

If only I had known...

**Integration of housing help
into a hospital setting**



Document Purpose To provide evidence and information about policy drivers to support the integration of housing help into a hospital setting will illustrative practice examples

Title If only I had known... Integration of housing help into a hospital setting

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Target Audience Health professionals, planners, commissioners and providers of services for older people in the NHS (hospital and primary care), local authorities and the wider voluntary and housing sectors.

Description Policy drivers relating to NHS (eg QUIPP) and local authorities (service integration, ageing, public health and well-being). Practical examples of local initiatives to integrate housing help into a hospital setting.

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Making the hospital and housing link

Most people in hospital want to go home as soon as possible.

It is generally better for peoples' health if they are discharged once they no longer need hospital level medical care. Hospital beds are expensive¹ and in demand; so hospitals need to use beds as efficiently as possible.

Despite these factors, some patients remain in hospital for longer than may be clinically necessary². The Kings Fund³ has concluded that using hospital beds more efficiently, and closing some beds as a result, could save the NHS at least £1 billion a year, as well as delivering benefits for patients.

- More than 70 per cent of hospital bed days are occupied by emergency admissions.
- 10 per cent of patients admitted as emergencies stay for more than two weeks, but these patients account for 55 per cent of bed days.
- 80 per cent of emergency admissions who stay for more than two weeks are patients aged over 65.

This suggests that reducing emergency admissions and ensuring that these longer lengths of stay by older people are clinically necessary, rather than being due to delayed transfer of care, has the greatest potential for efficiency savings.

Enabling older people to return safely home from hospital is not only about efficient transfer of medical and social care. Faster discharge and reduced admissions may also require changes to older people's housing and living situations.

This critical factor of the housing connection to older people's admission into and time spent in hospital receives far less attention than the care link. It is the focus of this report.

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Foreword

The relationship between health and housing conditions has sadly and all too often been lost within the health service today. The drive to reduce length of stay in hospital can all too easily lead to patching up the most pressing problem yet leave the all important factors lying beneath this untouched or even unrecognised. Home assessments, an important opportunity for health staff to 'see for themselves' patients' living situations, have become much less frequent today, and all too often hospital staff go no further than establishing that a person can be washed, fed and toileted to determine a safe discharge.

Comprehensive holistic assessment of older or disabled people following a crisis is central to providing good care. Poor housing has a profound effect on physical, psychological and social health, and hence on quality of life, and this is amplified when the individual is coping with disability. This report highlights how most older people live in their own homes, yet those homes fail to meet basic standards of warmth and safety.

Housing options have become more complex and varied in our modern economy, and social workers often lack the time and knowledge to guide a person through the maze, resulting in placement in a care home because it is the fastest option rather than the best one for the person. Many examples here illustrate how better housing conditions can often lead to marked improvements in health, independence and quality of life.

The financial crisis facing health and social care in Britain today has led to a realisation that closer integrative working across organisations is imperative.

Within busy general hospitals, we need to ensure that staff understand the crucial link between poor or unsuitable housing and repeated admissions, and recognise when these problems exist. We then need to discover and develop new working partnerships so that advice and support around housing options can become a routine part of the way older people experience care after a hospital admission. Partnership working in the ways illustrated here provide model solutions, and we must hope that now each health economy will follow these examples to find their own solution.

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Purpose, Aim & Structure of this Report

This report aims to:

- Provide service planners, commissioners and policy makers with the rationale behind and ideas for integrating housing related help within the hospital setting
- Provide local organisations who are already delivering housing information, advice and assistance with ideas and examples that they can adapt to local needs and take to local hospitals and Clinical Commissioning Groups.

PART 1 looks at relevant policy issues

Tight public finances make partnership work across the NHS, social care, housing and the voluntary sector especially important. This section shows how housing advice, support and practical help for older or vulnerable people can contribute to current strategic and financial priorities for health and social care. This includes improving patient and carer experiences and outcomes for patients, especially around hospital discharge.

PART 2 looks at practical examples of putting ideas into practice

It looks at recent examples where housing advice, assistance and practical support has been integrated into hospital based arrangements, particularly around discharge.

These local projects were all linked to an initiative by Care & Repair England, entitled *'If only I had known...'*, which was supported by a grant from the Department of Health's Third Sector Investment Fund for Innovation, Excellence and Service Development (Box 1).

Box 1: About the Initiative: *'If only I had known...'*

The aim of the *'If only I had known...'* initiative was to enable older people, their families and carers to make an informed decision about future housing, care and support, either following hospital admission or where an older person has a long term health condition.

The project involved providing housing and care service information to patients, initially via a Going Home from Hospital pack combined with local Care & Repair (or similar voluntary sector service) staff undertaking regular 'ward rounds' to top up packs, talk to ward staff and take direct referrals from patients and professionals of older people who would like to discuss their housing and care options and /or who need practical housing related help in order to be discharged from hospital.

The initiative also aimed to enable older people with long term health problems to think through the housing implications of their condition and to make plans accordingly, particularly with regard to their future housing needs; for example, to adapt an existing home or move to somewhere more suitable whilst they are able.

At a Glance: Summary of Key Points

Why?

- Most older people in hospital want to go home as soon as possible and it is better for their health if they are discharged once they no longer need hospital level medical care. And yet some older patients remain in hospital for longer than may be clinically necessary.
- 80 per cent of emergency admissions for more than two weeks are patients aged over 65. Reducing emergency admissions and ensuring that longer lengths of stay by older people are clinically necessary has the greatest potential for efficiency savings.
- Unsuitable home conditions can directly cause health problems, and hence hospital admissions. If individuals are discharged to unsafe, cold, unsuitable homes they are more likely to return to hospital.

What?

- Enabling older people to go home from hospital safely requires integration of housing help into the discharge system.

Where?

- Local initiatives to integrate housing related information, advice and practical help have been taking place in hospitals in Weston super Mare, Warwickshire, Coventry and Bridgewater.

Conclusions

- Housing help can lead to savings to health and social care providers
- Housing help can result in reduced health risk and a better quality of life for older people, their families and other carers
- Integration of housing services worked best when hospitals allow housing information and advice service providers to become an integral part of the hospital setting, with housing advisers visiting wards to meet staff and patients

The Health, Hospital and Housing Link

Some older patients medically ready to leave hospital may not be able to return to their previous home unless adaptations and improvements are made to it or, in some cases, a new home can be found. Others can return home and manage with equipment and temporary measures in the short term, but alterations to their homes or moving home would improve their quality of life and ability to live independently.

Either measure can reduce the risk of future health problems.

Poor Homes, Poor Health

Unsuitable home conditions can directly cause or at least contribute to a hospital admission (Box 2). If individuals are discharged to unsuitable homes they may have further problems and have to return to hospital. Unplanned emergency re-admissions have been a growing issue in the NHS in recent years⁴.

Box 2: Housing and health

Housing conditions have a significant and quantifiable effect on health⁵. The Building Research Establishment quantifies the costs to the NHS of specific aspects of poor housing as over £600 million per year.⁶

Many of the chronic health conditions experienced by older people have a causal link to, or are exacerbated by, particular housing conditions⁷. These include heart disease, stroke, respiratory conditions, mental health, arthritis and rheumatism.

This housing / health link becomes more important with age, as people become more prone to trips and falls and more susceptible to cold or damp related health conditions. Poor thermal standards in the homes of older people are a quantifiable contributor to excess winter deaths.

Vulnerable people over 75, particularly low income older homeowners, are the group most likely to live in poor housing, with a million occupying non-decent homes⁸.

Hospital Linked Information, Advice and Help with Housing

The shock of an accident or illness and associated stay in hospital can lead to older patients and their families reassessing their lives and their homes. Individuals who previously 'got by' in homes that were not entirely suitable may be more willing to consider changes, but they need reliable information about options that are available, advice about how these can be organised and paid for and, in some cases, practical help in order to make changes.

Older patients attending Accident and Emergency and / or leaving hospital are an important at risk group. Those who have one or more falls are more at risk of a further incident; and

the shock associated with a hospital episode means they and any family may also be more receptive to making a change in living arrangements.

Making such a change can be beneficial to health, hence the importance of integrating housing help within the hospital setting as an effective way of targeting appropriate assistance (Illustration 1).

Illustration 1

Mrs T is in her 80s. Though increasingly frail she did not want to leave her family owned home. She has a weak heart, cannot bathe alone safely and regularly passes out. Carers were visiting twice a day, but she was having sudden blackouts. Her son was very worried that it was not safe for her to continue living alone, but she was adamant about not moving. The son felt he was on 24 hour call.

A blackout led to a two week hospital stay. This resulted in Mrs T agreeing to move home. A hospital worker put her son in touch with the 'Housing Options' caseworker who was located in the hospital part of the time, and who talked through the various housing possibilities with Mrs T and her son on the ward. He then helped to find an extra care flat very quickly, checking that Mrs T's pension and attendance allowance was enough to pay the rent and service charges.

Mrs T is now in an extra care flat and is very happy there. Her son says she has had a new lease of life. Before moving, Mrs T was increasingly unsteady on her feet and was not at all mobile. Now she walks to the lift to get lunch downstairs and is socialising with other residents. She is fitter, healthier and happier and has not returned to hospital since.

Illustration from North Somerset Care & Repair

Housing related advice, support and practical assistance services can enable older people to make the major and minor alterations to their homes that will enhance their future health and well-being. The main types of practical housing services are described in Box 3 below.

Ninety percent of older people live in general homes (ie not especially built for older people), and around 75% are now owner occupiers. Therefore services such as Care & Repair or home improvement agencies are especially important for hospitals as many operate some of the services described below across housing tenures (ie for social housing and private tenants as well as home owners).

The illustrations in this report are drawn from pilot services where 'Housing Options' advisers and a mix of these services have been operating in a hospital setting.

Box 3: Examples of the main practical housing related services that promote older peoples' independence, health and well-being

Care and Repair and home improvement agency services: These help people (mainly, but not only, older home owners) undertake home adaptations, repairs, organise finance and related care and in some cases, help people to move home.

Handyperson services: Carry out small home repairs and minor adaptations to enable older and disabled people to remain living independently in their own home. Such services may also offer:

- falls and accident prevention checks and remedial action to reduce risk
- assistance with discharge to enable care at home e.g. fitting key safes, equipment delivery, moving / raising chairs and beds
- home safety remedial measures including fire safety checks; smoke alarms, electric blanket checks, chip pan/fat fryer exchange
- home security improvements

Housing options advice services: Help older people to consider the practical and financial issues related to staying in their current home or moving elsewhere. Housing options workers may; help tenants liaise with landlords and/ or make applications for housing; help home owners through the practicalities of moving home; advise on related welfare benefits and home support services.

Hospital discharge schemes: This is a broad term, but there are housing related schemes which offer a range of practical help including installation of equipment, minor adaptations, short term homecare, handyperson services, befriending initiatives, community alarm / telecare installation and financial benefits assistance. Some reconnect older people with their families, friends and neighbours to reduce isolation.

Falls prevention services: Usually work with health and social care as part of falls care pathways identifying those at risk and co-ordinating a range of interventions to reduce the incidence of falls and the impact a fall can have on health, well-being and independence. Linked services may include home safety, assistive technology, telecare, equipment, adaptations and housing related support services.

Part 1

The Policy Context

This section considers the current context for the health, social care and housing sectors with an emphasis on the key drivers of efficiencies, the development of quality outcomes, prevention and integration and the role of partnership working in order to make this happen.

Providing advice, assistance and support with housing as part of standard hospital procedure fits well with current national policies and priorities including better outcomes for patients.⁹ It offers the opportunity for efficiency savings at a time when health and social care are under particular pressure from reduced government spending and increased demand associated with an ageing population.

Both the NHS and councils need to make significant savings over the next three years. Making hospitals responsible for care for 30 days after discharge¹⁰ should result in a new impetus to better manage discharge and reduce re-admissions as there is now a clear business case. For social care the key saving is preventing or delaying admissions into a care home, although reducing levels of home care need are also important.

