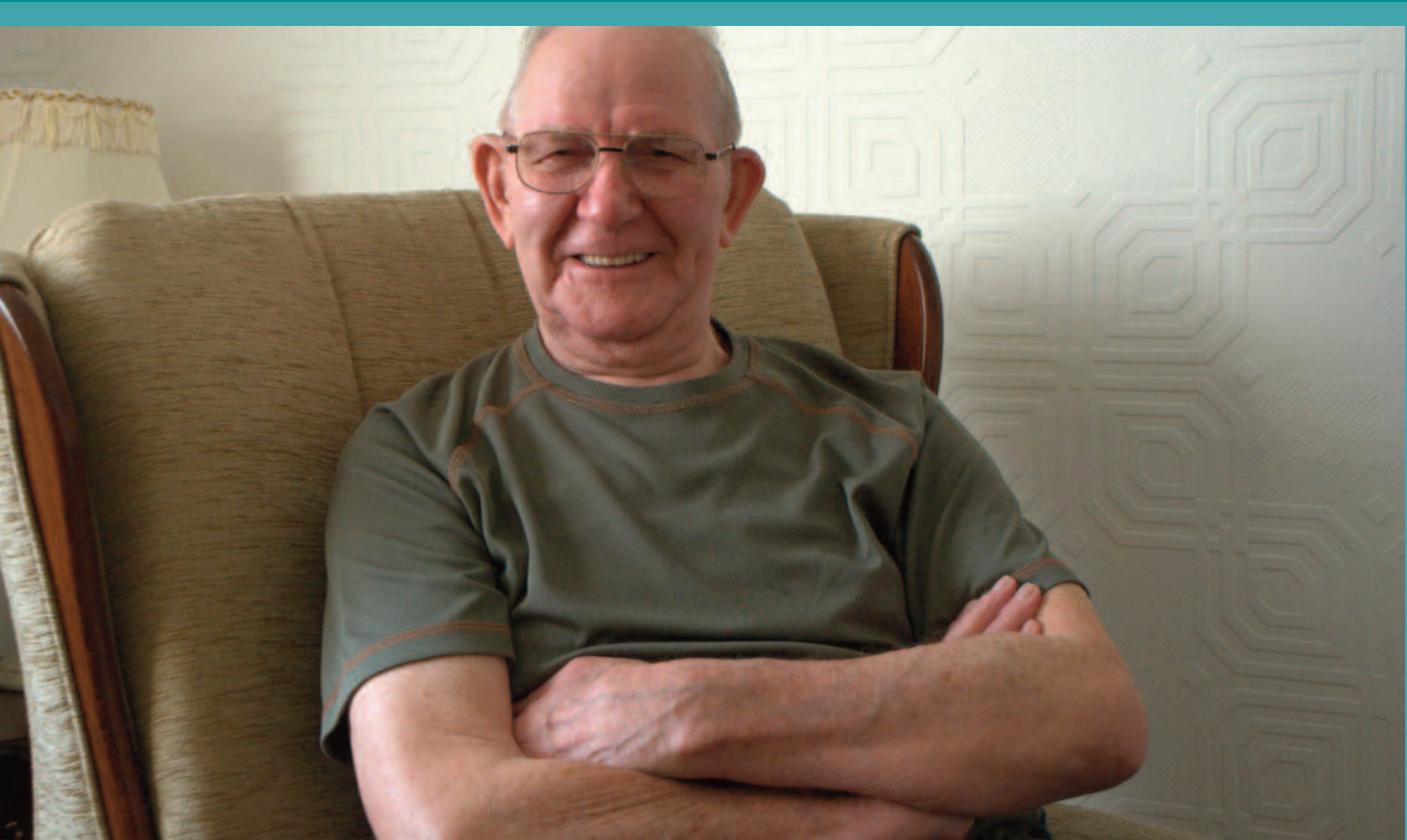


If only I had known...

**An evaluation of the local hospital
linked pilot projects**



Document Purpose To provide evidence and information about local pilot projects which have been pioneering the integration of housing help into a hospital setting

Title *If only I had known...* An evaluation of the local hospital linked pilot projects

Publication Date March 2012

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 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 people's health if they are discharged once they no longer need hospital level medical care. Hospital beds are expensive and in demand; so hospitals need to use beds as efficiently as possible.

Despite these factors, some patients, particularly older people, remain in hospital for longer than may be clinically necessary¹. The Kings Fund 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 older patients².

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. However, 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.

The local pilot projects that were part of Care & Repair England's '*If only I had known*' initiative aimed to make this crucial link through delivery of housing related information, advice and practical help within the hospital setting.

This report examines the results of those local initiatives.

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Purpose, Aim & Structure of this Report

This report aims to:

- Provide service planners, commissioners and service providers with the general rationale behind the idea of integrating housing related help within the hospital setting and to consider practical, tested examples of how to translate such ideas into practice
- Provide local organisations who are already delivering housing information, advice and assistance with tried and tested ideas and examples that they can adapt to their local situation and take to local hospitals and Clinical Commissioning Groups.

It also shares the wider learning from operating a small scale pilot programme in a variety of practice settings and makes recommendations for future development of integrated provision that addresses older patients' related housing and living conditions.

Relevant policy issues

Tight public finances make partnership work across the NHS, social care, housing and the voluntary sector especially important. This report only briefly mentions the policy context as there is a companion report (*If only I had known... Integration of housing help into a hospital setting* – also available on *Home from Hospital* area of the Care & Repair England website) which examines the policy context in greater depth, including an assessment of 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.

About the local pilot projects

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 closing 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

- Older people leaving hospital benefit from a mixture of short and longer term care, provision of equipment, adaptations and other physical work to their homes, social support and financial help. A cross sector 'home from hospital' partnership, such as those described in this report, is a good way of organising such support for patients. Housing help can lead to savings to health and social care providers
- The local pilot projects which were developed as a result of the *If Only I Had Known* initiative show that just before or after a discharge from hospital is an effective time to provide older people, their families and carers with information and advice about available local support, including housing and care options.
- 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
- Adaptations or improvements to existing homes, or a move to a more appropriate home, can bring major improvements to older patients' quality of life that health interventions alone may not deliver.
- There is evidence that housing and associated interventions for older patients can speed up safe discharge, thereby saving money on hospital bed days.

Introduction: 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.

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 years³.

Box 2: Housing and health

Housing conditions have a significant and quantifiable effect on health⁴. The Building Research Establishment quantifies the costs to the NHS of specific aspects of poor housing as over £600 million per year.⁵

Many of the chronic health conditions experienced by older people have a causal link to, or are exacerbated by, particular housing conditions⁶. 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 homes⁷.

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 had 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 a potentially effective way of targeting appropriate assistance.

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 local, 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).

Box 3: Examples of the main practical housing related services that promote older people's 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 home care, 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.

Development of the local pilot projects

The first phase of the *If Only I had known..* project sought to:

- Develop exemplar information packs for distribution in local hospitals
- Identify sites where these could be trialled
- Refine the packs as a result
- Identify ways to collect local data to show how many packs were used, what services were accessed as a result and what the outcomes were for patients and hospitals.

Background

In 2009 Care & Repair England began work on its '*If only I had known..*' programme (described on page 5) to improve housing related help in hospital settings. It started by contacting local Care & Repair and related service providers across the country to identify localities which were already:

- delivering a holistic home improvement agency (HIA) service that included housing options advice and information
- operated a handyman service as part of their core work
- had existing relationships with a wide range of sectors, including the health sector
- expected to either be able to incorporate the proposed extra work in hospitals within their current staffing and funding arrangements, or had funding applications/related proposals in the pipeline which would enable them to cover the expanded activity

Despite the tight criteria, there was interest from localities across England, but after a number of exploratory meetings with a wide range of local stakeholders and interested parties, three clear partners emerged for the following reasons.

1. North Somerset Care & Repair and Weston Hospital

North Somerset Council, a unitary authority, had recently made a successful bid to Dept for Communities and Local Government's 'enhanced handyman services' funding to meet the cost of a housing options worker. The LA was in the process of negotiating delivery of this service by the local Care & Repair agency, at that time managed by Hanover Housing but since transferred to West of England Care & Repair. This is a well established and holistic service delivering handyman and some limited home from hospital assistance as well as 'core' HIA services of helping older people who need repairs and adaptations to their homes (see Box 3).

After a number of meetings with representatives from Supporting People, the PCT, Private Sector Housing Renewal and Social Services these various parties came together with Care & Repair England to develop their own local ideas for how they wished to integrate provision of housing related information, advice and help within the hospital setting.

It also emerged that the hospital was concerned about the standards of discharge procedures and so might be receptive to a fresh approach, albeit with some caution.

The initiative was strongly backed by the Supporting People division of the council, who were commissioning a number of services which they felt could contribute to this vision for closer integration of housing into health provision. In addition, there was a key post holder within Social Services, part of whose remit was to broker better joint working across health and social care; she too understood the potential housing connection and was keen to support the initiative.

