability to manage health at home have improved.
- Almost all (97%) H2H customers now report that they feel as safe as they would like to be, compared to only 18% who stated this in relation to when they were in their old home.
- Levels of social contact have improved. When living in their previous home, over half of respondents (58%) reported that they had little or not enough social contact with others. Since moving, 85% now have adequate or as much social contact as they would like.
- 91% feel more confident managing their health at home now, compared to 12 months ago.
- The service enabled citizens to live independently for longer, with less reliance on intensive care packages.
- Carers' quality of life has improved (nine were surveyed). This shows that overall satisfaction with their quality of life has increased from 3.1 out of 10 whilst their friend/relative was living in their previous accommodation, to 7.9 out of 10 now. This is a significant improvement in the quality of life of those caring for H2H customers.

The service generated **savings** of over **£930,000.**

Who is affected by delayed transfers of care
The housing response

Older people

There are more than 10.3 million older people over the age of 65 in the UK. This represents an 80% increase since the 1950s[13]. The population will continue to grow older, with the 65+ population expected to reach 16.9 million by 2035[14].

Patients aged 65+ in 2014/15 accounted for 62% of total bed days, and those with longer stays (of seven days or more) accounted for 52%[15]. Many had existing and complex medical conditions requiring particular consideration and care in planning discharge and aftercare.

Reducing how long older people stay in hospital can have benefits for both patients and hospitals, and for demand for social care in the community. Evidence shows that longer hospital stays for older patients can lead to worse health outcomes and an increase in their care needs on discharge[16].

The efficient use of hospital beds relies on there being a 'home' for people to be transferred to, in which any needs for recovery, ongoing support or plans for end of life, can be met. To enable a timely and effective hospital discharge means coordinating relevant people and services in the community. Housing providers are well placed to assist with this process due to their experience as landlords and managers of housing, and increasingly as providers of a range of care and support services.

The **population** will continue to **grow older**, with the **65+ population** expected to reach **16.9 million by 2035.**

[13] House of Commons Briefing, Rutherford, T. (2012) 'Population ageing: Statistics' www.parliament.uk/briefing-papers/sn03228.pdf
[14] Kings Fund 'Life expectancy' figures http://www.kingsfund.org.uk/time-tothink-differently/trends/demography/life-expectancy
[15] Health and Social Care Information Centre, Hospital episode statistics, 2014-15
[16] https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital-Summary.pdf

Case study

One Housing Group

One Housing Group's scheme at Roseberry Mansions in King's Cross, London, provides support for older people. The ten step down beds are provided within an extra care housing scheme that has 50 units in total. The service provides time-limited reablement in purpose-built apartments where people can relearn skills and get support from a team of occupational therapists, physiotherapists, social workers and support workers.

The purpose of the service is to:

- improve the quality of people's lives by enabling and reskilling them to be able to return home or to other appropriate accommodation in a sustainable way
- facilitate earlier hospital discharge and avoid unnecessary or repetitive hospital admissions
- prevent or delay the need for long-term residential or nursing care placements, and
- deliver significant NHS and adult social care savings.

Outcomes

An evaluation based on a 10 month period in 2014/15 showed:

- 57% of referrals came from acute hospitals and 43% from the community. People stayed on average for 41 days, just under the six-week limit.
- Savings were made of between £400 and £700 per person per week in excess bed days. Across ten apartments this equated to between £200,000 and £364,000 of savings per year to the NHS.
- The service has resulted in a 30% reduction in the size of care package people need when they return home, compared to those not receiving the service; these are cost benefits to the local authority.
- 95% of people who moved on from the step down service avoided moving to residential care.
- 20% of people were previously unknown to Adult Social Care; without a multi-disciplinary team assessment and a place to discharge to, these people would have been at greater risk of delayed transfer.

Savings were made of between **£400** and **£700 per person** per week in excess bed days.

The role and importance of housing in supporting people living with dementia to remain living in the community is widely recognised. However, the Alzheimer's Society's report, *Home Truths*[17], notes that there are significant difficulties linking housing, health and social care services and support, including the link between people with dementia having the right housing options in place to support timely hospital discharge. This is reinforced in the recently published dementia-friendly charter[18].