More generally the government expects local public services to work better in partnership to ensure health is integrated with wider support¹¹. While extra Department of Health funds for improved integration have largely been directed to social care, wider government policy supports working more closely with other partners, including housing and the local voluntary and not for profit sectors, to deliver improved services.

Efficiency savings: Reducing delays and preventing re-admissions

Efficiency savings are needed in both the NHS and Social Care. The NHS needs to make £20 billion of QIPP¹² efficiency savings by 2014/15¹³. In 2011/12 Councils in England lost £4.7 billion in government grants and other local income (including council tax and fees and charges) as compared with 2010/11.¹⁴

This is at a time when demographic change is resulting in rising pressures on services, with an increase in overall population and in older patients. Between 2010 and 2035 the number of people in the United Kingdom aged 75 and over is expected to rise from 4.9 to 8.9 million. Numbers aged 85 and over are expected to more than double, rising from 1.4 to 3.5 million.¹⁵

Between 2004/05 and 2008/09 the number of emergency admissions in England rose by 11.8 per cent. There are national concerns about associated costs.¹⁶ Delayed discharge is also expensive; the average cost of an 'excess' bed day in 2010/11 was £255¹⁷. There are also concerns about the impact on patients of poorly managed discharge.¹⁸ Patient surveys suggest ongoing failure to involve patients and carers adequately in planning discharge.¹⁹ The costs of poorly managed discharge can also affect social services, especially if more patients are discharged directly to residential care.

Both the Department of Health and local commissioners are looking at ways of setting targets and outcomes frameworks that will encourage hospitals to manage discharge better. This means hospitals have financial and quality reasons to focus on improvements. When it comes to efficiency savings, initiatives that reduce emergency admissions for older people can be especially cost effective.

Nuffield Trust research²⁰ shows that about 40 per cent of the recent increase in re-admissions could be attributed to an ageing population. For older people, potentially preventable occurrences like trips and falls are major causes of admission.²¹ People over 85 are especially likely to have an emergency admission. Because of the projected increase in the over 85s this group are disproportionately important in considerations of demand management and efficiency savings.

Costs to hospitals of delayed discharge and re-admissions

If a patient is medically ready for discharge but has no home suitable to go to an expensive hospital bed is blocked resulting in inefficient use of medical staff and facilities. This can also have a knock-on effect on other hospital targets such as waiting times for elective admissions. Hospitals may be financially penalised by commissioners as a result.

Equally, if discharge is poorly managed patients may return to hospital sooner than would be expected if their home and care had been suitable and appropriate. Emergency re-admissions of this type are also disruptive and expensive. The number of emergency re-admissions of patients within 28 days of hospital discharge has been rising. Concern about poor management of discharges and re-admissions has led the government to amend funding arrangements for these cases. Hospitals may face financial penalties where patients are re-admitted within thirty days of discharge. Local commissioners will not pay for this as a second admission. This gives hospitals a new business imperative to minimise re-admissions.

Early and /or frequent returns may be linked to inadequate housing. Many of the chronic health conditions experienced by older people have a causal link to, or are exacerbated by, particular housing conditions. These include heart disease, stroke, respiratory conditions, mental health, arthritis and rheumatism²² (Illustrations 1 and 2). To address this hospitals need partners who can deal with housing issues, particularly for those many patients who are not eligible for a social services assessment or assistance.

Illustrations 2 & 3: How better housing can reduce hospital re-admissions

Illustration 2

Mr H is in his 80s. He lived in a small private rented house with an upstairs shower. The property was in a poor state of repair and was cold and damp.

His wife has Alzheimer's and moved into a care home in 2010. Mr H then fell and broke his hip, resulting in a prolonged hospital admission. When discharged home he had to live downstairs, sleeping on the sofa and using a commode. Carers came twice a day to help him dress and to deal with the catheter and commode.

This poor hygiene and lack of bathing facilities resulted in three further hospital admissions. A social worker then referred Mr H to a housing options worker who helped him apply for sheltered housing and supported him through all the paperwork, process and the practicalities of the actual move.

Mr H's health has improved significantly since moving, with no further re-admissions to hospital and with reduced care visits.

Potential public cost savings of better housing/earlier housing intervention: Likely to have prevented the hip fracture, and would almost certainly have avoided the re-admissions and required less care visits

SAVINGS TO HEALTH

Hip Fracture	£12,000
Re-admissions	
3 x unplanned hospital episodes @ £2,334 per episode	
3 x emergency transport @ £260 per episode	
Total	£7,782

SAVINGS TO SOCIAL SERVICES

Carers median package	£320 per week
Carers low level package	£207 per week
Difference	£113 per week
Saving	£5,876 per year

Estimated additional costs of sheltered housing provision - £4,300 per year

(these costs are already covered in the annual budget of a social housing provider)

Housing benefit is payable for both properties and so rental cost differences are ignored in this case even though the cost of privately rented property is usually significantly higher than social rented housing.

Average Cost of Housing Options intervention to enable home move: £2,500

See Appendix 1 for further detail about basis of costings

Illustration 3

Mr D is 74. He lived in a privately rented cottage in a state of serious disrepair. The only heating was an open fire that he lit using a gas canister. Mr DS had become less steady on his feet. While in hospital for a minor operation he fell and broke his shoulder.

He was discharged to residential care for intermediate care and then went back home. The Social Worker arranged for carers three times a day and provision of an oil filled radiator by a voluntary agency. However, the cottage was still cold, damp and in poor condition. Mr D could not use the now dangerous stairs to reach the bathroom. Due to the resulting poor hygiene he was readmitted to hospital four times with infections. Mr DS became very depressed and was convinced that he would die in hospital or a care home.

Improving the cottage was not a realistic option. An Environmental Health Officer who visited considered it unfit for habitation. So while Mr D was in hospital the Care and Repair housing options worker helped him to apply for and find a sheltered council flat.

This was not straightforward. The local council insisted that he must visit the flat before accepting the tenancy; the caseworker negotiated a delay of a week and took him to and from his hospital bed to view the property in order to meet this tenancy condition. A friend helped with the paperwork around benefit and tenancy changes.

He has now moved in. The property is warm and he can move around all the rooms. He is much happier and his health has improved significantly with no further hospital admissions. The friend said that she would never have managed to arrange the move herself without help from the housing options worker.

Potential public cost savings of better housing / earlier housing intervention: He would almost certainly have avoided the re-admissions and required less homecare visits. Without the housing intervention he would almost certainly have been admitted to residential care.

SAVINGS TO HEALTH

Re-admissions

4 x unplanned hospital episodes @ £2,334 per episode

4 x emergency transport @ £260 per episode

Total £10,376

SAVINGS TO SOCIAL SERVICES

Care package

Carers median package £320 per week / £16,640 pa

Carers low level package £207 per week / £10,764 pa

Saving £113 per week / £5,876 pa

Residential Care Home Costs £28,080 per year

Low level care package £10,764 per year

Saving £17,316 per year

Illustration 3 continued

Estimated additional costs of sheltered housing provision - £4,300 per year

(these costs are already covered in the annual budget of a social housing provider)

Housing benefit is payable for both properties and so rental cost differences are ignored in this case even though the cost of privately rented property is usually significantly higher than social rented housing.

Average Cost of Housing Options intervention to enable home move: £2,500

See Appendix 1 for further detail about basis of costings

Illustrations 2 & 3 are from Somerset West Care & Repair

Costs to social care associated with discharge

Department of Health examination of the use of resources in adult social care suggests that reduced spend on residential care is likely to be the best way of releasing resources to change social services in future.²³ Inadequate housing and lack of suitable care at home may result in a patient being discharged straight to a residential or nursing home instead of being enabled to live independently at home. This may mean considerable longer-term costs to social services, particularly if the individuals are not wealthy enough to self fund their placements.

The number of permanent local council supported admissions to care is falling, but variations between areas suggest that there are more savings to be made. Hospital Episode statistics for 2009/10 show that the percentage of the over 65 population currently discharged directly from hospital to residential and nursing care varies from 0.1 to 2.5 per cent in different PCT areas²⁴. In 2008 Laing and Buisson estimated that postponing entry into residential care for one year could save an average of £28,800 per person.²⁵

Integrating housing advice, assistance and practical support into discharge arrangements can shorten or prevent admissions to residential and nursing care. It is one strategy that may help those areas with high use of care homes to reduce new admissions (Illustrations 4 and 10).

Where one member of a couple is the main carer for their partner, a care home place may be needed if the main carer is hospitalised. Support at discharge can help carers return home earlier, which reduces the costs and stress of a temporary care home placement for the partner (Illustration 5). A move to extra care housing can also take the pressure off a partner carer, as care can be stepped up easily on site if the carer partner has to go into hospital. Stepping up care can be cheaper and less disruptive than a temporary move.

Illustration 4 (see also Illustration 10): Preventing a long-term admission to care

Mr M is in his late 60s. He rented a room in a shared house. His room was on the second floor. He shared facilities with others.

He was admitted to hospital as an emergency. Over time he had to have both legs amputated. This made it impossible for him to return to his previous home. His sister arranged an end to the tenancy and for his pension credit to be redirected to her address while he was in hospital.

She could see that her brother was becoming increasingly institutionalised, but he now had no home to return to.

With support from a Care and Repair housing options worker a place in an extra care housing scheme was secured. The caseworker organised housing benefit and helped Mr M's sister deal with other financial issues that had built up while Mr M was in hospital and too ill to deal with these matters.

Mr M has now moved in. He has an electric wheelchair and can get about his flat and the scheme independently. He is already making use of the social opportunities in the scheme and is much more positive about the future.

The only other alternative would have been residential care which would have given Mr M much less independence and a lower quality of life.

Mr M's sister feels that the reason the system finally 'worked' was the partnership between the hospital OT, the hospital social worker and the Care and Repair housing options caseworker.

"They worked very well together...I would never have known it all...even [the housing options advisor] hadn't seen one of the forms we had to fill in. Without the extra handholding I don't know what I would have done... I would have struggled without them"

Potential public cost savings of housing intervention: Without the housing options worker's help Mr M's discharge from hospital would probably have been further delayed and he would almost certainly have been admitted to residential care.

SAVINGS TO HEALTH

Uncertain in this case, but delays in discharge cost £260 per day

SAVINGS TO SOCIAL SERVICES

Residential Care Home Costs £28,080 per year

Extra Care Housing Costs £21,736 per year

Difference* **£6,344 per year**

*Level of saving to social services depends on the extent of local social care subsidy to the extra care scheme- these receive a variety of public funding for example capital grants and LAs revenue support through housing benefit

Average Cost of Housing Options intervention to enable home move: £2,500

See Appendix 1 for further detail about basis of costings

Illustration provided by Somerset West Care & Repair

Illustration 5 Simple, low cost housing measures can enable earlier discharge

Mr T is in his 70s. He lives in a first floor flat with Ms J, 85 years, who has late stage Alzheimer's and is her '7 day a week 24 hour a day' carer. Professional care workers come three times a day to help him with personal care.

Mr T missed his footing on the loft ladder; he fell and broke his leg in three places and was in hospital for nearly six weeks, hence Mrs J had to go into a care home.

The occupational therapists and social worker organised the equipment that Mr T needed to come home. However, because he lives on the first floor he could not get to the front door quickly to let in carers. Through the Care & Repair handyman service a key safe was fitted on the day he returned home.

Although he was confined to a wheelchair for three months while his leg healed, after just a week Ms J was able to come back home because the key safe enabled the carers to let themselves in. She is much happier at home.

This saved an estimated 11 weeks (the time that Mr T was in a wheelchair) of care home costs. More importantly, it was what both Mr T and Ms J wanted.