2. Warwickshire Age Concern (since renamed Age UK), hospitals across the county, and subsequently, Coventry Care & Repair joint work

Warwickshire Age UK was a major provider of services for older people operating across the whole county. This included housing related services Care & Repair, handyperson and housing/care options information provision in a number of districts. There were Care & Repair services run by Orbit Housing in other parts of the county, and they too supported the proposed work with hospitals.

The County Council's social services had recently developed links with FirstStop, the national provider of housing and care in later life information and were jointly developing an information brochure as well as backing employment of two local later life 'housing options' advisers. By brokering links between these two strands, it was established that all parties supported pooling their efforts and were willing to work together to improve provision of housing related information in hospitals.

Care & Repair England's *If only I had known project* officer pro-actively contacted and visited eight smaller hospitals across the county as well as the University Hospital in Coventry, which services the population of part of Warwickshire as well as Coventry City, and established widespread interest and support for the initiative.

3. Somerset West Care & Repair and Somerset PCT

Somerset West Care & Repair, an independent voluntary sector agency based in Bridgewater, offers the full range of HIA services, including handyperson, advice on options, technical and caseworker support for repairs and adaptations plus energy efficiency advice. When approached they had recently been chosen to receive a grant from First Stop to expand provision of housing options advice and information, so this added capacity fitted in well with the proposed work with hospitals.

A meeting with the local Director of Public Health and a geriatrician from Taunton Hospital confirmed interest from the health sector as admission rates/ discharge issues for older people were a matter of concern. Somerset West Care & Repair also had a good track record of co-ordinating joint working by a number of HIAs across the county and the vision that their housing options adviser would also be a source of guidance for caseworkers in other districts was widely supported.

Meetings with front line health staff in the smaller local hospitals further confirmed local interest and a willingness to co-operate with the HIA to try out a new way of working.

Other localities where the possibility of an *'if only I had known...'* type of initiative was discussed with potential providers (particularly Care & Repair, HIAs, Age UK) and service commissioners (Hospitals, Social Services, Supporting People and Housing) include:
Staffordshire, Derbyshire, Devon, Cornwall, Dorset, Leeds, Manchester, Wirral, Liverpool, St Helens, Nottinghamshire, Worcestershire, Bristol, Sandwell, Leicestershire, Northamptonshire, Dudley, Walsall, Wolverhampton, Stroud, Newham, Oxfordshire, Sefton, Blackpool, Knowsley and Newcastle upon Tyne.

3. Evaluation Methodology

This report describes and evaluates the ways in which a number of local Care & Repair and related providers have been trying to integrate housing related information, advice and help for older people in hospitals, particularly with regard to improving discharge and reducing risk of re-admission, in the localities described above.

The broad aim of the *If only I had known* programme was to help older people, their families and carers to make an informed decision about their future housing, care and support, either following hospital admission or where an older person has a long term health condition. This was also the aim of the local pilot projects, described below, although some had additional objectives and slightly different emphases.

The evaluation considers effectiveness of the model and the local projects with regard to:

- Supporting more informed choice about housing and care options for older people, their family and carers
- Maintaining or increasing independence and improving the quality of life for older people after they leave hospital
- Helping hospitals and social services deliver faster, safer discharge and reduce unplanned re-admissions (particularly in the 30 days after discharge)
- Helping health and social services to target preventative support on older people at higher risk of future unplanned hospital admission and/or care home admission.
- Indications of potential associated savings for health and social care arising from integration of housing help into the hospital setting.

It also considers the factors that affect how well schemes have worked and some of the barriers encountered to improving integration.

Evidence base

As the above description of the selection of the local pilots demonstrates, their creation and focus was a locally driven process. Each locality had to meet their own implementation costs, with the exception of the cost of developing and producing the bedside information packages, which were created and 4,500 of these provided as part of the national programme.

Every area had a mix of partners and different lead agencies. Each had their own local record keeping systems, including variable levels of individual data collection.

Whilst efforts were made to find common ground for tracking health outcomes for patients, for such a small scale programme with limited resources it soon became evident that this was beyond either the capacity of local record keeping systems and also was not technically possible using existing systems.

It was therefore agreed with each local pilot that they would maintain individual client records within their current systems and would broker follow up client interviews by an

external researcher that would enable individual case evaluation with regard to potential impact and cost benefits.

The findings in this report are therefore primarily based on in depth, qualitative semi structured interviews with:

- 8 project staff - the project lead officer plus the manager in each location (Somerset West, Warwickshire, Coventry, North Somerset)
- 14 health or associated staff in five hospitals plus related service planners and commissioners eg. Supporting People, Social Services
- 35 beneficiaries and/or their carers (17 people face to face home visits plus 18 interviewed on the telephone). This interview data was supplemented by case records.

The evaluation included a review of local management information on numbers and characteristics of clients, and the outcomes of interventions. As noted above, this information varied significantly across projects making quantitative comparisons difficult. Partnerships evolved over time, as did the associated data collection systems. There is no reliable health outcome data for all service users.

Whilst in this evaluation it is not possible to draw firm conclusions about the potential scale of health impact based on quantitative data, the available case data does highlight a number of important issues and the growing scale of information in some localities has the potential for future analysis (Appendix 1).

The report also draws on an earlier local evaluation of the local scheme in University Hospital Coventry.

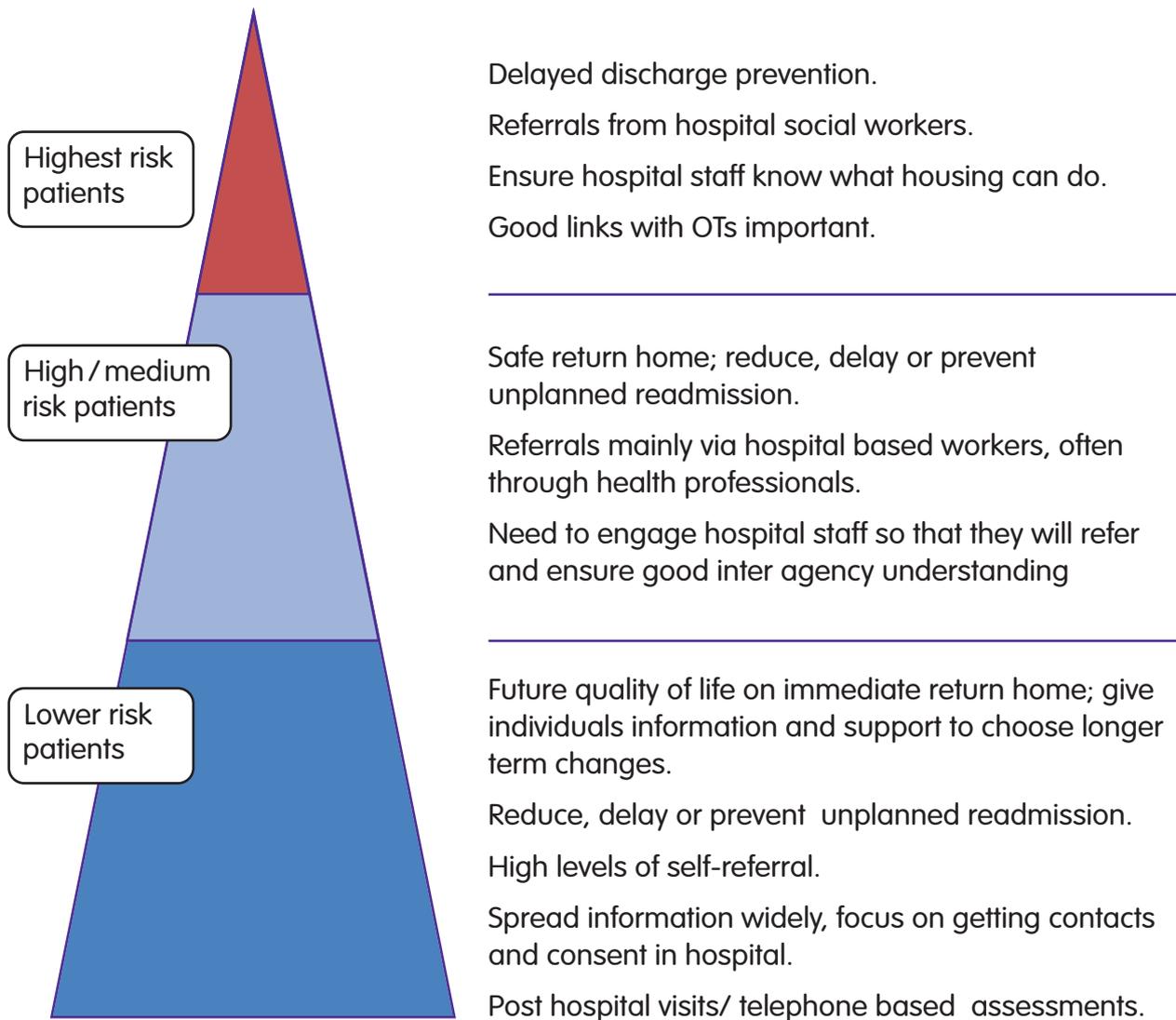
The evaluation uses evidence from three other areas (Bristol, St Helens and Stoke on Trent in Staffordshire) where local Care & Repair type services are currently involved with finding a fresh approach to integration of housing into hospitals. Again, these are based on face to face meetings with local project staff, managers and associated hospital link officers.