Case study

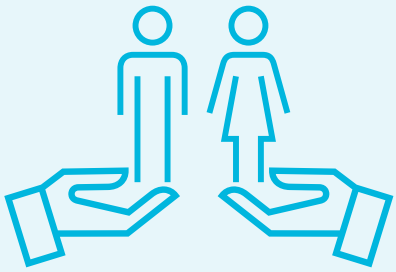
Alliance Living

Alliance Living's Home from Hospital service in North Somerset has a daily presence in Weston General Hospital and identifies patients who will need practical support to return home and remain safely at home, including people living with dementia.

The aim of the service is to support the safe discharge of patients from hospital through timely housing-related interventions. Discharge to a person's home environment supports independent living and helps to prevent future readmittance. The service supports any vulnerable person who would struggle to be discharged from hospital safely. Alliance Living has two dedicated full-time members of staff working in Weston hospital permanently.

Outcomes

- In 2016 the service supported 890 people.
- 297 excess bed days were saved – however, this is likely to be an underestimate due to under-recording during 2016. This equates to approximately £148,500 of savings in terms of excess bed days avoided.
- Over half the patients were contacted on the day of referral and 88.5% within 24 hours. This helped to reduce hospital staff time spent chasing referrals, responding to patient and family enquires and dealing with anxiety about delays and uncertainty.



In **2016** the service **supported 890 people.**

[17] Home Truths: Housing services and support for people with dementia, Alzheimer's Society (2012)

[18] Dementia-friendly Housing Charter, Alzheimer's Society (2017)

People with mental health problems

Healthwatch England undertook a substantial study[19] across England in 2015 in relation to people's experience of hospital discharge. The study was informed by the experiences of more than 300 people with a range of mental health conditions.

That study heard from people who had been kept in a mental health setting longer than necessary due to delays arranging their aftercare, housing and support. There was evidence that these delays were detrimental to people's psychological wellbeing, for example an unexpected delay in discharge could reduce confidence in managing outside of hospital. An estimated one in 20 bed days are used by people experiencing a delayed discharge in a mental health setting[20].

For someone in recovery from mental illness, a safe and secure home with a supportive environment provides the basis for them to recover, receive support and help, and ultimately return to work or education.

Case study

Havant Housing Association

Havant Housing Association provides step down beds and low-level support for people in psychiatric inpatient beds whose discharges are delayed. It provides these safe and inexpensive step down beds in the community setting alongside a low-level community support service.

It is offered to people whose discharge from the psychiatric acute ward in South East Hampshire is delayed because either there has been no accommodation to be discharged to or there has been a delayed transfer back to the patient's own authority.

A 'meet and greet' service is provided at the local psychiatric hospital to assist in creating a safe transition from hospital to the step down unit.

Outcomes

- Eight patients accessed the step down between July 2016 and January 2017.
- Total occupancy over that period was 179 days.
- Over this period the service generated cost benefits of £98,987 compared to the cost of people remaining in an acute psychiatric bed.

Between **July 2016** and **January 2017**, the service **generated** cost benefits **of £98,987.**

[19] Safely home: What happens when people leave hospital and care settings? (July 2015). Healthwatch England.

[20] Healthwatch England analysis of My NHS Mental Health Hospitals in England data at October 2014: http://www.nhs.uk/Service-Search/performance/Results?ResultsViewId=1014

People experiencing homelessness

The Healthwatch study identified that co-ordination between hospitals and housing services was a significant issue affecting homeless people's recovery after discharge. When it is agreed that someone should be provided with accommodation, it may only be temporary accommodation or a hostel, which may not be appropriate for somebody who has just been discharged from hospital.

Good coordination between health and housing services to ensure that homeless people have suitable accommodation to move into after a hospital stay can help to significantly improve their recovery and prevent or reduce readmissions to hospital.