Savings to Social Services

Residential dementia care costs for 11 weeks	£5,984
Ongoing care package (£320 pwk) for 11 weeks	£3,520
Saving	£2,464

Average cost of key safe installation by handyman service £90

See Appendix 1 for basis of costings

Illustration provided by Warwickshire Age UK

Better outcomes for patients and carers: Quality of care and quality of life

Protracted stays in hospital mean patients are more in danger of contracting hospital-acquired infections. Individuals who remain in hospital for long periods can become 'institutionalised' and less able to fend for themselves. Long stays in hospital are also depressing - loss of functional independence and clinical depression can result.²⁶

'The modern general hospital may contribute to the incidence of adverse outcomes for frail older people. For example, the rapid pace and technological focus of modern medicine, attitudes towards the elderly, inappropriate drug use and clinician skill mix may all conspire against the early recognition and the appropriate management of frailty factors such as delirium'

Acute hospital care for frail older people Editorial in Age and Ageing (November 2006) 35(6): 551

Illustrations 6 and 7: The negative impact on patients of long term stays in hospital

Illustration 6

Mr P (also see Illustration 10) remained in hospital for longer than necessary partly because of delays in arranging a necessary scan, and partly because of problems concerning his housing and related financial situation. These prevented him returning home as quickly as he would have preferred or was medically possible.

While waiting in hospital for resolution of a medical and housing issue he contracted MRSA and three urinary tract infections

Illustration provided by North Somerset Care & Repair

Illustration 7

Mrs B is in her 70s. She lives alone in her own house. She has no close relatives. She was in hospital for three weeks after a series of falls. She became increasingly worried about coping when she returned home, but felt unable to talk to hospital staff about this. She thought that 'small things' like how to maintain her garden and get about were not things she could 'worry' them with, but they loomed so large for her that she started to consider having to move to a care home.

A nurse referred her to an advisor from the local Age UK who explained the support options available and went through Mrs BC's finances. She realised that there was practical support available and that she could afford to pay for this help.

She has now been discharged back home. She has had rails put up to help her move more safely around the house and feels more confident because 'I know that there is someone there I can call on'.

Illustration provided by Warwickshire Age UK

Hospitals are responsible for ensuring medically safe discharge, but are not responsible for non-health quality of life issues. Health initiatives on prevention and on managing long term conditions do not currently address shortcomings in housing or prepare people for the practical problems associated with long-term conditions. For older people these are most common around mobility.

So whilst hospitals will arrange for a patient to return home safely, they are not responsible for ensuring access to a bathroom, to other rooms in the home or access in and out of the property. Reduced mobility can heavily curtail an individual's social engagement, which in turn may affect their psychological health and will certainly reduce their quality of life.

Housing related advice, support and practical help can be critical here. Minor changes to existing homes or arranging suitable home moves play a key role in maintaining quality of life and mental health.

Illustrations 8, 9: Help with housing can improve quality of life

Illustration 8

Ms C is in her 70s. She lives in a private rented flat owned by the widow of a friend who lives in the main part of the property. The widow is 83 and does not have her recently deceased husband's ability to organise repairs and maintenance, and Mrs C does not like to 'bother' her landlady.

Ms C fell at night and trapped a nerve, which affected the whole side of her body. She could not get up even using the furniture. However, she did not call for help for several hours because of not wanting to worry her landlady. She was subsequently admitted to hospital for four days. Her first discharge was poorly organised, and she had to return to A&E three days later because she had not been able to get out of bed or to reach her own toilet unaided.

After the readmission she was provided with the necessary equipment to aid independence and returned home, but was now considerably less mobile and spent more time sitting, which was leading to back pain. She was also very nervous about falling again.

The local Home from Hospital partnership arranged a pendant alarm (which she pays for herself) so that she could more easily call for help if she has another fall. The Care and Repair housing options worker did a home safety check. He found funding for and arranged installation of self-closing hinges on the bathroom and kitchen windows that Ms C could no longer reach safely. He had a smoke alarm installed. He obtained a chair that is much better for her back, and easier to stand up from. He arranged for a second key holder in addition to Ms C's landlady in case of further problems.

Knowing that she can call the local Care and Repair service if there are future issues has given Mrs C greater confidence in continuing to live independently. The minor practical changes organised have improved her quality of life as well as reducing the risk of further falls and injury.

Potential public cost savings of housing intervention: Earlier intervention would have reduced the falls risk, potentially saving two hospital admissions. Without the subsequent practical housing help Mrs C would have been at higher risk of further falls, injury and ultimately admission to residential care.

SAVINGS TO HEALTH

Readmission

2 unplanned hospital episodes @ £2,334 per episode

2 x emergency transport @ £260 per episode

Total £5,188

Housing Options officer help (£670) + 2 handyperson jobs @£90 = £850

See Appendix 1 for further detail about basis of costings

Illustration provided by North Somerset Care & Repair

Illustration 9

Mr MB, in his 70s, lived alone in a mobile home after his wife died. He is increasingly unsteady on his feet and has memory lapses. His home was cold and in a poor state of repair, with steps up to the door that he could easily fall on. The mobile home park was isolated from shops and public transport. His main carer, his daughter in law, cannot drive and is a full time carer for her own wheelchair bound husband.

Mr MB fell and was admitted to hospital. The housing options worker in the local Home from Hospital partnership organised minor improvements to the mobile home such as grab rails and a smoke alarm, helped Mr MB get pension credit and helped with an application for sheltered housing. Mr MB had been 'on the list' but did not understand how to make computerised bids for social rented accommodation.

After a second fall at home and a further spell in hospital Mr MB was temporarily transferred to a care home. His old home was no longer suitable. The steps were unsafe. He became increasingly unhappy because, as he said, 'everyone was dying' and he was not able to get out and about.

The housing options worker arranged for a doctors letter to ensure he had a higher priority for housing bids. With help he finally secured and moved to a one bed sheltered property within 15 minutes walk of his daughter in law. The property is warmer than his mobile home and cheaper to run. There are less trip hazards in his home and immediate environment. He can walk his dog round the playing fields a few minutes from his new front door. He has already made friends with neighbours and says his social life is better.

His daughter in law is now more able to visit and offer support. She felt that without the help of the housing options worker she would never have been able to organise his move and Mr MB might still be living in residential care.

Potential public cost savings of better housing/earlier housing intervention: He would almost certainly have avoided the falls and resulting hospital and residential care admissions. Without the housing intervention he would have remained in residential care.

SAVINGS TO HEALTH

2 unplanned hospital episodes @ £2,334 per episode

2 x emergency transport @ £260 per episode

Total Saving £5,188

High risk of hip fracture which would cost £12,000

SAVINGS TO SOCIAL SERVICES

Residential Care Home Costs £28,080 per year
(No care package is needed)

Total Saving £28,080 per year

Estimated additional public costs of sheltered housing provision - £4,300 per year (these costs are already covered in the annual budget of a social housing provider). He is meeting rental costs from his own resources.

Average Cost of Housing Options intervention to enable home move: £2,500

See Appendix 1 for further detail about basis of costings

Illustration 9 provided by North Somerset Care & Repair

Illustration 10: help with housing can allow a patient to rebuild an independent life

Mr MD is 67. He lived in a low value former council property bought under right to buy. There were six steep steps up to the front door. The house had no working heating. The back door had steps out onto a steep hill.

Mr MD has diabetes. Complications meant that he had to have one leg amputated in a general hospital, before moving to a smaller hospital for rehabilitation. The hospital wanted to discharge him, but his home had no heating and the steps meant that he would not have been able to get in and out of the property. The hospital pushed for a home discharge, but he refused as he was previously very sociable and a keen walker and could not bear the thought of being a prisoner in his own home.

His son picked up a pamphlet about the Care & Repair housing options service at the hospital and contacted them. Cost estimates for adaptations to his home showed that these would be expensive and not all covered by disabled facilities grant. They would also take at least 8 months. The value of the current house was not enough to buy a more suitable home, but the housing options worker explained that moving to a rented council property was a possibility. The housing options worker got him onto the local choice based lettings system as an emergency case and helped him to move out of hospital into temporary accommodation.

Unfortunately the automated bidding system resulted in offers of properties that were not suitable. For example, one was on a steep slope with a tight turn that would have been difficult and dangerous to navigate with a wheelchair or crutches, especially in wet or icy weather. The housing options worker got the information changed so that bids were not made for unsuitable properties. A one bedroom sheltered bungalow then came up in his second choice area, a village close to his old home and children. He accepted the property and moved in. He was initially unsure about needing a warden but is now happy with a regular visit.

The housing options worker made sure his finances were checked. He now has Attendance Allowance and temporary housing benefit prior to the sale of his home.

A temporary ramp allows Mr MD to use his front door. He is already reasonably mobile and expects this to improve as his leg settles down. Nearby buses already allow him to travel locally. He intends to convert a shed at the back to take a mobility scooter. While he is regaining his independence he also now has a warmer home and the unobtrusive support of the warden. This is reassuring to his children and gives him more security to take risks as his walking and balance gradually improve.

Housing support has given Mr MD the chance to rebuild a more active and independent life despite his disability. Without this help he might have spent months in an expensive care placement or been marooned in a totally unsuitable home where he might have needed an expensive daily social care package for months.

“The housing options worker....you can talk to. She is a human face. And having an advocate matters. She would give you the options, but leave you to choose.”

Illustration provided by Somerset West Care & Repair

Patient experiences and opinion: The importance of improving quality

Discharge arrangements are frequently criticised by patients and carers and are a major cause of dissatisfaction in patient surveys²⁷. The 2010 national in-patient survey showed that 16 per cent of patients felt they were not involved in discharge planning, and a further 30 per cent only involved 'to some extent'. 40 per cent reported a delayed discharge, 35 per cent received no written information to take away and 32 per cent said the hospital did not give family or other carers all the information they needed to look after the patient out of hospital.²⁸ Poor scores on quality can influence a hospital's reputation and may affect finances.

Working together: Partnerships to improve patient experience

Improved joint working across the boundary between health and other support has been a policy priority for many years.²⁹ Individuals require or benefit from a range of support to get them out of a hospital bed, to re-establish as independent a life as possible and to reduce the chances of early return. Integration between health and social care remains central to current policy. In 2011 the government gave extra social care funds to councils via the NHS to help achieve this. This will continue into 2012/13 when £622 million has been identified as money to go from PCTs/Clinical Commissioning Groups to pay for social care services to benefit health. This can include developing arrangements for post discharge care.³⁰

Historically the most attention has been given to the social care/health partnership. Now there is growing recognition that wider place-based approaches that include housing can help older people remain independent and with a better quality of life.³¹

PCT clusters should support local authorities in establishing Health and Wellbeing Boards so that they become effective local system leaders across health, social care and public health.

It will be equally important that... the NHS does more to integrate service delivery, not only across primary and secondary care between mental and physical health but also with social care organisations. Each sector needs to look at where it can work better with partners, including voluntary organisations, so that services are organised around the interests of patients and service users rather than institutions.

NHS Operating Framework 2012/13

The committee recommends that each area should establish a single commissioner who will bring together the different pots of money that are spent on older people... with the Government coordinating policy and regularly rebalancing spending across health, housing and care services...

Health Select Committee Report on Social Care, February 2012³²

Individuals require or can benefit from a range of support to get them out of a hospital bed, to re-establish as independent a life as possible and to reduce the chances of early return. This means partners involved in home from hospital arrangements need to work jointly. They need to be good at assessing broad needs so that individuals can be referred to the most appropriate services with as little duplication as possible. A recent Inquiry into *'Living well at Home'* held by the All Party Parliamentary Group (Housing and Care) recommended that:

...local statutory, voluntary and commercial housing, health and social care, along with professional bodies ...should produce joint good practice guidelines and procedures that facilitate effective, person-centred, transfer of care back home following a hospital admission³³

Housing related issues may have been contributors to long term ill health and specific accidents that may cause emergency admissions, especially trips, falls and cold related illness. So preventing a repeat problem may require a housing rather than or as well as a care or health related solution. This means housing related advice, information and support should be provided within any wider discharge partnership.

For partnerships to work well there needs to be senior strategic commitment and an effective local operating framework. Local history, leadership and personal relationships are all important in building a shared sense of direction and in cementing joint working.

This leadership may initially come from different places; for example, in the case of the partnerships described below the impetus came from the national charity, Care & Repair England, who, through its Dept of Health supported initiative to integrate housing help into a hospital setting, *'if only I had known...'*, was to bring in an outside perspective and help to galvanise support across sectors. Local success required strong commitment by key parties – in one area a critical factor was the local council's Supporting People manager, who also acts as the coordinator for the partnership, alongside a person whose role is to broker joint working across health and social care. Another developed because of a senior hospital manager's keen interest in the proposal and their subsequent leadership role in 'selling' the idea within the hospital setting.