In the case of Stoke on Trent and St Helens, tight targeted short term initiatives have been set up with specific aims of reducing delayed discharge for higher need older patients, as compared to the *If Only I had Known* pilots which had broader objectives concerning increasing older patients' access to housing and care information and self directed referral for a range of housing related help.

In Bristol, the local Care & Repair agency has a longstanding history of housing awareness raising amongst health staff dating for more than a decade, through delivery of cross sector 'Healthy Homes' training for front line workers which aims to instil a broader understanding of the impact of housing on health in order to pave the way for a more integrated way of working across sectors.

Evidence from these schemes supports particular findings from the wider programme and potentially informs discussion about identifying and targeting patients where there is the highest risk of delayed discharge or re-admission.

Figure 1 illustrates how different local pilots relate to different groups of patients



4. Operation of the local pilot projects

Bedside Information Packs

The starting point for all local projects was production of a small (A5) plastic folder containing a simple explanatory card, notepad, pen, magnifier and localised '*Housing and Care Options*' brochure.

This product had been inspired by a similar national initiative in Wales in 2008, when such a 'Home from Hospital' pack had been distributed to hospitals across the country, backed up by visits from local Care & Repair caseworkers.

This professional looking package was the starting point for negotiations with hospital managers and ward staff in each area. As something visible and tangible, it proved a useful 'foot in the door'.

Housing Staff in Hospitals

In all localities the information pack was backed up by local Care & Repair (or similar voluntary sector service) staff undertaking regular 'ward rounds' to top up packs, talk to ward staff and identify older patients who wished to discuss their housing and care options and/or who need practical housing related help in order to be discharged from hospital.

Aspects of local implementation

North Somerset Partnership Approach

As a result of the approach by Care & Repair England described above, a '*Home from Hospital Partnership*' was created to operate at Weston Hospital.

It set the objective of supporting older and more vulnerable patients going home from hospital to maintain successful independent living, prevent and reduce the level of admissions to residential care.

The partnership is co-ordinated through the Council's Supporting People team. Initial partners were the Adult Social Services & Housing Directorate of North Somerset Council, West of England Care and Repair (who run handyperson and a housing options service funded through the council), Age UK Somerset (who gained national Age UK funding for a hospital based advice worker) and Alliance Homes (the local major housing association who provide housing related support). Two care providers and a mental health support charity have subsequently joined the partnership.

Front line staff from Care & Repair, Age UK and Alliance Homes operated a rota whereby one of them goes to the hospital every afternoon to speak to staff and patients and take referrals. Through involvement of all of these partners, help with practical issues around housing, finances and care as well as brokering wider social support, can all be provided to patients.

From first contact to agreement for pack and staff placement in the hospital took nearly a year. It began in selected wards in July 2010 and aims to cover all discharges in North Somerset by 2013.

Warwickshire Gateway

By the end of 2009 eight hospitals had agreed to trial placement of *If Only I had Known* information packs, with personal follow up through Age UK Warwickshire advice and information workers. This subsequently evolved into ideas for the 'Gateway' call centre service, developed by Age UK Warwickshire with Warwickshire County Council and the PCT. The wider 'Gateway' service launched in May 2011 with the aim of supporting older and vulnerable individuals 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 scheme is particularly focussed on discharge and helping to minimise the risk of re-admission.

Needs are identified through direct referrals from hospital staff to advice and information staff in the hospitals, and/or by getting agreement in hospital to a follow up post hospital assessment by Gateway staff through telephone assessment and (if needed) follow up home visits. Gateway is also open to other referrers, but half of the referrals in the first 6 months were from hospitals. Individuals are referred to an appropriate service provided by Age UK Warwickshire or other local group, including the local Care and Repair, handyman and housing options services.

Further support is being trialled in two hospitals, one involving placement of advisors in Accident and Emergency Departments to try to prevent unnecessary admissions, and one is linked to the Coventry work described below.

University Hospital Coventry

The University Hospital Trust Coventry supported a pilot scheme in three wards in both their Coventry and Rugby hospitals. This combined the *Home from Hospital* information packs with advisors in hospitals provided by both Age UK Warwickshire and Age UK Coventry. Where any housing needs were identified amongst older patients, they were referred to Orbit Care and Repair.

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

The initiative aims to reduce delayed discharge, minimise the risk of re-admission, give hospital staff more options that help them meet patient needs, including housing related and practical help, and improve discharged patients' quality of life by giving them and their carers appropriate information and advice.

Current proposals may expand hospital discharge support to implement a home 'Meet and Greet' scheme with two subsequent home visits by Age UK staff, to reduce the risk of non health issues triggering re-admission within the first 30 days after discharge.

Somerset West Care & Repair

In Somerset West, the housing options worker built up strong personal relationships with staff in small local hospitals, but it was not possible to progress work in the main county hospital in Taunton as the hospital had a policy of making a charge for any placement of information.

There was a mix of practice in the different local hospitals, with some placing *Home from Hospital* packs in bedside cabinets on selected wards (usually those with the highest proportion of older patients), and in others hospital staff handed out the pack to older patients when they were discharged. Staff from Somerset West Care & Repair undertook regular 'ward rounds' to talk to staff and take direct referrals.

This relatively low key and informal approach generated more than enough cases that the housing options worker could deal with. It revealed a particular problem with older people living in poor quality, unsuitable private rented housing which was a major obstacle to discharge. The successful re-housing that the Care & Repair worker brokered in such cases was highly valued by hospital staff and these case studies have proved very useful in modelling cost benefits.

Part way through the pilot programme the provision of Home Improvement Agency services to operate across the county was put out to tender and awarded to a large social housing provider. As a district level voluntary sector group, Somerset West Care & Repair was therefore excluded from any further development and has lost its core HIA service funding in 2011. The successful one to one casework by the housing options worker has continued to March 2012, but because of this structural change in HIA provision, there was no further action taken on wider system change within hospitals.

Stoke on Trent

In Stoke on Trent, since 2011 the local HIA service, managed by Staffordshire Housing, is providing an advisor and a handyperson to react quickly to referrals from hospital social workers. Assessments and sometimes practical work have to take place within 24 hours of referral. The key services provided are a benefits check, home safety assessments, trips and falls/home hazards assessments, minor adaptations installation and/ or furniture and equipment moving. The advisor can in theory offer housing options advice but this has not been requested on referral forms from hospital staff, therefore has not been delivered.

The initiative is linked to the national funding for re-ablement and is high throughput and highly targeted within the hospital setting. A review is due in April 2012 – early indications are that funding will continue.

St Helens

In St Helens the Borough Council, which manages an in-house home improvement agency, has taken the lead on behalf of a partnership which includes the PCT which covers the combined Merseyside area; the local acute hospital and two neighbouring councils.

The partnership is aiming to reduce delayed discharge so that beds can be freed up for more elective surgery. A local review of discharge cases suggested that most delays were caused by problems with agreeing care packages and in finding placements in care homes of choice, and that there were some linked to equipment delays.

A package of measures agreed in November 2011 include funding additional occupational therapists (OTs) in the hospital to carry out more rapid risk assessment plus a two person handyperson team to respond urgently to practical issues in the home, including equipment and small adaptation installation. Social workers from all Boroughs now work as a co-ordinated discharge team. A senior OT from the St Helens private sector housing service is now a member of that team and can comment on housing issues and solutions at an earlier stage.

The scheme is due for review in April 2012; early indications are that funding will continue.

Experience of developing local pilots with hospitals

There are a lot of things to do in hospital and something like a partnership with outsiders can easily be low on the list

Social services manager

Hospital staff raised a range of unanticipated practical problems, including:

- not wanting to reuse packs because of concerns about infection control;
- not wanting Care and Repair project staff to have access to wards for infection and/or security reasons;
- concerns around data sharing, including establishing patient consent to the sharing of information that can allow others to contact patients at home;
- treating Care and Repair as a private organisation who either could not be allowed to 'advertise' in any way, or who must pay the hospital to be allowed to place information packs.

The level of bureaucracy in hospitals was a source of frustration for partnerships. The nature of the early difficulties in engaging with hospitals highlights the importance of identifying a champion within the hospital at a senior level at an early stage. The managers and operational staff interviewed in all localities stressed this. That individual could be from within a hospital (as in Coventry) or from within Social Services (as in Somerset, North Somerset and Warwickshire). The culture in some hospitals means that open senior approval is critical to securing operational staff involvement.

When infection control came up I pointed out that they had bibles in all bedside cabinets. They agreed to the packs.

Agency officer

In hospitals... staff often need to be 'permitted' to help ...

Social services manager

Get in at the top. If embraced at the top they will know who you go to on the shop floor. Sell it as a money saver not just a quality issue.

Senior nurse

The practical problems raised by hospital staff were eventually resolved in all of the pilot areas. But they illustrate how pilot schemes do take up hospital staff time and require tailoring to hospital procedures, so clarity about the potential benefits that will result for hospitals in order to secure that staff time is essential.

