250 clients have gone HOME FROM HOSPITAL with us....

An Impact Report on the first nine months of Home from Hospital in Bradford District

2012—2013

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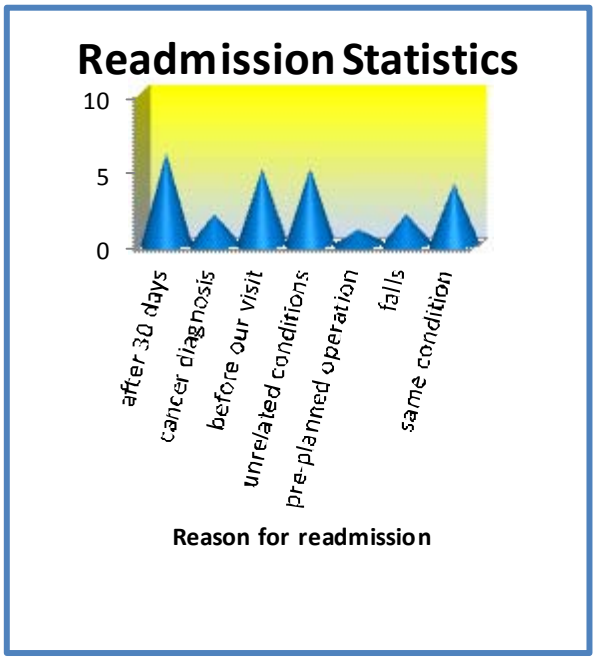
carers' resource
you care for them, we care for you

....only 4 have gone back in*

Key Findings:



Home from Hospital was set up to support patients identified as 'high risk of re-admission without support'. According to The Nuffield Trust ; '*The percentage of inpatients identified as high risk who were subsequently readmitted within 30 days was 59.2 %. Average cost of re-admission is £1,088.*'

Although our project has not been using an officially recognised readmission prediction tool we know from professional feedback that the patients they have been referring to us are at 'significant risk' of readmission therefore from our 250 cases potentially 100-125 may have been readmitted without our support thus saving between £108,800 to £136,000. Of the 250 clients referred to us a total of 25 went back into hospital—two due to cancer diagnoses, five with other conditions unrelated to their original admission, one for a pre-planned operation, two following falls and five before we could make a first visit (i.e. within 48 hours of discharge) plus six who had been at home for longer than 30 days. Only 2.02% of the 250 (4 patients) who were supported by the Home from Hospital team were readmitted into hospital for the same condition within 30 days.

Sally (Home from Hospital) and Kempton Cannon —one of our first clients.

Kempton's daughter Sheila Davey:

"We would have been in a real mess without HFH as we didn't know how to access any services that my Dad needed. You have been brilliant and especially because we live away in Scarborough"

* This figure counts only clients who were re-admitted within 30 days of their discharge date for reasons pertaining to the same condition for which they had received treatment and been discharged. Patients who were re-admitted after 30 days or with a new diagnosis/condition are not included.

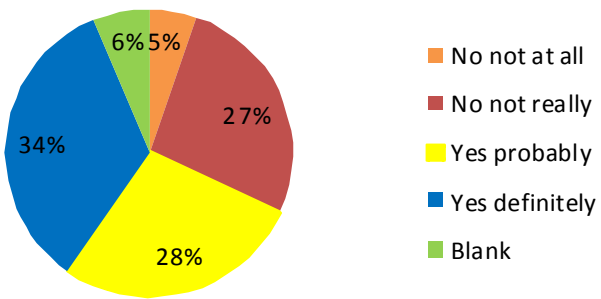
Home from Hospital Patient Feedback

All comments from the clients feedback forms have been transformed into a word cloud. The size of the word indicates how many times it was used in the feedback.

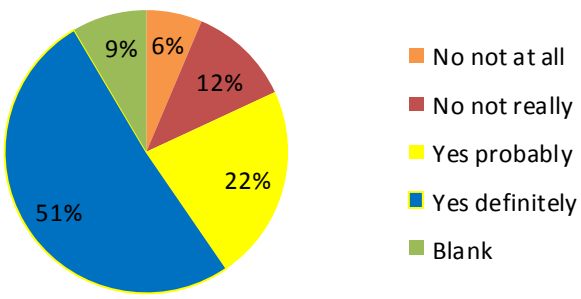
Other stand-out findings include:

- 71.3% of patients said they feel less anxious having had HfH support
- 61.7% of patients were more confident about managing their own health care going forwards
- 61.7% said it helped them get back to how they were before their hospital stay and 42.6% said they felt even better than before
- 87.2% of patients said it was good to know there was someone there to help
- 85.1% looked forward to the calls/visits
- 72.3% has said the scheme has made them feel happier
- 89.3% of patients said their visiting team were friendly and helpful
- 87.2% of patients would use the scheme again if they needed to

It helped me get things in order and get back to how I was feeling before



Having the help made me feel more confident about coming home



What the professionals say...

More than 46 different teams, wards, services and individuals across Bradford and Airedale have referred into the service so we asked some of them why they used it and what difference they felt it made

"It provides services that I feel are essential to patients, but statutory services no longer provide."