It is not easy to evidence the effectiveness of partnerships. It is also difficult to prove preventative (usually multi-factorial) housing activity results in quantifiable cost savings to individual hospital, clinical commissioning group or council budgets. The partnerships described in this report are collecting and analysing data about the services provided. They can measure outputs and over time may be able to measure some outcomes more effectively. Until then costed and/ or illustrative individual case studies and the personal testimonies by patients, carers and the hospital staff working with them remain the principal means of measuring effectiveness.

Integration – the order of the day

Older people often need a package of assistance that crosses traditional boundaries of health, social care and housing. So housing needs to be integrated with wider support, and the examples in this report all involve partnership working across disciplines.

The NHS Operating Framework for 2012/13³⁴ highlights the need for integrated approaches:

It is important that the NHS does move to integrate service delivery, not only across primary and secondary care... but also with social care organisations. Each sector needs to look at where it can work better with partners, including voluntary organisations, so that services are organised around the interests of patients and service users.

Promoting this integration is one of the primary roles of the new Health and Well Being Boards. Effective engagement with the statutory and wider not for profit housing as well as care sector needs to be a part of improved integration.

Part 2

Practical examples of putting ideas into practice

In the following section we examine initiatives to integrate housing advice, assistance and practical support into hospitals in Weston super Mare, Warwickshire and Coventry.

The local projects concerned are three of a number developed as part of an initiative by Care & Repair England, entitled *'If only I had known'* (described in Box 1, page 6), supported by the Department of Health's Third Sector Investment Programme for Innovation, Excellence and Service Development.

Each case study section explains how links were initially built up between hospitals and the third sector organisations offering housing support, and how current partnerships fit with local strategies and organisations' business plans.

It examines how the partners reach older patients and carers to provide appropriate information, advice and housing help before, during and after hospital discharge. It describes the kind of support required by older patients, and how these approaches can benefit hospital and social care staff as well as helping patients, their families and carers.

These are qualitative descriptions of process of development and the nature of local provision. The level of detail included aims to enable other providers and commissioners to introduce similar, adapted models in their own local areas.

And evaluation report about the *If only I had known* local pilot projects and a number of associated resources are also available from Care & Repair England – go to *'Home from Hospital'* on www.careandrepair-england.org.uk

Home from Hospital Partnership: Weston Hospital, North Somerset

The Home from Hospital Partnership at Weston Hospital aims to support older and more vulnerable patients going home from hospital to maintain successful independent living, prevent re-admission and reduce the level of admission to residential care.

The partnership can arrange help with practical issues around housing, finances and care as well as brokering wider social support. Key impact to date:

- It has improved coordination between a group of voluntary and statutory partners resulting in more efficient working practices.
- It has encouraged hospital staff to refer patients who need practical housing and related support earlier i.e. prior to being medically ready for discharge
- Staff training and day to day personal links have enabled nurses and other hospital staff to understand the potential benefits to patients. As a result they making more referrals
- Patients can go home earlier and more safely

Background

In 2009 a group of local organisations met with Care & Repair England and the local Care & Repair service to discuss how best to reach patients, particularly older and disabled people, who could benefit from practical help to return home after a stay in hospital. The initial approach by Care & Repair England coincided with Supporting People, North Somerset Social Services and Private Sector Housing Services wishing to improve strategic links with the hospital.

Out of that first meeting came the idea of a Home from Hospital Partnership which was backed by Supporting People and the Adult Social Services & Housing Directorate of North Somerset Council.

At the time of the initial meeting two local organisations already involved in aspects of supporting hospital discharge had recently obtained additional funds for their work at Weston hospital. North Somerset Council had successfully made a bid to Department for Communities and Local Government for special funding (linked to the national housing and ageing strategy 'Lifetime Homes, Lifetime Neighbourhoods') and commissioned North Somerset Care & Repair to deliver 'housing options' outreach work and expanded handyman services. Age Concern (now Age UK) Somerset successfully bid to their national office for funding for provision of hospital based advice and assistance primarily for residential care self-funders.

Alliance Homes (the largest local social landlord) were already working within the hospital on an initiative (funded by Supporting People) to enable safer discharge, for example ensuring food and medication was available and any other practical, short term support at home was in place.

Thus the Partnership was a timely way of co-ordinating these three separately funded initiatives and offered the opportunity to take a more strategic approach to joining up provision.

A series of meetings between the Partnership, Care & Repair and various hospital staff and managers subsequently took place in order to reach agreement about placement of 'Home from Hospital' information packs (including a local brochure produced by the group), ward targeting and practical procedures for referral/contact with staff and patients.

The partnership began working in the hospital in July 2010. For the first year the hospital restricted the service to a limited number of wards on a trial basis. They are now slowly expanding, and referrals are increasing.

Partnership aims

The Partnership particularly supports the early intervention and prevention agenda. This includes improving access to services and advice. It targets individuals, particularly older and disabled people, who could benefit from practical help when returning home after a stay in hospital. This ensures that they are able to continue to be as healthy and independent as possible in their own homes.

The partnership aims to cover all discharges within North Somerset by 2013.

How the partnership works

The Home from Hospital Partnership at Weston hospital is co-ordinated by North Somerset Unitary Council Supporting People team. Current partners are North Somerset Unitary Council, West of England Care and Repair, Age UK Somerset, Alliance Homes and most recently, Rethink Reconnect,(a group who give home based floating support to some people with mental health difficulties). Two care providers have just joined the group.

Involved partners meet regularly at a strategic and operational level. The strategic group is co-ordinated by the Supporting People lead officer and includes the hospital discharge manager. An operational support group now meets monthly at the offices of Alliance Homes. This allows the frontline staff involved to discuss cases and share knowledge.

The partnership has developed one jointly badged information brochure about local housing and care options for use with older patients, carers and hospital staff.

A staff member from each of the local Care & Repair, Age UK Somerset and Alliance Homes visits the hospital every week day to take referrals and, wherever possible, to be available on relevant wards to talk to staff, patients or carers. The rota is shared between the principle partners, who are individually responsible for ensuring cover arrangements.

To make this a seamless service for hospital staff and patients the partners have had to work together and ensure referrals are properly recorded, effectively allocated and action followed through. The front line partners also make referrals to a number of other local statutory and voluntary groups where appropriate.

Referrals are currently manually logged by the discharge manager for the partnership advisers to pick up. The adviser will follow up the details and pass information on to whichever partner is considered the most appropriate to deal with the particular case. Patients may receive support from more than one partner depending on their needs. Details on all referees and patients are logged centrally by the Supporting People team.

It has taken some time to arrange adequate support at the hospital for the advisors. Practical problems around security access cards, desk space and on site computer access are gradually being resolved.

The not for profit groups involved in the partnership were all in receipt of Supporting People contracts from the council. This means they have met specified standards of service (for example, ensuring staff are checked for criminal records) and so agreement was reached that the hospital did not need to repeat such quality checking.

The partners have developed good relationships with frontline hospital staff over time. Some of this is down to individual personalities. For example, the Age Concern information worker is an ex nurse, giving her an immediate ability to talk to hospital staff on their own terms.

Referral records show that the hospital based staff making the most referrals are the discharge and rehabilitation teams, occupational therapists, physiotherapists and hospital social workers, but increasingly nurses are also now referring. The partnership hopes to continue to raise the profile of the scheme among nursing staff by contributing more to the next iteration of the hospital's own discharge training. They currently contribute a short 15 minute slot at the end of that training, which allows them to give a couple of case examples to raise the profile of their work with the nursing staff (Box 4).

Box 4: Raising awareness through staff training

At Weston there is considerable turnover among nursing staff. The hospital decided to arrange discharge training days to bring new staff up to speed more quickly. The partnership asked to be involved. They currently have a short slot at the end of the training sessions. This allows them to introduce the partnership and describe a couple of illustrative stories about patients who have been helped. The aim is to increase understanding of the benefits of the partnership to patients and encourage referrals.

Improving outcomes for people

There is a steady, ongoing rise in the number of referrals being made, with a growing number of patients helped. There were 77 referrals in the first 6 months of presence in the hospital, but 158 in the six months to September 2011. Referrals vary from 1 to 7 per day; experience from other local hospitals suggests that there is still considerable room for growth.

Partners also want to encourage earlier referral. This is especially important for housing related work, as housing issues cannot always be resolved quickly. A keysafe or grabrails

can usually be fitted within 24 hours; a broken heating system or leaking roof will take longer. This time is further extended for patients with limited means, where raising funds from loans, grants or charities to pay for essential repairs is necessary. Equally, a benefits check and advice on possible housing options can be given quickly; identifying alternative housing and arranging a move can take months. However, all of these processes can be made faster if fund holders and other partners are willing to instigate fast track processes for hospital patients.

The partnership is successfully targeting older people; 79 per cent of those helped are over 75. In many cases family and other carers also benefit. Many service users interviewed stressed the increased confidence they got from having someone to talk to who understood that health, care, housing and personal finances fitted together. Older people said how much they liked having a face and a name that they knew, a number to call, and a person or organisation who they felt they could trust. The confidence this gave them was itself important in helping them to move safely back home, live independently but be able to access extra support if needed.

...(I can't move so quickly now to reach the door)....because I have a key safe now I don't have to leave the door open. So I feel safer. And I know I can call them [the handyman service] about other things if I need to.

Service user

...I thought I could do it (a housing options application form) myself but there were pages and pages about drug abuse and other things. I didn't know what to do so I called the number I had been given and [the housing options worker] sorted it out really quickly.

Service user

Increased efficiency, reduced duplication

Partners now work together better, with housing and advice sector workers now more comfortable with health sector terminology. Cases are increasingly discussed in terms of health outcomes, rather than outputs or changes to buildings.

The recent decision to hold regular meetings of frontline staff to discuss cases and options should improve this further for the future. Common recording allows the Supporting People team to collect details on patients referred, their health issues, their needs, the services they are offered and in some cases the outcomes. This gives a better picture than would emerge from organisations doing this individually and should help with future health and service planning and commissioning.

“Good communication has reduced duplication.”

Housing options worker

Housing advice and support is often needed by patients and their carers

Nearly half the services provided so far by the partnership are housing related. Physical improvements to homes include heating and insulation work, adaptations and a range of minor to major repairs. Advice and support includes negotiating with landlords, looking at alternative housing options and benefits advice.

Casework records held by West of England Care & Repair include more details of housing related work with individuals contacted because of the hospital partnership. A number of individuals have moved into more appropriate accommodation due to the advice and support provided by the housing options advisor. Others have had a range of minor and major adaptations undertaken to make their existing or new homes more suitable and comfortable.

In two cases elderly couples have been helped to move into extra care housing. In both cases the couples themselves and their families reported that the quality of life for all concerned had improved.

In one case the move prevented the admission of one partner into a care home. One partner was feeling unable to continue with the care needed whilst living in their previous home due to problems with their own health. In the extra care housing facility the couple are able to remain living together utilising the support that is available on site.

It is clear from case studies that some of the housing changes have prevented admission of patients to more expensive residential care, and in individual cases housing interventions have prevented patients returning to hospital. Because it is difficult to prove what might have happened if something had not been done, quantifying such gains across all interventions in the longer term is not possible with any certainty at this stage.

Home from Hospital service for North Somerset patients in Bristol hospitals

A number of patients from North Somerset are referred to and so discharged from the larger Bristol hospitals, especially Bristol Royal Infirmary (BRI). Since November 2011 West of England Care and Repair has agreed to co-ordinate referrals and requests associated with these patients on behalf of the North Somerset Home from Hospital scheme. They are doing this through their standard telephone enquiry number that is already well known within Bristol hospitals.

If this method of referring works West of England Care and Repair would like to extend the system to cover patients from South Gloucestershire, and potentially all three Bristol hospitals. One number for most patients irrespective of postcode should make referral for help at discharge easier for hospital staff, patients or carers.