An internal senior champion is necessary to give operational staff in hospital the backing they need to take an interest and get involved. Someone at an operational level in the hospital who takes responsibility for brokering solutions to practical difficulties is also important.

The partnership is still small and clunky, but it works in a small hospital.

Social services

An illustration of local variation is the level of concern over infection control. Some of the acute hospitals wanted any bedside packs to go home with patients. If the patient did not want to take the pack home, it was binned to eliminate any infection concerns. The solution was to create much cheaper and simpler 'packs' given the number of patients. However, the community hospitals were generally happy to re-use sprayed/wiped down plastic box packs.

If wards have a faster turn-around of patients they need advisors there every day of the week. Some longer stay wards only needed more limited (but regular) visits by housing workers.

Interviewees suggested four likely priorities in hospital business plans that could best be used to sell schemes. These were:

- Reducing delayed discharge if this is an identified local problem. Reducing unnecessary bed days can allow more elective surgery, which has financial and reputational advantages for hospitals.
- Minimising unplanned re-admissions within 30 days of discharge, as hospitals will not be paid again for such patients.
- Improving patient satisfaction around discharge. This is often a low scorer in satisfaction surveys and some hospitals are keen to demonstrate improvements.
- Improving information flows to patients in order to enable informed choice and control.

The first two have a direct impact on income and reputation and so are major initial selling points for managers. Nurses, physiotherapists, social workers and OTs often liked the second two as it enabled them to offer something extra to their patients and made them feel that they have done a better job.

[Most].. hospitals looking at discharge focus on clinical pathways and length of stay, not on quality of discharge.

There is a current strategic tension. In Councils and hospitals we are looking for direct cost savings, not the what if ? of [less clear cut savings resulting from] prevention.

Social services managers

Social services priorities may also include addressing delayed discharge as there are cost implications if they are responsible for delayed transfer of care. They will also be looking at schemes for integrated health and social care funding and to reduce use of residential care and nursing homes.

This does mean some tensions in 'selling' home from hospital projects for the voluntary sector. Their priority aims are more patient, not institution, based. Their key aim is improving quality of life rather than cost savings.

Learning what works: Developing local projects

- It is time consuming and difficult to engage hospitals in partnership initiatives which are not seen as directly linked to clinical work.
- A senior champion within a hospital is vital to break through this barrier, but this has to be combined with building front line relationships and demonstrating practical benefits.
- Senior support from Social Services can help to broker the hospital link as they are more likely to have an existing working relationship with hospital management.
- Whilst the projects aimed to improve older patients' choice and quality of life, successful set up involved demonstrating benefits to hospital and integrated care business plans.
- Personalities matter as much as scheme design. Outgoing and persistent housing project staff working on the wards were credited as key to securing hospital staff involvement and co-operation.
- Project staff say making the right personal links with key operational staff – normally hospital social workers, discharge coordinators and OTs – is key.

5. Emerging data from local pilot projects

As noted in chapter 3, there were challenges with regard to quantitative data collection from such disparate pilots involving a range of partners and a variety of existing case recording systems. However, there are a number of useful findings which are considered in this chapter.

Collecting data on pack placement, usage, services and outcomes

Data collection by the pilots has generally identified the resulting housing services that were accessed by patients but it is not able to provide standardised data on patient outcomes. Schemes struggled to obtain accurate data on the hospital source of a referral, or in measuring long term outcomes. Some schemes monitor the speed of response to referrals.

The expansion of partnerships meant more non- housing related work, and the new partnerships ended up using localised data collection schemes which themselves have changed over time.

Involved Care and Repair agencies have maintained their own client and case databases, but direct read across to partnership figures is not always possible, especially as in-house databases often count 'jobs' individually even if all relate to one client and (possibly) one integrated package. Some of the individual agency databases can be used to identify the amount and speed of activity following direct hospital referrals where a key aim is to minimise delays to discharge.

The main finding from the data available about the scale of pack distribution, staff time on wards and the resulting levels of referrals are:

1. People as well as packs increased take up of the offer of housing related help.

Information packs alone had a limited impact on requests for housing help, but Care & Repair and associated front line workers talking to staff and patients appeared to make the greatest difference to referral rates and take up.

2. Housing related interventions are an important part of post discharge offers across all partnership sites. If small practical housing tasks, like fitting a key safe are included in data collection around half of recorded services in all the databases have a housing related component. This housing related provision includes handyman jobs, fire safety checks, home security checks, home hazard assessments (eg. to minimise environmental contributors to trips and falls), help with home adaptations, repairs, moving furniture and installing equipment as well as help with identifying and moving to an alternative home.

3. Housing referrals are a higher percentage where there are housing caseworkers involved in 'selling' the scheme in hospitals.

4. Analysis of the more complex housing casework records suggest that the pilots have been successful at reducing discharge delays and care home admission as well as ensuring individuals can remain safely in their own homes for longer. Such records only exist for the sites with dedicated housing options workers (Somerset West and North Somerset, not Coventry or Warwickshire).

5. Data on monthly referral numbers and service type is important for reporting volume throughput to commissioners. In the absence of outcome data, and the problems with recording and evidencing this without time consuming follow up calls, some reporting of case study outcomes is also useful.

Learning what works: Implementing pilots

- Link project briefings directly to the priorities in local hospital or health and social services commissioners business plans and create data recording systems to help to evidence this.
- Involve your senior champion within the hospital in helping to resolve operational difficulties.
- Expect practical concerns about infection control, security access, data security and confidentiality and concerns about 'preferential treatment'. Be ready with locally tailored answers.
- Regularly report outputs and outcomes that demonstrate results to senior champions to maintain support and interest.

6. How far did the pilots meet project aims?

The table below summarises the aims of the various home from hospital partnerships that grew out of the *If Only I had known* initiative, highlighting aspects that are related to housing. These include;

- providing information and advice that allows a more informed choice
- developing efficient partnership arrangements and improving links with, and referrals from, hospital staff
- ensuring appropriate housing expertise and services are available, covering practical help and housing options
- improving patient and carer quality of life
- collecting data to monitor activity and performance and evidence effectiveness and
- helping save public money through prompt, effective discharge and avoidance of unnecessary care home or care package costs.

This evaluation looks first at how well the projects performed in each of their chosen areas, and at what helped and what hindered that performance.

It then looks in more detail at evidence for effectiveness through achievement of the outcomes set out below, and whether or not desired outcomes can be linked back to housing change.

TABLE 1: Summary of project aims and outcomes

Explicit and (implicit) aims	Associated outcomes indicating effectiveness
<p>1. Improve Informed choice Improve available information to increase informed choice about housing options for older people. Include option of personal advice.</p>	<p>Improved feeling of independence and better long term quality of life for some discharged patients and their carers/family</p>
<p>2. (Efficient partnership arrangements) including more referrals from hospital staff as well as patients and carers.</p>	<p>Better integration of housing with local social care and health planning and provision</p>
<p>3. Ensure appropriate housing expertise is available</p>	
<p>4. Improve patient and carer quality of life</p>	<p>Better long term quality of life for discharged older people; individuals more able to remain independent; reduction in stress/anxiety for patients, carers/family</p>
<p>5. Save public money Reduce re-admissions and save associated costs to hospitals and local commissioners of health services.</p>	<p>Some earlier discharge. Fewer rapid (<30 day) re-admissions of older people to hospital for non-medical reasons. Save hospital money Fewer unplanned re-admissions in longer term. Save PCT funds. Some residential home placements avoided. Better home circumstances allowing reduced level of care packages. Both may save social services money.</p>
<p>6. Monitor and collect data to evidence effectiveness</p>	<p>More funding for housing element of integrated care allowing it to become embedded in system Better integration of housing with local social care and health planning and provision Involvement of housing organisations in health and well-being partnerships</p>

Providing information to inform choice

Patients, families and carers have better information about housing and care options and help than before local schemes started. They are making more use of related housing and care services; referrals are increasing in all the pilot areas as more wards are covered by schemes. The Gateway service approach, through post discharge telephone assessment, allows further conversations and information provision after patients have returned home.

Local data about referral trends does not show whether the greater focus by local agencies on hospital patients is at the expense of other advice work by the voluntary sector partners involved. Some interviewees felt that there was a re-focus of their work onto hospitals, with an associated shift from prevention for all older people to more targeted advice for the users of health services.

Bedside information packs evolved and changed over time at all sites. All local areas, except Somerset West (which did not have that level of capacity/ resources), expanded their work to include a daily presence of advice workers on hospital wards for discussions with patients and staff. After using the national packs in the first phase, all simplified their packs to reduce costs, particularly in hospitals that wanted to have a new pack for every older patient as part of infection control and/or ease of administration for ward staff. A 'national blueprint' pack was never considered the best way to provide information, but was seen as a useful starting point. It performed that function as the packs were important in getting projects started, as a visible sign of partnership possibilities and as an information source for hospital staff and family and carers that could be locally adapted.