Case study

Bournemouth Churches Housing Association

Bournemouth Churches Housing Association (BCHA) has staff based at three hospitals in Plymouth to support people who are homeless to be discharged from hospital to suitable housing in a timely way. Initially funded by the Department of Health, the hospital discharge service, as part of a wider Housing Information Signposting and Support service (HISS) provides advocacy and support to individuals who have come into hospital and are homeless or at risk of becoming homeless (patients with no fixed abode).

The overall objective of the service is to ensure that people are supported into appropriate accommodation and that they are engaged or re-engaged with appropriate health and community services. This group of patients typically have longer lengths of stay and more frequent readmissions than other groups.

Outcomes

BCHA ran a comparative study of a sample of 61 patients who accessed the service in 2015 at Derriford Hospital. The main measures were the number of hospital admissions and the subsequent bed days 12 months prior to, and 12 months after the intervention from the service.

- These 61 people were frequent users of the health service; in the 12 months prior to being supported by the hospital discharge service, together they were admitted 122 times and took up 595 bed days. In the 12 months after the intervention the same group were admitted 109 times and took up 457 bed days, a reduction of 23%.
- This equates to a reduction in bed days of 138, with an estimated cost of £400 per day[21] an annual saving estimate of £55,200 to the NHS.
- Due to the progress the service is making and the evidence above, it has recently been awarded an additional £35k a year to provide further support to those leaving hospital homeless.
- In the three years the service has been running, it has made significant progress in bringing various agencies together, providing appropriate accommodation and supporting people quicker with earlier referrals, all contributing to reducing admissions and bed stays and improving access to support.
- Across 2016, the service supported another 72 people in hospital. Based on the sample data of 2015, the service could save the NHS around £65,150 in 2017 (average of £905 of savings per individual).

The **service** could **save** the **NHS** around **£65,150** in 2017.

[21] data.gov.uk, 2015

Other issues related to delayed transfers of care

Housing providers delivering cost benefits

There are other problems associated with delayed transfers, such as a higher need for reablement after transfer, and increased risk of hospital-acquired infection.

This chapter sets out some of the areas affected and how housing providers have demonstrated that they can help reduce pressure on services and deliver cost savings.

Excess bed days

In 2015/16 the total cost of non-elective inpatient care in England was £16.7bn[22]. Non-elective care represents provision for people coming in to hospital in an unplanned way i.e. mainly via emergency departments. Where a patient stays longer in hospital than would be expected for their condition, this is described as an 'excess bed day'. In 2015/16 each excess bed day in an acute hospital bed occupied by someone admitted for non-elective care was costed at £306.

Housing providers are able to help facilitate timely hospital discharge, which reduces expenditure on excess bed days.

In **2015/16** the total cost of **non-elective inpatient care** in **England** was **£16.7bn.**

[22] Department of Health. Reference Costs 2015-16 (Dec 2016)

Case study

Staffordshire Housing Group

Staffordshire Housing Group provides a Hospital Discharge Support Service.

The objectives of the service are:

- to support prompt, safe discharge from hospital, reducing the number of delayed discharges, and
- to support people to live independently at home, reducing the number of readmissions resulting from lack of support after discharge from hospital.

To achieve this, the service provides:

- bedside assessments within two hours of referral, providing prompt and accurate assessment of each patient's needs before they go home
- a 'meet-and-greet' service, for patients requiring immediate support at home after discharge, and
- A home visit for all patients within 48 hours of discharge, ensuring patients are seen quickly after leaving hospital.

Outcomes

- An evaluation of the service showed that 92% of people using it were not readmitted to hospital within 30 days.
- The evaluation estimated that where 25% of patients are prevented from experiencing a delayed discharge, £320,000 p.a. of cost benefit in terms of saved excess bed days is achieved. Where the service prevents 10% of patients being readmitted into hospital, cost benefits of £130,000 p.a. are achieved.
- Patient satisfaction levels are high: 98% of patients say they would recommend the service to other people.

98% of patients say they would **recommend** the service to other people.

Accident and Emergency attendances

In 2015/16 the total cost of A&E services in England was £2.7bn[22]. Each A&E attendance costs £138 on average. Housing providers can provide immediate responses to people with emergencies and have staff who know the individual well. People diverted away from hospital reduce the costs and pressures on A&E services.