This includes fitting key safes. A number of clients receive more than one service

Home from hospital in Warwickshire and the development of 'Gateway' by Age UK Warwickshire

Hospital advice and information provided through leaflets and advice workers has developed into the Age UK Warwickshire 'Gateway' service, a call centre for assessment and referral. The aim is to support older and vulnerable patients who would benefit from practical and social support but who do not qualify for social services assessment under the Fair Access to Care criteria. The provision includes housing related advice, information and practical help.

The scheme is particularly focussed on discharge and helping to minimise the risk of readmission. Needs are identified through Age UK Warwickshire advice and information staff in the hospitals, and/or Gateway staff through phone calls and follow up home visits (where judged to be necessary). Individuals are referred on to an appropriate service provided by Age UK Warwickshire or other local groups, including local Care and repair agencies.

Key impact to date:

- Patients, hospital staff and carers have better, timelier access to information and advice about practical and social support, including for housing
- More needs are being met, and met quickly. The number of referrals from hospitals is increasing. Patients who agree to be contacted after they return home have been contacted within one working day of discharge*
- More housing related issues are being dealt with:
 - A high percentage of all referrals include a housing/handyperson element.
 - Rugby Care and Repair developed a closer relationship with the discharge co-ordinator, nurses and OTs at Rugby St Cross hospital during the initial project. This has meant an increase in hospital referrals.

Two of the eight hospitals that cover the county are working with Age UK Warwickshire to expand available support.

Background

Warwickshire was another of the early pilot areas for Care & Repair England's 'If only I had known...' initiative (detailed above) to pioneer provision of housing and related care information, advice and help in a hospital setting, delivered through a partnership with Age UK Warwickshire.

The pilot work commenced in 2009 when contact was made with eight Coventry and Warwickshire hospitals to discuss trialling placement of 'Going home from hospital' information packs in bedside cabinets. These packs contained information on housing support, advice and assistance as well as information on complementary services for older people offered by Age UK Coventry and Age UK Warwickshire, including handyperson and home improvement agency services. Senior management in all the hospitals were receptive and a small-scale trial of pack placement commenced. However, few patient referrals were

*Three working days is the maximum agreed; in the first 6 months Gateway staff achieved more rapid contact

made by hospital staff. All partners felt that a personal approach was needed to back up written information.

A hospital advice worker had been employed to work in Rugby and Coventry hospitals to supplement the written information in the packs and be available for discussions and to take referrals from hospital staff and patients. This approach resulted in a higher take up rate. Subsequently Age UK Warwickshire amended the remit of all of their Information and Advice staff, so that all would spend three hours a week on hospital wards. Their advice and information service was restructured to focus more on hospital discharge.

At St Cross hospital in Rugby this work also improved the personal links and service understanding between Rugby Care and Repair staff, the hospital discharge coordinator and other hospital staff. Referrals to Rugby Care and Repair increased.

In early 2010 Age UK Warwickshire held talks with the new Director of Adult Social Care about further improving accessibility to low-level preventative support services for individuals leaving hospitals. Central to the proposal was for Age UK Warwickshire to operate a telephone call centre that would follow up those patients [who had given consent] within seventy-two hours of leaving hospital. The County Council backed the idea and along with the PCT provided some development funding. The Gateway scheme began in May 2011.

How the Warwickshire Gateway works

Initial work around *If Only I had known* showed that consent forms can easily get mislaid (or not be completed). So the Gateway scheme focussed on simplicity. Any member of staff in a Warwickshire hospital wanting to refer a patient for possible post discharge support uses a one page form. The hospitals use printed sticky labels to identify individual patient files, medicines etc within the hospital. These are available on wards or can be quickly printed off and include patient names, addresses etc.

To make referrals as quick as possible for hospital staff, a Gateway Referral Form uses a hospital sticker (to identify the patient). The nurse or patient does not need to type or write in this information. The only other requirement is a signature or verbal consent from the patient allowing their personal details to be shared with Age UK. Those who make referrals are asked for name, ward and role for monitoring purposes. No other information is required, so work for hospital staff is minimised.

The form is faxed or scanned and then e-mailed to Age UK Warwickshire. An agreement on secure data sharing now allows Warwickshire County Council Call Centre to pass on referrals in the same way.*

*Age UK Warwickshire has worked with the County Council to ensure that all personal data is securely stored and appropriately password protected

A patient is contacted within three working days of discharge by a telephone call. All referrals in the first six months were contacted within the first working day. Gateway staff ask about the patient's situation and possible needs, using a checklist and question script that covers seven service areas. These are:

1. Looking after yourself
2. Getting Around
3. Personal Safety (for example, preventing trips and falls, alarms)
4. Accommodation
5. Finances
6. Staying Healthy and
7. Mental Health and Wellbeing.

The questions asked include a number of housing related checks. People are asked if they need or would like any adaptations, safety or security checks including fitting equipment, Home Fire Safety checks and repairs. People are offered benefit checks and asked about any other housing issues (for example an interest in moving).

People are also asked for some personal information which will allow better analysis of users and needs in the future. This includes asking about housing tenure.

Gateway will maintain contact with the patient for at least 30 days in case they need further help or circumstances change.

After the conversation the Gateway operator either refers the caller directly to the most appropriate service(s) or, if there are concerns, will arrange for the Area Assessor to go round and visit. Housing referrals may go to Age UK Warwickshire services such as 'Handyfix It' (their local handyperson service) and information and advice officers for benefit checks, or to the relevant local Care and Repair provider or housing options service. Service visits such as home safety checks can lead to additional housing need discoveries (Illustration 11).

In the first 6 months just over half the referrals have come from hospitals, with the rest coming from a mixture of self-referral, referrals by Age UK staff and referrals from the County council's own call centre.

A steering group meets bi-monthly to look at progress. Because all referrals now go through the Gateway service Age UK Warwickshire are building up a profile of demand that should be useful for future planning by Age UK and potentially by local service Commissioners. For example, the data set identifies which hospitals are referring, and which staff within hospitals. It will be possible to track referrers and users and focus marketing and information accordingly.

The Gateway staff have a background in care services. To keep as up to date as possible about available services they work closely with the Age UK information and advice team and get up to date training on key issues such as benefits as well as more generalised customer service training.

Age UK Warwickshire has talked to all Warwickshire GP practices about using the Gateway system to refer patients. Nine signed up in the first nine months, though only one has made multiple referrals to date; of these, a third had a housing component through Handyfix It or home safety.

Better outcomes: increases in take up and feedback from service users and an agreement to expand support in one hospital

Hospital referrals have increased since the service began in June 2011, though with a dip in October. This was an exceptionally busy month for the hospitals. Although the Gateway referral system has been made as easy as possible it is new and not part of the core job of hospital staff. The drop may be because any non-core work is given lower priority during periods when staff resources are stretched.

The increase in referrals suggests a previously unmet level of need amongst older patients leaving hospital for extra low-level support. Individuals who agree to give their details for future contact do not all take up the services at the time that they are offered. However, even those who do not take up a service may benefit from the telephone call and discussion they have with the Gateway team. Users contacted as part of the research for this report said that they valued the existence of the telephone information and call service as well as the practical help and support on offer. All said that knowing there is someone they can talk to, and that support is available if needed, gives them extra confidence.

The combination of housing, financial, care and social support that Gateway offers can make the difference between a successful discharge to a patient's own home and a loss of independence and a move to a care home (Illustration 11).

Illustration 11: A package of financial and practical support to enable a patient to leave hospital and return to a home of his own

Mr A, in his 70s, has emphysema and is on continuous oxygen. He had no medical need to remain in hospital, but Mr A had become estranged from his partner and was classified as homeless by the local council. They offered him a sheltered unit.

A hospital bed and commode were organised by the hospital and some furniture by social services, but the discharge co-ordinator knew that more support would be needed. She referred the patient to Age UK Warwickshire through the Gateway service. Staff visited Mr A in hospital.

Mr A's bank accounts had been in joint names with his then partner. So he was referred to Independent Advocacy. An advocate visited and agreed to help him to set up a new account in his sole name. The advocate also assisted with an Attendance Allowance claim.

A member of the Gateway team visited Mr A again on the day of discharge to assess remaining needs. Mr A agreed that Age UK would assist him with his weekly shopping and collect his pension through their Lifestyle service, as until the bank accounts were changed his pension came as a Giro cheque that he could not cash.

An Age UK handyman fitted curtain rails so his nets/curtains could be hung to give Mr A some privacy. A key safe was fitted to prevent Mr A from having to either struggle to reach the door or leave the door open, reducing his security.

Mr A arranged his own laundry and cleaning.

Mr A was successfully discharged. Lifestyle staff have built a close relationship with the sheltered housing Site Manager and liaise with her if they have any concerns. The Site Manager has helped Mr A find additional furniture, bed linen etc.

The re-ablement team are now supporting him, although with his medical history the achievable level of independence may be limited. Long term personal care support may have to be arranged via a Care agency, with up to four daily calls to help with personal care and meals.

The package of low level support has allowed Mr A to establish a new home of his own and with it a measure of independence. Without this, it is highly likely that Mr A would have been transferred to residential care.

Source: Age UK Warwickshire

Future developments

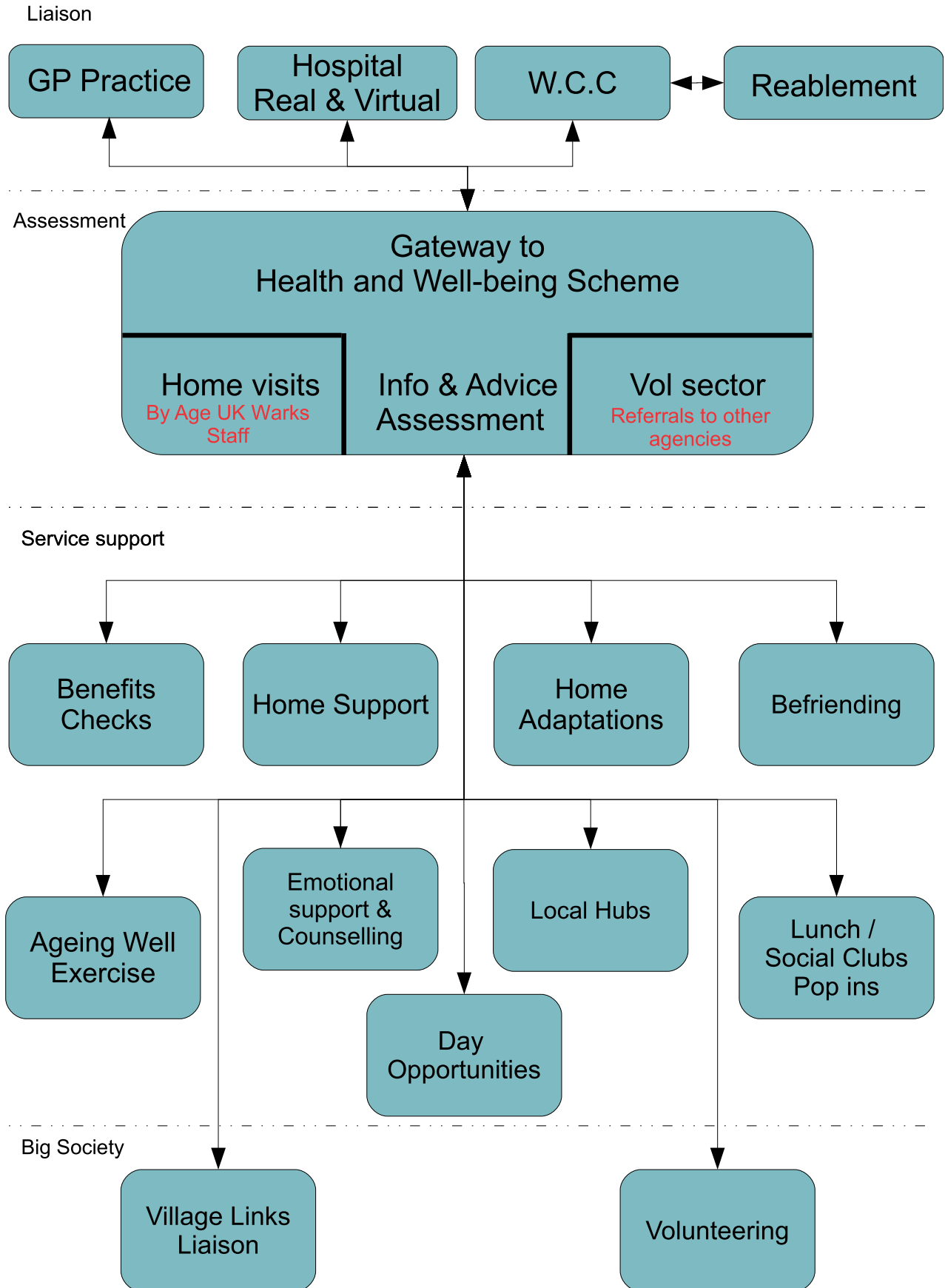
The Gateway model is flexible and can be expanded relatively easily because of the use of telephone support. Age UK Warwickshire is currently looking at a number of options for increased work with hospitals.