The packs...opened doors

Voluntary sector manager

All interviewees confirmed that with regard to provision of information, face to face contact was more important than printed materials for many older patients.

(Packs)...are no longer the main method of diffusion...instead we use knowledge of successes, leaflets with information, a single phone number...

Weston caseworker

- Regular visits by advisors to hospital wards to talk to staff and/or patients and family are credited by all involved as important in spreading information to people who particularly need it.
- Where hospital staff are regularly reminded they make more referrals.

Being there is critical...recognition by staff is crucial – you [advice workers] need to become part of the furniture

Social services manager

For an important sub set of patients, family or carers are the key decision makers with regard to arranging future housing and care. They also need advice and support and were often the most appreciative of the housing advice and help available through the pilots. Some advice staff suggested that carers can lose out in hospitals, with busy staff focusing on patients even where pathways include reminders and prompts about including carer information, views and needs.

You find you just don't know. It isn't easy for anyone not part of the system to work it all out. There are so many forms and information leaflets. It can seem in hospital that no one has time for you.

Son of one beneficiary

Some individuals will not be able to take in information and make decisions whilst in hospital, especially about something as potentially major as changing their living arrangements. Information and advice may be needed more after discharge, at a point when patients and/or their family and carers are more able to take a considered look at housing decisions.

Patients can receive a flood of information....(partners) need to talk about effective timing ...crisis is not always the best time to try and sort out housing

Partnership members

Learning what works: Information and advice delivery in hospitals

- A written information pack is much more effective when combined with advisors to speak to in person and a simple referral system for hospital staff
- Where a number of partners previously all marketed their separate information services and provided leaflets a combined pack/summary brochure (eg. Weston) may reduce cost and confusion
- An 'approved' pack gives patients reassurance on the reliability of services included.
- Identifying and exploiting more than one route for provision of information and advice plus referrals increases project 'reach'
- Good personal relationships between advice/agency staff and hospital staff increases appropriate referrals significantly.
- It is important to target information at family and carers as well as patients.
- Some information, advice and help can, and should, be provided after discharge – some people may want time to think. Patient consent to follow up telephone calls is one way of ensuring individuals have time to consider their options after discharge but still get support.

Efficient partnership arrangements including links with, and referrals from, hospital staff

Clear referral pathways embedded in procedures and systems matter, but relationships with individuals are still key to successful joint work which is not yet embedded in hospitals. In the partnerships 'outside' organisations are still not seen as equal to hospital partners; the pilot schemes are seen as optional add-ons rather than core to better patient provision.

Personal links, training sessions and awareness raising all helped to make hospital staff more aware of what housing and other external partners can usefully offer to patients. A focus on effective integration of patient referrals within hospital systems is as important to the success of any home from hospital partnership aiming to improve cross sector working between housing, health and care.

It is neither practicable nor appropriate for housing information and advice staff to get to know patients as well as the hospital staff do, so direct and indirect referrals from hospital staff are critical. All interviewees felt that engaging the front line hospital staff was helped by employing the right kind of project worker to spearhead new schemes.

It was important to spread information about any initiative widely within the hospital, eg through team meetings and staff training, to make the project's purpose and appropriate referrals as easy as possible for hospital staff.

They (hospital discharge specialists) focus on clinical issues...and then start thinking 'social'...it is not in from the start. Housing etc is an afterthought for health staff. So a multi angle approach is key....including educating patients to ask.

Social services managers

The local pilots all developed workable referral systems (though North Somerset has been held back by delays in getting agreement for on site-hardware and access to office space). Written self-referral forms in booklets or packs were not successful; enabling hospital staff to make referrals with minimal form filling were more successful. Very simple paper forms that could be faxed or collected by project officers and 'book based' referrals resulted in greater numbers, but this does mean that time has to be spent on electronic entry by other partners. Short forms also mean that potentially useful data eg. for monitoring, is not included.

Despite limited staffing in some schemes, especially at the start, a professional approach from housing options and other partnership staff has given hospitals confidence in the reliability of their new partners.

The variety of systems for referral and follow up that evolved in the local pilots reflect the different sizes and types of hospitals and partnerships, as well as the range of approaches to partnership and target groups. Interviewees identified occasional tensions between partners over the time that they put into the partnerships, speed of referrals and ensuring selection of the most appropriate provider.

Where co-operation and relationships between partner organisations are good, partnership approaches to hospital discharge can improve efficiency of advice and information provision by reducing duplication of effort.

There has been a change in attitudes to working with partners – we see ourselves as part of a team now

Voluntary sector partnership worker

Examples of Process

- In **North Somerset** hospital staff write down patient referrals in a book; the day's advice worker (four providers share a rota covering the five weekday afternoons) collect the referrals. Where appropriate they will discuss the case with the hospital's discharge coordinator, and make a decision as to the best lead partner for that individual and refer the person on that same day.
- In **Warwickshire and Coventry** there are Age UK advisors on wards. Hospital staff can make specific direct referrals (for example, request installation of a key safe) but there is also a focus on ensuring older patients who may need more help consent whilst on the wards for a follow up assessment after discharge – a less targeted but broader future preventative approach. Age UK Warwickshire uses their 'Gateway' service, a 'call centre' assessment approach, for follow up. Age UK Coventry use generic advisors for follow up initial assessment through their Call and Connect service.

Managers and hospital based staff were all clear about the importance of appointing the right people to lead pilot projects. Personal links developed between information and advice staff and ward staff are acknowledged as critical to making schemes work. Getting hospital staff to think about non-health services is a cultural shift that requires constant reminders.

So far we haven't got them (the hospital discharge team) to own referrals for wider (social and housing) support. There is now recognition of the value from some, but not ownership....

You must constantly educate hospital staff...turnover is huge in hospitals. (High use of) agency staff brings inconsistency. Educating the (constantly changing over) junior doctors is hard.

Senior social worker/partnership co-ordinator

Illustration: How personal links and direct promotion help raise the profile of housing

The key housing worker on the Stoke on Trent scheme worked hard to get the hospital social work team to think about patients' housing. She frequently worked in their office, went to their Christmas party and wore clothes branded with the home improvement agency logo as a constant unspoken reminder to her colleagues of the 'housing offer'. Her referral records show a sudden drop during one particular week when other circumstances meant she spent more time working away from the hospital. Her view is that the housing offer is still too new and different to be automatically considered by her social work colleagues, and that a constant sales pitch is vital.

Illustration: The importance of training

- Information from Bristol Care and Repair suggests that a long term training programme about the health and housing link can help to shift the perceptions and approach of health and social care staff in an area over time.
- In St Helens a secondment scheme between hospital and community OTs helped staff to learn about and understand each other's roles and perspectives.
- The North Somerset partnership now provide a short 15 minute session on their Home from Hospital pilot at the end of the hospital's routine discharge training for nurses. This has made a difference to the level of referrals.
- In University Hospital Coventry the lead nurse helping to implement the pilot programme will regularly raise the initiative briefly at matron meetings, ward meetings and team meetings as part of a constant drip feed to raise awareness.

The need to work hard on making links with hospital staff was always recognised by all local pilot project staff. Less attention has sometimes been given to links between the various organisations delivering post discharge non-health services to patients. Advisors need to know enough about all services offered by partnership members to make appropriate and rapid cross referrals. Partner organisations also need ways to iron out any practical issues, for example delays in cross referral or selection of the most appropriate lead agency for a patient.

The banner of the partnership has helped all get further. All use the same assessment process, share the marketing etc. Having a named partnership manager has opened doors in the hospital.

We don't get scattergun referrals now. We can plan and prioritise [across agencies].

Partnership manager

In two areas where a partnership member was involved in formal discharge planning meetings within the hospital, this was considered helpful as it allowed mutual understanding and opened up the possibility of earlier, up-stream interventions for patients. This is especially important for housing issues, as it may not be possible to sort out practical building problems immediately. For example, if a person has been admitted to hospital for surgery which is going to result in loss of mobility, home adaptations will probably help to enable safer discharge and these will take time to organise. Waiting until the person is ready to go home is too late. Earlier referral can help to ensure that practical housing issues do not delay discharge.

The number of services patients may need in order to return home safely can result in several visits and assessments by different organisations, with the potential for confusion and duplication. Unless assessment and referral is well co-ordinated, extra unnecessary hospital bed days or patient discomfort can result eg. if small jobs like furniture moving or key safes and handrails are not identified and organised by the main assessor.

It is not helpful if related jobs for patients are being carried out by more than one outside agency eg. a number of providers of trips and falls assessments and handyperson remedial work. Agencies need a local forum to discuss and resolve inter-agency or inter-service concerns and to work with commissioners to find a balance between choice and duplication.

The local pilot area partnerships have developed at different speeds and evolved over time, but the numbers of patients being referred and helped are increasing in all areas after slow starts (Foot note). Interviewees felt it was important to persevere, and not expect an instant welcome and help from all hospital staff.

It is hard to know how much this is down to referral systems improving, as partnerships have also been expanding their activity into more wards in the hospitals. Nurses report that packs were also being shared informally at times with ward staff in non-pilot wards, with subsequent referrals from outside the targeted groups. A number of interviewees also said that they had passed on information to other patients at a later date, so personal recommendations by staff and patients as well as improved referral systems may be behind increases in usage.