Case study

Oldham Council

Oldham Council provides reablement flats within extra care housing schemes.

It provides a short-term community reablement and assessment space to support improvement back to independent living for people who are ready to be discharged from hospital, either through residential care, intermediate care or for those who are unable to return to their previous home.

The service provides

- A wrap around well-being service providing a morning check, leisure activities, a 24 hour presence and emergency response on site, in addition to a reablement package of care.
- Court manager support and night concierge support.
- A reablement package from Oldham Care and Support Services, which initially provides four visits a day to support daily living skills and tasks, as well as building a person's resilience and independence.
- The opportunity for people to be supported to rehabilitate and learn and regain skills. This allows for a more realistic, formal assessment of skills and abilities, and as a result provides more relevant and successful next steps for the people using the service.

Outcomes

- In 2015/16, Oldham Council benefited from reduced costs in social care of £77,000 because people who had used the service did not require residential care, or had a reduced need for home care.

  For example, two people moved into the reablement flats from hospital. One of these people had three A&E admissions immediately before she moved to the reablement flats. She left the scheme equipped with more skills and was more stable – preventing the likelihood of admissions to A&E. This brought positive cost benefits: the service meant hospital discharge time was shorter, and it prevented and reduced her reliance on community, intermediate care and hospital services.

The **council accrued savings** of **£77,000** in 2015/16.

[23] ibid

Community nursing

In 2015/16 the total cost of community nursing services was £2.8bn[23]. Each contact (for example a home visit) costs £45 on average.

Where housing providers offer preventive services – e.g. adaptations that promote health and wellbeing; physical activities to improve circulation and control body weight, plus a healthy diet – these can reduce the incidence of chronic problems that require regular community nurse visits over several weeks, such as leg ulcers.

Case study

Radian Group

Radian Group provides 'Radian Adapt' for tenants who are older or have disabilities across its operating area (southern England) to enable people to remain independent in their own homes.

The aim is to deliver a comprehensive, effective and timely adaptations service to Radian residents to assist them to live independently and safely at home including avoiding delayed transfers of care and promoting older people's wellbeing. To do this Radian has employed its own in-house occupational therapists.

The Radian service is provided to tenants in its own housing and offers occupational therapy assessments for rehousing or local authority grant applications for major works. Radian uses its own trades teams or contractors to undertake minor adaptations up to the value of £1,500. Requests for simple items like grab rails, half steps and additional bannister rails are managed through customer services teams raising jobs which are completed within one week with the aim of preventing falls.

Outcomes

- Financed 1135 minor adaptations up to a value of £1,500.
- Processed 187 Disabled Facility Grant funded jobs (approximate total value £1m) in 19 different local authority areas.
- Radian's occupational therapists were involved in 404 adaptations cases.
- 93% of those residents surveyed were reported as being satisfied with their aids and adaptations.
- Provided adaptations to enable successful timely discharge from hospital.

93% of **residents surveyed** were **satisfied** with their **aids and adaptations.**

[24] ibid

Ambulance services

In 2015-16, the total cost of ambulance services in England was £1.7bn[24]. Of this cost, £1.2bn was for cases where the service 'sees, treats and conveys' i.e. takes the person to hospital. For each person who was given immediate treatment and then taken to Accident and Emergency, the average cost was £236.

Housing providers with staff who can respond swiftly to emergencies and provide increased levels of support where needed can reduce the numbers of cases where ambulances are called out and where ambulance crews decide they need to take somebody to hospital.

Case study

Gentoo Group

Gentoo Group in Sunderland provides a service to enable older people to remain independent in their own homes.

This service is offered to older people living in any type of housing and aims to prevent people from entering institutional care, losing tenancies or homes and to support those older people who are at most risk of admission to hospital.

Outcomes

- During 2015-16, 2,013 older people were supported by the service and continued to live well at home.
- For the financial year 2015-16 a social return on investment (SROI) assessment identified potential social value worth £1,422,039, and SROI has been calculated at a ratio of £3.41 of cost benefit for every £1 invested.