South Warwickshire hospital trust have agreed (January 2012) to Age UK Warwickshire piloting an offer of practical support to potentially vulnerable older patients in Accident and Emergency at Warwick hospital. The aim is to prevent admissions that are not medically needed.

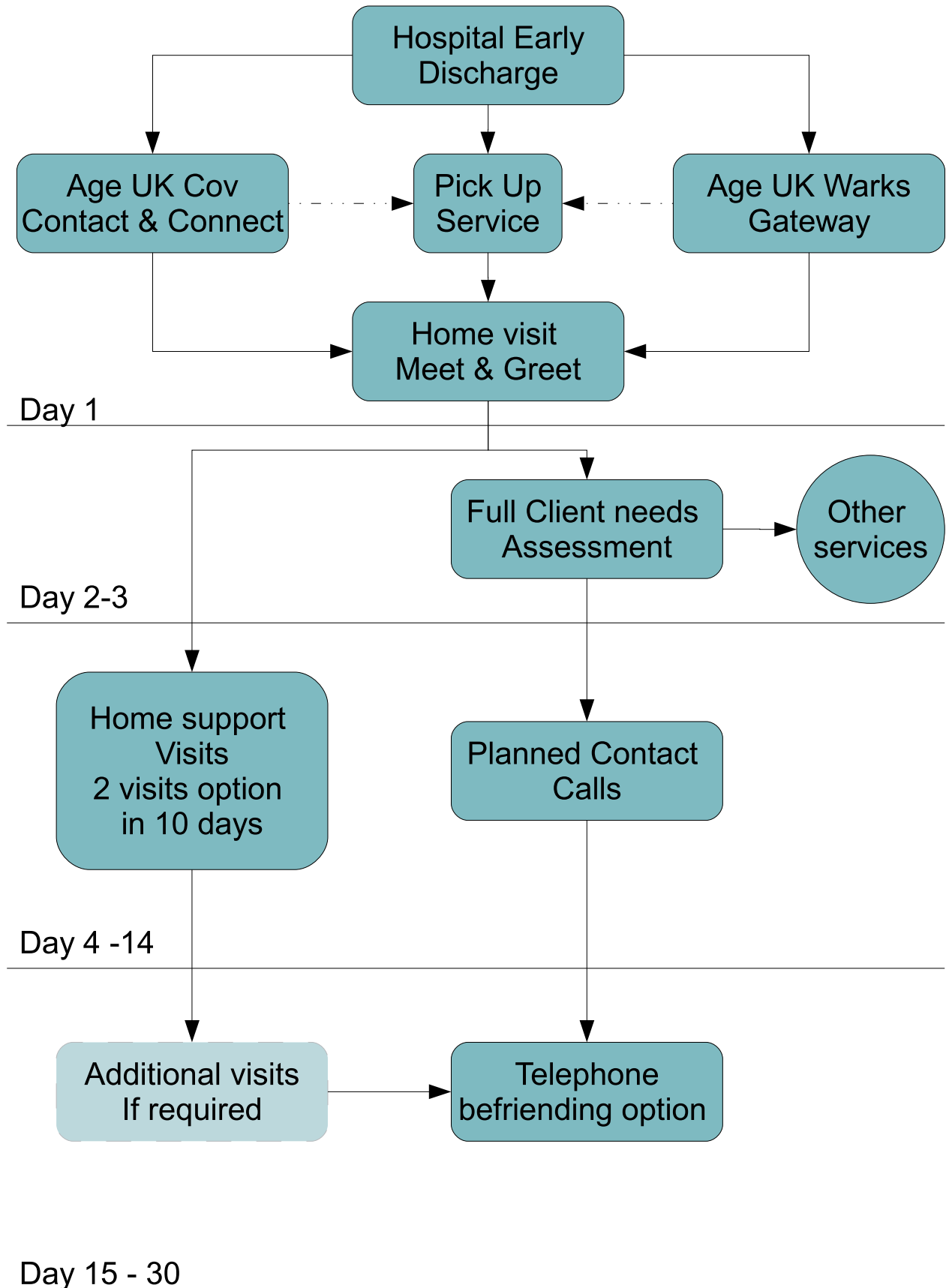
Age UK staff will also work with hospital staff in short stay wards (stays of 24/48 hours) where discharge may be delayed by social issues (including housing).

St Cross hospital Rugby is in Warwickshire is part of the University hospital trust whose main hospital is in Coventry. More information on developments involving this Trust is given in the next section.

Age UK Warwickshire Gateway Service Model



Early Hospital Discharge Model



University Hospital Trust Coventry: Initiatives to improve advice and information for older patients in Rugby and Coventry Hospitals

The University Hospital Trust Coventry supported a pilot scheme in three wards in both their Coventry and Rugby hospitals. The scheme combined information packs developed through the *If only I had known* project with advisors in hospitals provided by Age UK Warwickshire and Age UK Coventry.

The advisors were able to refer on to a range of local organisations through the already existing Coventry Contact and Connect scheme, a referral service run by Age UK Coventry in partnership with (among others) the city council, the pension service (DWP) and not for profit partners including Orbit Care and Repair.

After a formal evaluation the hospital trust agreed to expand the scheme for 2012; additional funding subsequently agreed by the local merged PCT (The Arden Cluster) will allow a further roll out to all relevant wards from April 2012.

The initiative is focussed on discharge. It aims to reduce delayed discharge, minimise the risk of readmission, give hospital staff more options that help them meet patient needs and improve discharged patients' quality of life by giving them and their carers appropriate information and advice.

Key impact to date:

- Closer working between the hospital trust and some voluntary sector agencies at strategic and operational level
- Comparatively less re-admission in the pilot wards (though firm statistical link has not yet been established)
- Rugby Care and Repair developed a closer relationship with nurses and discharge staff at Rugby St Cross hospital, with more referrals
- 80 per cent of patients identified by hospital staff as potentially benefiting from this help agreed to subsequent contact. This group of patients are probably at higher risk of repeat admission, so support at/ after discharge is especially important
- The better information and advice about practical and social support, including for housing, has been welcomed by patients, carers and hospital staff.

Background

University Hospital Coventry Trust treats patients from both Coventry and Warwickshire. University Hospital Coventry (UHC) has a longstanding link with Age UK Coventry, who provided discharge support by referring patients to services using the Coventry Care and Connect advisors*. Coventry's Orbit Care and Repair services provided patients with housing related help, either through direct referrals or because of signposting from Care and Connect.

UHC Trust also manage the Rugby St Cross hospital in Warwickshire.

UHC had internal concerns over discharge and re-admissions, particularly among older patients. When UHC were approached by Age UK Warwickshire in 2010 about taking part in the If Only I had known project, they readily agreed. Concurrently, Age UK Warwickshire and Age UK Coventry jointly submitted a subsequently successful bid for development funding from Age UK national for an advice worker to be located in the trust's two hospitals. The two initiatives were quickly combined.

In the larger UHC the advice worker linked in with the discharge team. In the smaller St Cross, personal links could be made with the discharge coordinator.

For UHC Trust the initiative fitted well with three of their strategic objectives:

- improving discharge,
- improving information for patients and
- improving care for patients with dementia.

Age UK Warwickshire restructured their own staffing to make sure that they could continue to provide in hospital advice once the funded advice post finished. Age UK Coventry recruited OT and social work students and trained volunteers to fill the gap until further appointments could be made once funding was agreed. An evaluation report was taken to the Trust board in October 2011. The board agreed a recommendation to expand the scheme to other wards for 2012.

The local PCT are also interested in discharge and subsequently agreed to support expansion of the scheme to all relevant wards from April 2012.

How the partnership works

When patients enter selected wards at UHC or St Cross hospital, Rugby they are given a small plastic pack containing leaflets with information about services that are available for patients when they return home. The pack includes some information from the hospital about drugs and pharmacies, but is mainly about a range of additional services available from the local not for profit sector. These include housing related advice, assistance and support, for example handyperson services, benefit checks, Care and Repair services and home safety checks.

*Care and Connect is a partnership project involving the DWP, Coventry City Council, Age UK Coventry, Coventry Fire and Rescue service and a range of other voluntary organisations. Orbit Care and Repair Coventry are part of the operational group

Patients and carers can discuss and ask questions about the services while they are in hospital as an adviser from Coventry Age UK visits the selected wards on a regular basis. As long as the patient gives consent for their details to be shared, the adviser can make a referral on to relevant services. Ward staff will suggest that the advisers talk to particular patients or may get their consent for follow up. The adviser discusses any referrals with the discharge coordinator and the ward staff nurse.

When a patient is discharged they can take the information pack home with them. Each new patient receives a new pack, to ensure that there are no infection control problems.

Patients welcomed the initial packs and there was an increase in referrals to local Age UK services. However, ward and Age UK staff decided that for some people the packs contained too much material. They were not always suitable for all elderly patients, particularly those with some memory loss and/or dementia, and content was reduced. Discussions with staff and patients showed that the key to referrals was the presence of the adviser in the hospital alongside use of the packs.

Senior management level hospital staff enthusiasm and support for the initiative encouraged ward staff to get involved, with the project regularly mentioned at ward meetings. This senior support helped the advice staff to make links with a number of hospital staff. Operational hospital and advice staff all confirm that this senior management support has been critical to the successful introduction of the service.

The initial national development funding for an advice worker to walk the wards ran from 2010-11. When that funding ended Coventry Age UK kept the service going as far as possible with a mixture of social work students and volunteers to take referrals and provide advice. Following a positive internal evaluation report in July 2010 the hospital and the local PCT for Coventry agreed funding for an adviser for 2011/12 and 2012/13.

A project group including hospital and Age UK staff is looking at the next steps, including what to put in a smaller (and hence cheaper to produce) pack, how to deal with practical issues for volunteers and staff in hospitals around infection control, CRB checks etc, and at the best way to develop and promote the expanded scheme to ward staff.

Better outcomes: re-admission rates and hospital staff reaction

The hospital trust is looking at existing hospital data to see if this can be used to identify measurable health or financial benefits for the hospital. A comparison of discharge and readmission rates in the pilot wards over a similar period of months one year apart showed a small drop in the readmission rate. This fell from 14.7 in 2009/10, the year before the pilot, to 10.6 per cent in 2010/11. This change is encouraging but not conclusive, given the low numbers involved and the possibility that other factors are responsible. A further evaluation will try and isolate the impact of the expanded scheme on hospital and health issues.

Ward based hospital staff like the pack and the referral options. It allows them to do something for a large group of patients they previously felt unable to help, which in turn makes them feel they have done a better job. One senior nurse commented on a tendency for staff from wards not involved in the pilot to 'borrow' packs for their patients or their own families and friends. The specialist nurse for older people believes that the written information in the packs is most useful for the relatives but the patients need a person, and that the combination of the two approaches is important to the success of the project.

Better outcomes for patients: more referrals, more services delivered

Between March 2010 and June 2011, 1500 packs were distributed in the UHC Trust hospitals and services directly supplied to 154 referred patients - 1 in 10 of the relevant patients. Housing advice, assistance and support were among the most popular services provided.

Age UK Warwickshire have recorded a big increase in hospital related referrals, though historic data is limited. What is not possible to track from existing systems is the number of patients, families and carers, or hospital staff, who used the information in the packs to resolve situations without needing to ask for services from Age UK.