Learning what works: Referrals and partnership arrangements

- The personality of the lead housing advisor matters for new schemes.
- Personal links with key health staff (e.g. discharge co-ordinators) are critical.
- Hospital staff will refer more if they are given constant small reminders of the new services on offer and on housing/health links
- Referral processes need to be simple and quick to ensure hospital staff participate
- Involvement in hospital discharge planning meetings is helpful
- Working together can be cost effective for voluntary sector provider organisations, who can share marketing and administration costs
- Housing related service provider organisations should pay attention to building partnerships with other providers as well as with hospitals.
- Clarity on the appropriateness of referrals to partners, rapidly passing on and responding to those referrals, is critical.
- Partners may sometimes also be ‘competitors’. Partnerships should recognise and address associated concerns.

Appropriate housing expertise: Covering practical help and housing options

Some housing issues are complex. A patient may need a housing worker who understands complicated housing and related issues, knows the local housing market and related provision and has expertise in local options for home adaptations and repairs as well as for potential housing moves.

Hospital social workers and OTs who have worked with housing options caseworkers, and patients who have benefited from this specialist support, value this input for patients very highly. This expertise is not always available within the normal hospital discharge schemes, weakening the range of housing and care choices available to patients.

All the local pilot services had been set up to include provision of help with a number of housing related services including, handyperson services, home safety checks, falls advice and key safes. But detailed advice on wider housing and care options, and Care and Repair expertise in home adaptations and repairs was not adequately embedded in all of the pilot areas.

- In North Somerset, Care and Repair West of England is a core partner. The housing options adviser, who is also a Care & Repair caseworker, is particularly committed to the Home from Hospital partnership, providing the hospital advisor role one day per week and delivering a strong housing element in internal hospital training. This ensures that patients’ housing issues are far more likely to be identified and addressed.

- The Gateway referral service which forms the core of the Warwickshire partnership has less access to housing expertise or specialist housing focussed case workers. There is no dedicated independent local agency providing housing options support for patients, and different home improvement agencies delivering different services in local districts makes consistency of provision more difficult. This is reflected in the profile of the referrals and resulting provision.
- The increase in general advice provision for older patients in University Hospital Coventry delivered by Coventry Age UK has not resulted in more referrals for housing related help to the local Orbit Care & Repair service, suggesting that advice staff may not fully appreciate potential housing issues and the possible remedial help that Care and Repair could deliver.

Housing casework can take time; housing moves and major adaptations are rarely quick events. However, they can be life-changing. The in depth interviews with service users demonstrated just how valuable this housing expertise can be in identifying alternative options for older people with unsuitable housing and long term health concerns, and the significant potential savings that can result.

Descriptions of such instances and cost benefit analysis of individual cases are included in the more detailed Care & Repair England report linked to this initiative, *If only I had known: Integration of housing help into a hospital setting* which is also available on the *Home from Hospital* area of the Care & Repair England website.

Housing is often an afterthought for health, and needs (specialist) knowledge...it often takes time

Social services manager

Hospitals are too health focussed, with so many departments...their social worker didn't know some of the basics needed for long term patients with disabilities

Husband with wife confined to a wheelchair following a stroke

Illustration: housing issues can be complex and benefit from a local specialist

One couple facing up to a long term health issue explained how useful it had been for them to get help from someone who understood housing, benefits and adaptations.

The woman was confined to a wheelchair by a stroke; her husband and now carer was on long term sick leave. They owned their own small house, but it was not ideal for a wheelchair.

The housing options worker found short term support for them from a local charity in the form of a re-conditioned stairlift and an electric wheelchair. He reviewed their finances and options for staying put or moving home, and went through the detailed costs of those options with the couple. He explained that they would not be eligible for social housing, but that a grant with adaptations help would be possible because of their imminent income drop. The housing options worker found a specialist charity to sort out all relevant disability benefits, and helped them with a successful appeal over the wife's proposed use of her personal budget.

The stairlift and chair improved their short term quality of life by restoring the wife's access to her whole house and increasing her independence. The caseworker's financial understanding ensured the couple obtained disability benefits, and this in turn opened up the unexpected option of adapting their home rather than moving.

Mr and Mrs J, both pensioners, could no longer cope in their own home. Both had serious health and mobility problems. The housing options worker suggested an extra care village near to where their daughter lived that they were not previously aware of. Given the low value of their current home and the cost of purchasing extra care, they did not think they could afford the move. However, the housing options worker reviewed their financial circumstances and helped them to make successful claims for attendance allowance. He then did the calculations for them to show how a shared ownership option would work, including confirming that it would still be affordable if one of the couple died. The couple have moved home and are very pleased with the change, their health is better and it is a great relief to their daughter.

Case study evidence suggests that housing options staff have a level of expertise that can significantly widen the housing and care options available for some discharged older patients and results in significant improvements to health and reduced care needs.

Organising home moves is complex for owners and tenants alike. Applications for social housing through choice based lettings may need computer literacy. Understanding how the housing allocation systems work can be hard for many older people as well as for their families. There is certainly no way that hospital staff have the time or knowledge to broker such major changes, even when unsuitable housing is an obstacle to safe discharge.

We are not housing experts..... It save us so much time and [the housing options worker] knows things we don't....Social workers can talk about housing options, but once it gets complex there is a gap.

Hospital social worker

The lynchpin was the OT/ hospital social worker/ housing specialist combination....I do not know what I would have done without them. There were forms that even the housing specialist had never seen... I was someone for them to contact as he [her brother] is not always the easiest patient.

Sister of double amputee who moved into extra care housing

The housing options worker's understanding of the system and ability to talk to him [Mr B] about moving was invaluable. This is really important as like some other older people, my father in law can dig his heels in...so for me, having a third 'impartial' person who could work with him [Mr B] was key to the successful home move

Daughter-in-law and main carer of Mr B who moved from an unsuitable park home in poor repair into a sheltered flat

Care and Repair staff can often offer a comprehensive package of practical help, drawing on local understanding and in depth housing knowledge. Interviewees gave a number of powerful examples *[reported in the related publication noted above]*. But the pilot areas could not all evidence an increase in Care and Repair referrals. It was not clear why such referrals were not being made; there may be a training issue for some referrers.

Learning what works: Ensuring housing expertise is part of hospital discharge partnerships

- Specialist housing options advisors increase choice for older patients and can address problems that are not core to social worker or other support worker expertise
- Help with a home move or a major adaptation can be critical to quality of life. It may need a housing expert to organise and broker these.
- If Care and Repair services do not receive extra referrals from hospital discharge integrated partnership schemes, they should investigate and seek to address reasons.
- Front line, generic advice and assessment staff may need 'Housing Awareness' training and need to understand the contribution that Care & Repair services can make to holistic patient provision.

Improved patient and carer quality of life

Interviews with clients of the discharge schemes were almost all totally positive. Even patients who had not subsequently used a service appreciated receiving information. They liked knowing that there was back up if they needed it at a future date. Family and carers were also appreciative.

Housing support often helped restore patients' independence and improved quality of life. Certain changes, especially completing major adaptations to allow safe bathing and toileting or enabling moves to specialist supported housing, can particularly reduce stress on family and carers.

Whilst health services will get patients back home, they do not ensure patients can get around and use their home, or can get out of the home again unaided.

The hospital wanted to discharge me. The hospital matron said 'you have a home to go to'. But it was 6 steps to the front door and on a steep hill and I didn't want to be a prisoner in my own home

Patient - recent amputee

Interviews with patients identified housing linked changes that had improved independence and quality of life in the short and longer term. These housing interventions may be quite small. For example:

- **Creating a warmer home for a cancer patient:** Immediate provision of oil filled radiators ensured adequate heating, allowing discharge home. Longer term repairs were arranged by Care and Repair, with a grant obtained from the Royal British Legion, which dealt with the central heating system breakdown and a leaking roof.
- **Reducing hazards and increasing security for a less mobile patient:** Immediate provision of a personal alarm gave a sense of security; a self-closing addition to a kitchen window meant a potentially dangerous manoeuvre to open or close this was no longer needed and reduced the risk of further falls (which had resulted in hospital admission).
- **Rebuilding independence for an amputee:** Immediate provision of a temporary ramp to the front door allowed an amputee to get in and out of his house independently. In the longer term a bath was replaced by a walk in shower, allowing independent bathing.

An important group of adaptations or moves are those that allow patients to use a bathroom and wash independently again, rather than relying on a commode and a strip wash by a care worker. The restoration of dignity involved is a huge improvement to these patients' quality of life.

A move to specialist supported housing such as a sheltered property often results in improved social life for the individual involved, including reduction in loneliness and worry. Housing improvements such as adaptations; repair to heating; the additional security provided by housing scheme managers and alarm systems, can also reduce worry and stress for families, especially where work and family circumstances limit their ability to visit and provide emergency cover at short notice.

Since the wet room and the ramp...he is just a different person mentally.