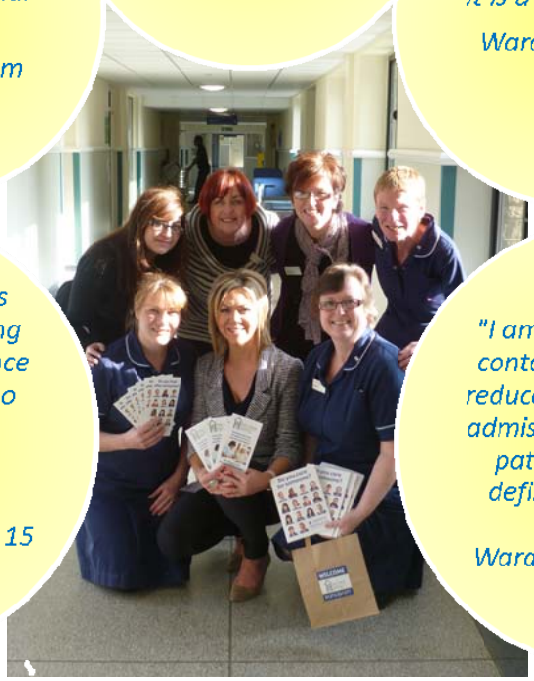
Ward 29 BRI

"Home from Hospital can prevent unnecessary 'social' admissions."

Adult rehab team AGH

'It is a great service'

Ward F6 St Lukes



"I think the scheme is working and identifying other patient needs once they are at home. Also referring to other services avoid re-admissions."

OT medical team ward 15 AGH

"I am confident that the contact with Hfh should reduce the numbers of re-admissions. I feel that the patients we refer are definitely at risk of re-admission "

Ward 5 Stroke Unit AGH

What our volunteers think...

Home from Hospital is very much a partnership between staff and volunteers—they help us reach more clients, offer more support and make a huge difference to the lives of those they work with. We asked them for their thoughts about the scheme, the challenges and benefits of being part of the team:

When I was a nurse I saw a need for this type of service. Now I enjoy volunteering for it

What we do is just a drop in the ocean in the care of clients

Saying goodbye to clients after 6 weeks is very difficult

HFH is a missing link for any-one who is vulnerable, alone or isolated, by helping them tune into appropriate services

Knowing you are making a difference is very rewarding

In summary:

This is a wonderful scheme. S... is my contact & she is helpful, knowledgeable , friendly & enthusiastic. I need her - she's better than an angel!

"The service is very good. It is done very well and the team really looked after me. They made things happen to make my life easy."

HOME FROM HOSPITAL ...at a glance

Our Outcomes

- ⇒ For patients at high risk of re-admission when discharged
- ⇒ Up to 6 weeks low level support at home

Home from Hospital is designed to:

- ⇒ Increase the number of people getting a reablement/ rehabilitation package
- ⇒ Improve quality of life and health/wellbeing—regaining pre-hospitalisation levels
- ⇒ Increase self confidence
- ⇒ Decrease social isolation
- ⇒ Increase choice and control for patients
- ⇒ Prevent emergency re-admission to hospital within 30 days

The team will meet the patient in hospital to explain the scheme to them and check it is suitable for them

A Co-ordinator does an initial home visit taking a food hamper -usually less than 48 hours after the client arrives home

Together they complete a unique safety and wellbeing checklist to identify key individual needs

A schedule of follow up calls and visits is planned to give information and support for up to six weeks

I was surprised the scheme existed, but very grateful it does.

How does Home from Hospital help?

Key liaison role in 83 cases including with family, landlords, adult services, GPs, OTs and home care staff

28 applications for Attendance Allowance, several other benefits claims and lots of work around utility suppliers to reduce costs/pay bills/clear debts

41 specific information requests for clients ranging from DVLA to dog walking, befriending to buses and legal issues to libraries

94 referrals to other agencies including Adult Services, SSAFA, Age UK, Stroke Association, Domiciliary Care providers and many more

Case 144

Hamper. Offered emotional support to client and neighbour (carer). Referral for Attendance Allowance – awarded at highest rate. Referral to befriending scheme. Took hearing aid to Audiology at AGH for repair. Collected prescription, delivered to client. Arranged for handrail outside to be fitted by Helping hands. Discussed medication concerns with GP, arranged for future Dossett Box delivery

Case 162

Hamper. Provided emotional support, supplied information regarding bereavement support. Registered client with new GP practice. Delivered information on making a will. Helped client obtain better deal on gas/electricity tariff. Referred to course on money management. Referred to Carers' Resource CReate scheme for employment.

Case 221

Delivered hamper. Linked client with volunteer for ongoing emotional support and mentoring. Volunteer accompanied client to Stroke club. Specialist advice sought by team from stroke ward re: speech therapy exercises, volunteer supported client to regularly do these. Volunteer accompanied client to GP surgery appointment and on occasional outings to rebuild confidence.

7 blue badge applications

13 carers Identified/referred for support

Emotional support to 155 clients

Helped 8 clients get key safes fitted

Had fire/smoke alarms fitted for 6 clients

Shopping for 17 clients

29 clients on the Message in a Bottle scheme

Arranged eyesight/hearing tests for 6 clients

Sorted dossett boxes for 16 clients to help better manage their medication

44 referrals to Safe and Sound