Better housing related outcomes for patients

The Care and Repair scheme in Rugby is run by Orbit housing, who also report an increase in referrals as a result of better advice and information provided in hospital and the improved personal links with discharge staff. Early in the pilot phase Age UK and Care and Repair staff gave talks to social workers and OTs in St Cross hospital and they report a rise in direct referrals as a result (again, no historic data or systems for tracking trends were available).

Sometimes a request for low level housing related support, such as a home safety check or grab rail installation, reveals more significant needs that would otherwise have been missed (Illustration 12.)

Illustration 12: A home visit by a housing specialist can lead to a better quality of life and potential future savings for health and social care.

Mrs P is in her 70s and lives alone in Rugby. Her bedroom and bathroom are both upstairs. Mrs P had a fall, which resulted in a fracture and a stay in St Cross hospital. When she was discharged Orbit Care and Repair were asked to carry out a home safety inspection.

During the inspection the Care and Repair case worker realised that Mrs P was struggling with the stairs and her bathing needs. Her method of coping with both was dangerous. The case worker thought that without help she was likely to suffer additional falls.

A referral was made to Social Services for an Occupational Therapist to visit and assess Mrs P. While this was happening rails and smoke alarms were fitted by the Care and Repair Handy Person.

The OT assessment agreed with the concerns identified by the Care and Repair case worker. Social Services recommended a stair lift and a level access shower; both were put in by Care & Repair Rugby, funded by a grant from Rugby Borough Council. This hugely improved Mrs P's better quality of life; she could use her whole home and bathe safely.

Without the referral by the discharge scheme Mrs P would not have been helped. It is likely that she would have fallen again, with the potential for an emergency re-admission, expensive rehabilitation and a greater subsequent need for care. Either a move or similar adaptations to those now installed might then have been needed.

Key public cost savings: avoidance of fall and expensive hip fracture

Cost of adaptations: £6,302, potentially preventing costs of hip fracture of £24,000

Alternative scenario:

Mrs P falls and fractures her hip. She subsequently needs the same adaptations and a care package to be able to return home.

Cost details: [Adaptations costs from PSSRU unit costs 2011. Hip fracture costs from NICE]

Handrails	@ £52
Stairlift	@ £3,293
Level access shower	@ £2,957

Average cost of hip fracture to health service: £12,000

Estimated average social costs of hip fracture: c. £12,000 (Mrs P may have to pay this)

Total one year costs that may be avoided: £24,000+

Illustration provided by Orbit Care & Repair Rugby

Coventry Care and Repair has not yet seen an increase in referrals. However they are still involved in hospital discharge cases and hope to benefit from the expansion of the scheme. A recent case study (illustration 13) shows how important it is to understand the local housing and charity market, as demands on local authority capital (such as for disabled facilities grants) make it increasingly difficult to pay for many small improvements that can help with quality of life.

Illustration 13: Local knowledge & local finance improve housing and hence quality of life, after hospital discharge

Mrs U is 69. She lives alone in a mid terrace property in Coventry. Mrs U was assaulted in town; she fell and broke her hip in 3 places. She needed surgery to repair the damage and was naturally quite nervous about how she would manage on returning home. She was referred to Care & Repair by the discharge team at Coventry University hospital.

The Occupational Therapist (OT) supplied Mrs U with two perching stools, one for her bathroom to enable her to strip wash and one for her kitchen to enable her to do her chores without standing for long periods. She can manage to get around the house using the sticks the OT provided. However, Mrs U could not get into the bath or do any gardening. She found not being able to wash properly and looking at an increasingly overgrown garden depressing. She also had a wasp nest in her roof space over the kitchen, so couldn't open a window or the back door as wasps would come into the house.

Mrs U asked Care and Repair about having a shower over the bath, but as her condition is not long term she does not qualify for disabled facilities grant.

Care and Repair organised a benefits check which secured some additional council tax benefit and income support to top up Mrs U's pension. A successful application for charitable funds from The Coventry Jubilee Trust and The Tansley Trust raised £850 to install an electric shower. The OT supplied a bath board and grab rails to allow Mrs U to use the shower safely.

There was enough funding left over to allow Mrs U to pay a friend to tidy her garden and to help pay for the cost of the council to come and treat the wasp nest.

Care and Repair also arranged for community safety officers from the local police to visit and offer advice about security in her home and advice about keeping herself safe whilst she is out and about.

Mrs U was very grateful for the help. She said she now feels more confident, safe and comfortable in her home.

Illustration provided by Orbit Care & Repair Coventry

Lessons from the front line: Making integration of housing related help for patients in a hospital setting work

The local initiatives described above have started to demonstrate how it is possible to integrate systems for providing older patients with housing related information, advice and practical help with hospital discharge, usually as part of a wider home from hospital support arrangement.

They have developed ways to enable older patients, their families and carers to have face to face or phone discussions about their housing and care options alongside provision of practical housing related help and assistance.

Replication

Local housing conditions and population characteristics vary, and there are significant differences in hospital size and internal procedures. So there is no one simple way of amending hospital systems that will suddenly fully integrate the housing help that can benefit patients and result in efficiency savings.

However, there are some general principles that seem to underpin success in moving towards more integrated ways of working.

• **Personal interest and relationships matter**

- Senior support at a strategic level and effective frontline relationships at an operational level are equally important – both need to be in place for successful integration
- Training, short talks and/or briefings to raise 'housing awareness' among hospital staff increase understanding and result in appropriate patient referrals
- If hospital staff experience demonstrable, tangible benefits for patients they are more likely to refer people for housing related help

• **Communication is key**

- Good written information about housing and care options needs to be easily accessible and made widely available in the hospital setting, as much for relatives and carers as for patients
- Talking to people face to face matters as much, perhaps more, than provision of written information, especially for patients, so housing advisers need to be located in the hospital setting
- Hospital staff and patients need to have easy access to knowledgeable, trusted advisers who can provide in depth information, advice and practical help concerning housing and care options for older patients

• **Support must be patient focussed**

- Referral systems between partners have to be extremely simple and smooth – hospital staff have limited time

- Partners who understand, appreciate and use each others' expertise are more likely to work together well
- Support must be for patient choice, not a 'standard prescription'
- Housing related help that remains available and accessible after patients have left hospital is important

The lessons about providing advice and information about housing and care to patients going home from hospital

The critical factors identified in this section as practical pointers include

- the right information at the right time in the right way
- seamless cross referrals that bring specialist support at the right time

Providing patients solely with written information such as leaflets and brochures about housing and care options may not lead to those who need services the most receiving the help that they need.

Patients are often not in the best position to assimilate new information or think about future practicalities. They are weaker and sicker than usual, often under the influence of drugs and potentially in pain and confused. Hospital can seem overwhelming; staff are very busy and several staff will be dealing with individual patients, who are often unclear about who is responsible for what.

Many patients who subsequently received housing help eg. with home adaptations or housing options advice, and agreed to be interviewed for this report, could not remember how they found out about the service.

“It is very hazy. I was quite drugged up on painkillers.”

Service user

“People need one person....there are so many people involved [with a patient] in hospital...patients need one person who understands.”

Hospital OT

So some patients and carers need to be able to talk to an individual who has time to discuss wider housing and care related issues with them and who has a breadth of non –medical knowledge. For some people the first conversation may be best had in hospital; for others, it may be better shortly after discharge.

“[Information] Packs are for relatives. Patients need people.”

Senior nurse

The initiatives described in this report all simplified and shortened the written information about housing and care provided for older patients as their local projects progressed. All reported that key to increasing appropriate referrals of patients in need of housing and care advice and information is a personal touch, through on-site advisers/referrers or through dedicated phone numbers with trained responders.

Impact also increases when health and social care staff as well as voluntary sector advisers are involved in identifying and referring patients who are likely to need help.

In simple cases this can be a direct request for a practical housing service – for example, the fitting of a key safe to allow carers and wanted visitors to enter a home when someone lives alone and cannot physically reach the door easily or safely. Sometimes these seemingly minor interventions can uncover greater needs; for example, one handyman sent to fix a grab rail discovered that the patient had no working heating and a seriously leaking roof. Because Care & Repair teams have a wider remit than simply completing a booked task, he referred the person back to the agency for help to fix the roof and install heating.

In other cases hospital or social care staff may realise support at home is needed but know that the patient concerned will not be eligible for Social Services assistance under the local fair access to care [FACS] criteria. Referral and personal contact between patients or their carers and a suitably knowledgeable member of a home from hospital service may uncover a range of housing, support and care issues. This contact may be face to face or phone based.

Responding to individual patients' needs requires effective cross referrals between all parties concerned. This makes simple referral arrangements for frontline hospital and social care staff to housing help critical. It also means partners need good internal communications and procedures to prevent duplication and ensure appropriate referral.

In a minority of cases complex housing issues can prevent discharge for long periods. Social workers and hospital discharge staff who have worked on cases with housing specialists recognise the benefits from working with local experts. The interactions between housing tenure, home adaptations assistance and welfare benefits can be confusing and complex and change over time as an individual's health fluctuates (Illustration 14).

Giving out written information is often not enough. Claim forms for welfare benefits can be (or can feel) complex. Applications for social housing often require computer literacy. Choice based lettings systems are not always easy to navigate. And small things can become apparently insurmountable obstacles to discharge. For example, in Illustration 3 above, the council insisted that potential tenants must visit a property before accepting it and would not allow delay, even if the prospective tenant was ill in hospital. It took the negotiating skills of the housing options adviser to get around this problem in order to arrange re-housing and enable hospital discharge.

Someone who understands the local rented housing market and social housing system can make sure people get the right (often higher) banding or priority when applying for social housing. They will know about the local housing options for moving home, including options

to buy or part buy into retirement/sheltered housing, and understand how benefits interact with housing and care.*

Navigating the various systems is not always easy. Hospital staff working with housing options workers on complex housing issues said how grateful they were to have a specialist.

“I don’t think Mr A would have gone home without her. Now I know that she [the housing options worker] is there and what she can do I will use her more....”

Hospital OT

“We are not housing experts. She is. It saves us so much time and she knows things we don’t. ... Social workers can talk about [housing] options, but once it gets complex there is a gap....”

Hospital social workers

Illustration 14 : Unpicking complexity in housing: the crucial role of the expert

Mr PG is 56. He lives in a privately rented bungalow. He has always paid his rent promptly and on time. He had a good job which meant he had no eligibility or need for benefits.

In November 2010 he lost mobility because of a back problem. Initially he went into hospital but was discharged over Christmas without any support. Shortly afterwards he fell again at home and was readmitted. He needed a specialist scanning machine to check his problem. An underground accident had left him with severe claustrophobia. This meant he could not go into a normal whole body scanner. In the meantime he was confined to a wheelchair.

The hospital wanted to discharge him pending a resolution of the scan issues. However, his wheelchair was too wide to allow him to go through the doors of his home, and it had a bath, not a shower. The landlord did not want any major alterations done to the property.

While waiting in hospital Mr PG was aware that he was becoming institutionalised, but could not leave.

The housing options worker was asked to help by a social worker. She made sure that Mr PG was put on the council’s waiting list and given a high priority, but no suitable property came up as available. In April 2011, Mr PG’s entitlement to sick pay from his employer ceased. He did not have significant savings so could no longer pay his rent. The housing options worker helped him apply for housing and council tax benefit, but the former was refused on the grounds that as a wheelchair user who could not get his doors widened in the property that he rented he could not return home – and so was deemed to have no intention of returning home. Therefore he was not eligible for housing benefit.

Mr PG was still hoping that his back could be sorted out and did not want to lose his home when there was no alternative available. However, the council decision meant that Mr PG was

[continued on next page](#)

*For example, benefit rules can cause difficulties for long term hospital patients as housing benefit eventually stops being paid

Illustration 14 continued

in danger of losing his home through not keeping up rent repayments. The housing options worker asked Shelter if they would take a test case against the council and they agreed. Mr PG explained to the letting agents that there was a problem but he was taking steps to sort it out. Because of his good payment history they advised the owners to delay any eviction action.