Sister of client

Learning what works: Patient and carer quality of life

- Health services priority is to get patients home, but unsuitable or poor housing, particularly inadequate bathing, can result in loss of independence, dignity and poor quality of life. Housing changes can restore these.
- Handrails, stair lifts and ramps can restore access to a whole property and even the wider neighbourhood – not just a room.
- Housing changes can deliver a warmer, safer home and reduce risk to older patients.
- Moving to specialist supported housing can help to improve social life and reduce loneliness.
- Improving older people's housing also reduces stress on families and carers.

Savings to the public purse

The local pilot projects could all provide case study examples where housing related work supported and facilitated more rapid discharge, thereby reducing hospital costs.

Some case studies suggest support can prevent the need for residential care home admission and can reduce the need for higher levels of care at home in the short or long term.

These case studies with associated costings are set out in detail in the associated report about this project, *'If only I had known... Integration of housing help into a hospital setting*, available on *Home from Hospital* area of the Care & Repair England website. An example is included in Appendix 1.

Whilst there were illustrative case studies with strong indications of how housing had resulted in cost-benefit direct proof that re-admissions are prevented on a significant scale is not available from this modest initiative. This would require an in-depth longitudinal study with control groups. However, a small hospital sample comparing ward admissions over a two year period does suggest that this approach to integrated support might be helping with such a reduction.

More rapid discharge

There had not been a systematic analysis of reasons for discharge delays in the pilot areas prior to commencement of the partnerships. The *If Only I Had Known* initiative was not solely focussed on discharge delays or on reducing social care costs, but on provision of housing and care options information and advice to older patients, the result of which might be such savings. Two other schemes studied, in Stoke on Trent and St Helens, are specifically focussed on reducing delays.

The potential for saving from faster discharge is linked to the current efficiency (or inefficiency) of hospital discharge arrangements. The performance of hospitals in terms of prompt discharge varies considerably. Tightly defined and targeted schemes may reduce discharge delays, but these may not analyse or assess the potential contribution of addressing patients' housing issues or the broader reasons for delays and re-admissions.

Information emerging from the Stoke and St Helens targeted schemes and the case studies from the wider pilot partnerships, suggest that a number of particular interventions can underpin prompter discharge, particularly if referrals are made early enough. These include:

- Dedicated handyman services which are rapidly deployed eg. to move furniture and set up specialist equipment.
- Immediate installation of keysafes as soon as they are needed to allow external carers access to the home in order to care for patients who cannot reach the front door.
- Immediate provision of small adaptations of handrails and equipment to enable safe movement around the home and patient self-care, plus carer and patient use of bathrooms for toileting and washing.
- A stock of oil filled radiators to allow immediate safe heating if patients are returning to homes that are poorly heated. (This is a short term measure and should be linked to resolution of the heating inadequacy).
- Assessment of home safety, hazards (trips and falls), and home security and installation of the remedial measures.

Where there are major concerns about delays in discharge of older patients, housing will not be the main cause, but will be an important part of a more complex picture. Housing responses need to be part of a broad package to address such concerns.

For example, in St Helens, the major problems identified as contributing to discharge delays were organising care packages and in finding spaces in preferred residential care homes; so new resources and activity have also gone into employing additional social workers and improved care packages. However, further investigation of the cases might have revealed that one of the reasons for high levels of residential care home admissions was inadequate housing conditions – the methodology for assessing reasons for delays need to be carefully considered.

It is also worth noting that whilst housing may not be the main reason for delayed discharge, targeted handyperson services (listed above) has a very low unit cost compared to other options, such as intermediate care wards, employing more social workers and paying for spaces in residential care.

Avoiding entry to care homes and reducing the cost of care packages

There is case study evidence from the pilot areas to support the idea that a housing related intervention can sometimes prevent the need for an individual to go into a residential care home. For the reasons noted above, precise numbers of cases in this category are not available because there was no way of recording outcomes in the disparate areas. Also, in some cases the outcome of non-intervention may have been an individual continuing to live in unsuitable conditions rather than moving to a care home, so the impact was on the older patients' quality of life and risk.

The case study examples described in the major report which illustrate this factor include:

- Minor adaptations and a key safe installation enabling a carer to resume caring responsibilities more quickly after his own discharge from hospital, thereby reducing the length of stay for the cared for person.
- Two couples where the carer could no longer provide all necessary help, moving to supportive extra care housing, which provided enough support to negate the need for a care home placement for either partner.
- Finding a suitable sheltered property for an individual unable to return to his previous park home because of disrepair and his own increased frailty. Temporarily he was placed in a care home; once a suitable sheltered property was located he was able to move there instead, at a greatly reduced cost.
- Finding a suitable sheltered property for an individual who had become homeless just before entering hospital due to relationship breakdown. He faced admission to residential care as a fast way of discharging him from hospital. However, moving to a sheltered housing scheme with a moderate care package adequately met his care needs.
- Moving out of poor private rented property into a sheltered flat which was warm and where the patient could use the bathroom independently resulted in a significantly reduced care package.

So if a hospital discharge partnership project includes a housing options case worker, then it is likely that support with appropriate home moves will mean care home admission is not needed in some cases. It is worth noting that at an annual cost of around £28,000, avoidance of just one admission will pay for a housing options worker.

Housing options workers and Care and Repair schemes can also enable repairs and adaptations to be carried out that help to maintain health. A care package may be reduced because of such housing interventions. For example, adaptations may allow someone to wash independently, rather than 'be washed' by a paid for carer.

Reducing unplanned re-admissions

There is no certainty over what can prevent unplanned re-admissions, despite significant research. There is equally limited understanding of what causes re-admissions within 30 days. A limited comparison of re-admissions in pilot wards in St Cross Rugby did show an improvement one year on from the introduction of the *If Only I had Known* pilot programme but the sample is too small to be statistically significant and it is not possible to separate the multi factorial interventions.

However, it is likely that some re-admissions are caused by environmental or social factors that integrated partnership discharge schemes can address. For example, assessments may reduce environmental hazards that are likely to result in trips and falls. Minor repairs and improvements to heating and insulation can make a home more comfortable and help reduce concerns about exacerbation of cold related health conditions such as stroke, COPD and heart disease.

A number of re-admissions in the first 30 days can be caused by minor housing related issues that could be sorted out if the individual discharged could get immediate help with small changes, for example to sort out furniture moving, bed rails or additional grab rails.

This suggests that minor problems that can be addressed through a 'meet and greet' approach for referred individuals who live alone, may help prevent some unplanned re-admissions. One is available for some referred individuals as part of the Weston partnership. Age UK Warwickshire and Age UK Coventry hope to add such a service to their current schemes.

Although it is likely that post discharge support does help prevent re-admissions it was not possible for this small initiative to undertake a systematic study to identify the scale of potential savings. Such a study would be a useful next step.

Learning what works: Saving money

- The right housing support can help reduce discharge delay. Schemes targeting delayed discharge should first properly assess local causes of delay and develop a comprehensive approach.
- Handyman services that deliver housing interventions within 12 to 24 hours from referral can speed up discharge.
- Good OT risk assessments in hospital can speed up discharge; these should be immediately relayed on to handyman or Care & Repair where minor adaptations, repairs and equipment are needed.

Other cost savings are not yet quantifiable on a significant scale but there are strong indications from the cases dealt with by the local pilot services that:

- Immediate support for discharged people who live alone such as 'meet and greet' schemes may help reduce unplanned re-admissions within 30 days.
- Trips and falls assessments and installation of remedial measures such as minor adaptations can help reduce unplanned re-admissions as many are linked to subsequent falls.
- Good housing options advice and moves to suitable housing can help prevent both hospital admissions and the need for some people to move to a residential care home.
- Support with appropriate adaptations, especially around toileting and bathing, can result in less need for high levels of personal care.

Embedding housing within integrated health and care partnerships

The pilot partnership schemes linked to the *If only I had known* project have all helped improve joint work between voluntary organisations, including housing service providers, and hospitals. However, the housing focus varies between areas.

Some hospitals are more involved in and committed to local partnerships than others. Home from hospital partnerships do not necessarily mean that housing providers are adequately involved, nor that wider local planning for better integration of health and care is addressing housing factors.

The local pilot partnerships have all increased the understanding in local hospitals of the contribution that housing related services can make to helping some patients leave hospital safely and prevent further admissions. The hospital social work staff interviewed showed a range of understanding about housing's potential contribution. Some had worked closely with housing options case workers; others had limited experience and still saw housing as peripheral compared to care provision.

There remains a challenge in communicating the benefits of the Partnership in terms of reducing re-admissions and assisting hospital staff with the discharge process

Extract from Council report on the scheme

Individual discharge co-ordinators and OTs had sometimes built up quite strong links with housing options advisors in pilot areas, but these were still primarily based on personal relationships rather than being integrated into hospital structures and processes.

The initial difficulties encountered in identifying pilot project sites also suggests that hospitals have not all yet fully embraced a wider integration of health, care and housing. Funding to support pilot partnerships mainly came from existing Supporting People funded services, special national funding streams (for housing options and handyperson services), or other council funds. Funds identified by the charitable organisations helped start up the schemes in all cases. One hospital did contribute, but this was exceptional and there was considerable debate on the appropriateness of making such a contribution among board members.