A social return on **investment** (SROI) assessment **identified potential** social value worth **£1,422,039.**

[25] ibid

Next steps
Scaling up the housing offer

The case studies featured in this report clearly demonstrate the significant impact that housing services can have, both in making a real difference to people's lives by helping them to stay well for longer and in reducing pressure on acute services to help achieve substantial savings for the NHS.

Evidence from these existing schemes shows that they successfully reduce delays in discharging people from hospital and help to prevent unnecessary hospital admissions.

There is a strong case for increasing the scale and scope of the housing offer, and within the sector there are high levels of support for doing this. This would have significant cost benefits for the NHS. The savings achieved as a result of the individual schemes featured in this report represent a tiny fraction of the total cost savings that could be achieved if provision of these services was extended across the country.

Housing providers are ideally placed to do this, and have developed a joined up plan to extend and increase the services they offer to help people out of hospital, into a suitable home with the right support.

There are four key components to this sector-wide offer:

1. An increase in the number of housing step down units or beds nationally which can facilitate efficient discharge from hospital.

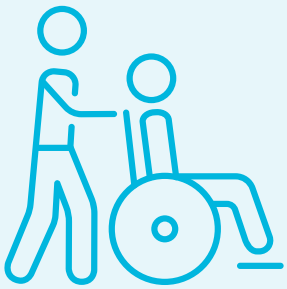
2. More housing staff seconded to discharge teams locally to coordinate and speed up transfers of care.

3. Care packages to help prevent people from needing to go into hospital in the first place and to reduce readmissions.

4. A commitment to facilitating robust evaluation of this solution.

This offer will ensure that people are getting the care and support they need, and will free up the NHS to deliver its services to those who need them most.

Given that the population of older people is set to rise steadily over the coming years, the potential savings that housing providers could make in the future will increase significantly.



One Housing Group's scheme for older people saves **£400 to £700 per person** per week. Based on an average of around **6,000 excess bed days** per month across England, this equates to savings to the NHS of **between £10m and £18m a month.**

Projected population by age, United Kingdom, mid-2014 to mid-2039

millions

Ages	2014	2019	2024	2029	2034	2039	% increase in age group 2014–2039
0-14	11.4	12.0	12.3	12.3	12.3	12.4	9%
15-29	12.6	12.4	12.3	12.6	13.2	13.5	7%
30-44	12.7	12.9	13.6	13.7	13.3	13.2	4%
45-59	13.0	13.4	12.9	12.6	12.7	13.4	3%
60-74	9.7	10.4	11.1	12.0	12.4	12.0	24%
75 and over	5.2	5.8	7.0	7.8	8.7	9.9	90%
75-84	3.7	4.1	4.9	5.4	5.6	6.3	70%
85 and over	1.5	1.7	2.0	2.4	3.2	3.6	140%
All ages	64.6	66.9	69.0	71.0	72.7	74.3	15%
Children	12.2	12.7	13.1	13.1	13.2	13.2	8%
Working age	40.0	42.0	43.0	44.2	44.3	44.6	12%
Pensionable age	12.4	12.2	13.0	13.6	15.2	16.5	33%
Old Age Dependency Ratio (people of pensionable age per thousand people of working age)	**310.4**	**290.4**	**301.3**	**308.1**	**344.1**	**369.6**	

Source: Office for National Statistics

Notes:
1. Children are defined as those aged under 16.
2. Working age and pensionable age populations based on state pension age (SPA) for given year.
3. Between 2012 and 2018, SPA will change from 65 years for men and 61 years for women, to 65 years for both sexes.
4. Then between 2019 and 2020, SPA will change from 65 years to 66 years for both men and women.
5. Between 2026 and 2027 SPA will increase to 67 years and between 2044 and 2046 to 68 years for both sexes. This is based on SPA under the 2014 Pensions Act.

NATIONAL HOUSING FEDERATION

The National Housing Federation is the voice of affordable housing in England. We believe that everyone should have the home they need at a price they can afford. That's why we represent the work of housing associations and campaign for better housing.

Our members provide two and a half million homes for more than five million people. And each year they invest in a diverse range of neighbourhood projects that help create strong, vibrant communities.

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