Meanwhile the scanner needed was found (by Mr PG!). The scan showed that an operation could sort out the back problem. The housing options worker immediately explained the new situation to the lettings agents and the council. In June 2011 Mr PG had his operation. On August 18 2011 he was home, walking with sticks. The council agreed to pay housing benefit and backdated payment to his first application, so no legal challenge was needed.

The housing benefit does not fully cover the rent, which Mr PG tops up from ESA and his mobility and disability allowances. However, he is coping while he slowly improves. Friends have installed temporary ramps and rails. His ex-employer may be able to offer a job when he recovers.

Mr PG thinks the housing options worker was a godsend. Her support kept him going, and keeping his home is helping him recover faster.

“Without her help I would have lost my home, so that there would have been nowhere to go after the operation (except a temporary care home or bed and breakfast arrangement), and my recovery would have been still further delayed. After all, part of getting better is coming back home.”

Mr PG

Illustration provided by Somerset West Care & Repair

Demonstrable Benefits

There are longer term benefits to health services in general and hospitals in particular from offering housing and care advice, practical assistance and support to patients and their families.

For example, a local study in Wales³⁵ of rapid response home adaptations delivery suggests that every £1 spent saves the health service £7.50 through faster discharge and prevention of hospital admissions by preventing accidents and falls in the home.

Targeting

It is not always easy to measure the effectiveness of specific interventions delivered to the older population in general to reduce emergency hospital admissions, for example mass home safety checks to prevent trips and falls. Research increasingly suggests that the most cost effective interventions are directed at those who are at high or moderate risk, rather than population in general.³⁶ Improvement to environmental factors (like housing conditions)

does reduce the likelihood of falls if it is targeted at those considered more at risk.³⁷ Thus targeting housing related help within a hospital setting is a useful way of reaching older people who are at risk.

The majority of older people have no contact with Social Services and many neither know about nor make use of the services potentially available to them, including the practical housing related help described above. When older people find themselves in hospital, possibly facing difficulties with returning home, information about available help to enable independent living becomes even more pertinent and hence is a useful location to target such help.

Creating integration partnerships to fit local circumstances

As noted above, hospitals, local area characteristics, populations and the local housing condition and markets vary enormously. Key lessons from the pilot work were:

- the importance of understanding the characteristics and dynamics of a local area and also appreciating the nature of the specific hospital in order to set up a effective local partnership that involves all the key players
- the importance of developing bespoke partnerships that respond to local need – there is no ‘one size fits all approach’ that would work in all localities

Community hospitals clearly have a significantly different patient profile and throughput compared to acute hospitals and responsibilities for patient experience and discharge vary considerably between hospitals.

For example, in the main University Hospital in Coventry the relationship with the whole Integrated Discharge Team was considered by hospital staff and information workers alike to be the key to good liaison when it came to provision of housing and care advice for patients. In the small St Cross hospital in Rugby (which is part of the same Hospital Trust) there is just one key person (the discharge coordinator) and the whole initiative depended on that relationship. So different people will be key partners in different places.

Local history around service commissioning and provision will influence the leadership of partnerships and affect the partners available to provide advice and information in hospitals. Local home improvement agencies that help people carry out home repairs and adaptations offer a widely differing range of services in different local areas. Handyperson or housing options advice may be delivered by one organisation or several providers - or often will not be available at all.

Local authority administrative boundaries also affect provision. Hospital patients do not necessarily all come from one local authority area. And in two tier areas statutory housing, adaptations and housing related support provision is the responsibility of districts, while social care is a county function, so more complex partnerships are needed and there will be many more links required with a wider number of organisations to make a partnership work.

Local housing markets and prevalent physical housing characteristics make a difference to local needs and to older people's housing options. The local availability of social rented housing, retirement, sheltered and extra care housing for sale or for rent varies across the country, affecting the housing choices on offer for older people.

For example, good, safe heating is particularly important for older people's health. In rural areas where many properties do not have access to mains gas, there will be particular issues around provision of affordable heating.

In the pilot area of Somerset West (not described in as much detail in this report for the reasons outlined in Appendix 2) poor quality private rented housing in the local area resulted in particular problems for hospital patients (and hence significant hospital discharge delays and re-admissions).

In the case of North Somerset, as in many rural and seaside areas, there are mobile home parks with a high proportion of older residents. It can be hard to adapt some park homes for people with mobility problems. Many homes have relatively narrow internal doors that will not accommodate wheelchairs, and steps to the front door which cannot be easily replaced by a ramp. So residents may need to move to maintain or regain quality of life if they have increased mobility problems. However, the resale value of the home may be too low to allow another purchase, limiting alternative housing options

In Conclusion

Local joint commissioning groups and the public health and well-being boards will need to adapt and develop models that fully integrate housing related help, advice and information into health and care systems, including hospitals, to fit their local situations.

As all of the examples cited in this report show, better integration between hospital, housing and social care works.

- It helps speed up safe patient discharge, which saves money and improves patient satisfaction
- It widens choice for individuals – although choice is only possible if people have the appropriate local information and suitable alternative housing options and housing related care and support services are available
- It helps hospital staff do a better job. They have someone they can refer older patients to when those patients do not meet social services high criteria but still need support to live at home
- Good partnership work helps ensure help is targeted at older people who need it; and, above all
- It improves quality of life for older patients as well as their carers.

Looking Forward

Demographic change and growing pressures on public finances in the NHS and social care mean that operational efficiencies have to be found. At the same time, there is an increasing focus on quality of outcomes for patients, so significant change and innovation is essential.

There is a growing body of evidence demonstrating how low level, preventative services can delay or minimise the need for hospital stays and delay entry to residential care.³⁸ These services, and wider improvements to the suitability and standards of housing, can also improve older people's quality of life and levels of independence³⁹.

The evidence also suggests that during or just after a hospital episode is a good time to identify older people who would benefit from housing related practical support. Person centred, planned discharge also increases patient and carer satisfaction.

There are a number of innovative arrangements to improve joined up working across sectors already in place in some local hospitals. Those described in this report have particularly focus on enabling self help through provision of housing and care information and advice. However, the scale of such provision is currently very small and current schemes are only scratching the surface of known need.

Recommendations

The following recommendations for change to bring about improvements for older patients are based on analysis of the policy context and examination of local initiatives including those described above.

- New public Health and Wellbeing Boards and Clinical Commissioning Groups have an opportunity to transform local service planning and commissioning for older people. *They need to ensure that housing related advice, support and practical assistance is included in local strategies and is fully integrated with social and health care provision.*
- Organisations providing housing related information, advice, support and practical assistance should collect outcomes data that identifies the benefits of their involvement with patients to health and social care. *They then need to present this information to hospital and social services management.*
- Providers also need to demonstrate to hospitals how they can help to minimise discharge delays, make discharge safer and so reduce the risk of returns within 30 days, as well as improving patient experience. *They can help to fill the support gap between universal health care and tightly targeted social care support.*

- Cross sector arrangements linked to hospitals should be developed to target older people who would benefit from practical housing related support. To work well these need to be embedded within hospital procedures, providing direct access to a wide range of linked support understood and supported by operational hospital based staff. Senior strategic support should be supplemented by involvement in training and in team development, by establishing personal links on wards and by ensuring simple but robust referral arrangements.
- Voluntary sector and other housing support providers need to work together to develop a partnership approach service delivery within hospitals. This would need to include joint data collection in order to evaluate and demonstrate effectiveness. *Such an approach could be facilitated through the strategic role of the local public health and wellbeing boards.*

APPENDIX 1

Basis of Cost Analysis for Health, Social care and Supported Housing

Health Care Unit Costs

Unit and episode costs taken from PSSRU Unit Costs of Health and Social Care 2011
<http://www.pssru.ac.uk/uc/uc2011contents.htm>

These quote an average in patient stay as £2,931 for an elective patient. For non-elective (i.e. admitted as an emergency) the average long-stay cost is £2,334. The majority of older patients arrive by emergency transport, which costs an additional £253.

Unit costs vary by speciality. Daily rates are difficult to average. Daily recharge costs charged to non NHS health users under the injury costs recovery scheme were set at £737 per day in April 2011. Day case reference costs are cited by PSSRU as £667; elderly mental health beds as £319 per day.

These costs exclude the potential additional expense of beds needed for re-ablement (average cost per patient £2,083) and/or any spell for supported rehabilitation in a care or nursing home.

Dept of Health Excess Bed Days Reference Costs

Hospital episode statistics measure how long patients with specific conditions spend in hospitals. This information is used to develop ranges of time that are considered acceptable for those conditions. Stays beyond this are counted as 'excess' bed days.

2010/11 reference costs publication, DOH, November 2011 Reference 2 suggests that on average each 'excess bed day' costs £260.

Hip Fractures

NICE estimates the total annual costs of hip fractures (including both health and social care costs) at around £2 billion for 70-76,000 fractures pa ie £26,000 to £28,000 per fracture. Estimated costs to NHS of a broken hip are at least £12,000.

Costs of Social Care

Laing and Buisson estimate that postponing entry into residential care for one year could save an average of £28,080 per person *Care of Elderly People; UK market survey 2008*. Laing and Buisson (2008). This well recognised market standard is the costing that has been used in this report.

PSSRU estimate the average weekly cost of a residential home set up for dementia sufferers as £544 per week.

Unit costs for home care packages are taken from the PSSRU data (as above).

Unit Cost of Social Sheltered and Extra Care Housing

Social sheltered housing does cost the public purse, but rent defrays this. A recent evaluation (2011) of First Stop by the Cambridge Centre for Housing and Planning Research⁴⁰ suggests using a cost to the public purse of £4,327 per year (the unit cost from PSSRU 2010 minus the average rental and service charge). This approach is used in this report. However, the PSSRU unit cost is based on old research. Changes to the management of social sheltered housing (including greater use of technology and wardens also supporting individuals not resident in sheltered units) may have reduced costs.

Social Extra Care Housing receives a variety of public funding, for example capital grants from national government and LAs revenue support through housing benefit. This report uses PSSRU costing for Extra Care housing for one year at £21,736 (£418 per week).

Unit Cost of Housing Options Adviser Intervention

A value for money analysis undertaken by the University of Cambridge as part of their evaluation of the national housing options service, FirstStop, produced an average cost per client of £670 in a study of the Warwickshire scheme.

However, a significant difference in caseworker time is spent on people who require information and advice about their housing options with limited interventions, compared with those who need intensive support to move home. In the latter case an average cost of £2,500 was calculated in a study of Somerset West Care & Repair. In cases where a patient has been helped to move home this latter amount has been used.

For Details See: <http://www.cchpr.landecon.cam.ac.uk/outputs/detail.asp?OutputID=270>

Cost of Handyperson Services

The national government funded evaluation of handyperson services (interim findings report, 2011) calculated an average unit cost of £90 per job.

Details <http://www.communities.gov.uk/documents/housing/pdf/1837939.pdf>

APPENDIX 2

Somerset West Care & Repair

Another local pilot area for *If only I had known* was located with Somerset West Care and Repair, an independent voluntary sector project which covers two districts Sedgemoor and West Somerset. As well as the core service of help with home repairs and adaptations for disadvantaged older and disabled people living in their own homes, this Care & Repair service offers handyperson help and energy efficiency advice. The work in hospitals was undertaken by the Housing Options caseworker who helps older people who are thinking about their housing options if they are struggling to manage at home, providing information, advice and practical help with moving home.

It also provides training and information about older people's housing options in Somerset to health, housing and care professionals, older people and community activists.

The individual casework undertaken by this pilot area was of a very high quality and provided a number of the case studies in this report which clearly illustrate the cost benefits. The service developed a particularly good reputation in small community hospitals which seemed to have particular problems with older patients whose health was badly affected by living in poor private rented housing.

Despite the excellent casework and front line success, this project was not described as an in depth case because, for a variety of local reasons which were outside the agency's control, there was no system change within hospitals.

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- ¹⁴ Audit Commission (2011) *Tough Times* London, Audit Commission
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- ²⁵ Laing & Buisson (2008) *Care of Elderly People; UK Market Survey 2008*

- ²⁶ Kings Fund data briefing on discharge 2011, op cit, based on Glasby J 2003 *Hospital Discharge: Integrating Health and Social Care* University of Birmingham
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