Hospital discharge schemes must deliver results to be taken seriously. Those described in this report were all doing so, but some hospital staff could give anecdotes from other hospitals of services that did not. For example, some handyperson schemes do not deliver reliable 12 - 24 hour turnaround times for hospital discharge patients.

Partnership projects to integrate wider housing and related help for patients into hospitals also need longevity. They need to raise the profile of what they do in hospitals on a continual basis, as staff turnover rates can be very high. In interviews hospital staff were not always aware of all details of local partnerships, and were not aware of the impact on their own patients.

Changing wider health staff awareness and attitudes will take time and training. Specific integration initiatives of the types described here may start to build understanding, but there is a long way to go. This suggests that work to involve housing and discharge partners in training of health professionals, and to establish such training as regular and universal, is important for the longer term success of a vision of cross sector working.

Learning what works: Embedding housing considerations within health services

- Wider partnership initiatives must deliver consistent results for patients so that they will be considered as reliable partners
- Including wider housing and related information about joint discharge schemes in regular hospital training will help embed local schemes
- Providing local Housing and Health awareness training should help to improve health and social care workers' wider understanding, and hence their use of housing related services for patients
- Longevity combined with results and profile raising will help schemes become a more accepted part of hospital organisation.

7. Conclusions

Older people leaving hospital may require or benefit from a mixture of short and longer term care, provision of equipment, adaptations and other physical work to their homes, social support and financial help. A cross sector 'home from hospital' partnership, such as those described in this report, is a good way of organising such support for patients.

- All local pilots resulted in new or improved partnerships between the hospitals and local not for profit organisations.
- The partnerships helped to fill the gaps between universal health services, tightly rationed social services support and housing related assistance.

The local pilot projects which were developed as a result of the *If Only I Had Known* initiative show that just before or after a discharge from hospital is an effective time to provide older people, their families and carers with information and advice about available local support, including housing and care options.

- Older people who have had one hospital admission are often at higher risk of re-admission and therefore should be a priority for preventative services.
- Support that allows earlier hospital discharge and reduces the likelihood of an emergency re-admission in the short or longer term saves the health service money and allows hospitals to focus more on planned elective surgery.

Written information placed in hospitals about locally available housing, care and support options is a useful back up for patients' families and carers, but the placement of skilled advisers, including housing advisers, within the hospital setting who take personal referrals from hospital staff and patients are a more effective way of reaching older people who can benefit from such help. In some cases discussions are best held before a patient leaves hospital, perhaps at the time of admission or even pre-admission for elective cases, especially if the patient is at high risk of re-admission and/or if their existing home is unsuitable for their needs.

For older people at lower risk who may be able to return home without significant changes to their housing or living situation, support through either a telephone call or a home visit can work well. A home visit is particularly useful for identifying housing related issues, as it is an opportunity for a home safety check, a home security check and a falls assessment. It may also be easier to carry out a welfare benefits check face to face.

Partnerships work best where there is senior level support within a hospital, as this gives operational hospital staff the backing they need to take an active role in a partnership and to change established ways of working.

- Senior level hospital support is more likely if a clear link is made between the intended outcomes of a cross sector partnership and the hospital's business priorities around discharge; partnerships should aim to report accordingly to help maintain interest.

Partnerships need to have effective internal assessment and cross referral arrangements. While there is no one best arrangement, rapid decisions on appropriate referrals and individual patients' 'lead' agencies are important. Depending upon local circumstances, co-ordinating a hospital partnership may best be done by an agency with an overview of all local needs, such as a local council, rather than one single provider.

Hospitals are relatively closed workplaces. Staff from partners involved in new home from hospital schemes cannot expect hospital staff to immediately understand and appreciate their role and start to work with them.

- External partnership staff need to develop personal relationships with important hospital based staff, particularly discharge co-ordinators, OTs and social workers.
- They need to demonstrate benefits to patients, making it easy for hospital staff to make referrals, and find ways of constantly reminding hospital staff about the services they can offer.

Where an older person needs to consider moving to a more suitable home a housing options caseworker can be key to a successful move. They can help individuals, their families or carers reach an informed decision through; providing them with in depth information about local options and their likely availability; helping to find suitable properties, including negotiating local choice based lettings systems in the case of social housing and by setting out the various financial options in the case of owners and self funders. A local housing options worker can be a supporter and advocate, helping individuals through the often complex interactions of finances and local eligibility criteria.

Linking housing options workers directly with hospital based staff can better embed an understanding of the benefits that housing improvements and changes can bring for older patients.

- In the pilot partnership areas where staff delivering more complex housing casework had well established direct links with hospital based staff, there was a higher rate of identification of patients who needed housing related help and referrals to Care and Repair and housing options services.

The interviews with patients, staff and stakeholders who had been involved with or benefited from the *If Only I had Known* pilot projects highlighted the importance of good and appropriate housing for older people's quality of life. Older people spend a significant amount of time in their own homes, especially if they have long term health and mobility issues.

- Adaptations or improvements to existing homes, or a move to a more appropriate home, can bring major improvements to quality of life that health interventions alone may not deliver.
- It was evident that adaptations in particular can give people back the dignity and independence associated with being able to wash and bathe safely, and can make it possible for people to move around their home and to leave it to visit others.

- A move to a specialist supported housing can make some older people feel safer and reduce social isolation. Housing changes can also improve the situation of carers and reduce stress on other family members.

While cost benefit issues such as reducing discharge delays are important, these quality of life improvements are equally important to stress as benefits from good cross sector partnership hospital discharge arrangements.

However, especially at a time of tight resources the potential for savings is important.

- There is evidence that housing and associated interventions for older patients can speed up safe discharge, thereby saving money on hospital bed days.

New Home from Hospital partnerships will need to find better ways to collect data and monitor patient outcomes in the longer term so that they can better evidence effectiveness. A number of the local pilot partnerships were keeping data on referrals and outputs, such as the number of and type of service provided, and some assessment of immediate outcomes, largely based on Supporting People data collection systems. However, none had been able to link data on service provision to other hospital patient data in ways that could prove that interventions prevent re-admission.

- Hospitals need to engage with partnerships to find ways to use their internal data collection systems to track medium term health outcomes for older patients, particularly with regard to emergency admission rates.

It is harder to evidence a direct link to reducing unplanned re-admissions or more expensive moves into care homes. The interviews conducted as part of this evaluation and the feedback from staff involved in hospital discharge provision of housing advice and support highlighted the likely cost savings of particular cases but:

- A larger scale, in depth, longitudinal study would be necessary to evidence the potential scale of savings to health and social care of a cross sector partnership approach to hospital discharge.

8. Recommendations

- Local areas without cross sector 'Home from hospital' partnerships should develop a local scheme to coordinate the work of local voluntary and statutory agencies able to offer older patients comprehensive assessment and practical support on and after leaving hospital. These partnerships may be led or co-ordinated by local councils, hospitals or third sector agencies.
- Home from hospital partnerships should develop integrated, simple referral systems for hospital staff that minimise additional workload.
- Partnerships should find ways to integrate record keeping that builds up a picture of local needs and evidences outcomes and benefits. Partners should consider linking information on partnership service provision to patient data eg. in order to track re-admission connections.
- Home from Hospital services need to provide written information about housing and care options within the hospital setting but always alongside hospital based advisors from the external agencies involved in the partnerships.
- A home from hospital partnership should include relevant statutory and voluntary sector partners who offer services that can help patients at and after discharge.
- Housing service providers should always be included in such partnerships. This should include a full range of Care and Repair type housing services – adaptations, help with repairs, home safety and security. In particular, specialist housing options caseworkers with a broad remit which includes helping older patients to find and move to alternative accommodation are an essential element in holistic partnerships.
- Hospital discharge staff and hospital social workers should be kept aware of the impact of the partnership to eg. through training sessions and/ or attendance of relevant housing and other staff at team or other meetings to present case study examples.
- For high risk older patients in particular, practical housing support should be available to discharge co-ordinators and social workers to facilitate safe but speedy discharge. This could include agreed rapid (ie same day/24/48 hour) turnaround for some tasks (such as provision of equipment, moving furniture, installing small adaptations and key safes, carrying out home safety checks and falls assessments with immediate remedial measures).
- For lower risk patients partnerships should offer both immediate and longer term holistic support that can improve quality of life as well as potentially preventing future emergency admissions.

APPENDIX 1

Cost Benefit Illustration

Extract from 'If only I had known... Integration of housing help into a hospital setting,' available on Home from Hospital area of the Care & Repair England website. Costings are based on PSSRU Unit Costs of Health and Social Care 2011 which are also detailed in the report.

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 D 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.

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.

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

SAVINGS TO HEALTH

4 x unplanned hospital episodes @ £2334 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

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)

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

APPENDIX 2

North Somerset Home from hospital partnership data

The data collected by this particular local pilot partnership shows that a wide range of staff are referring patients for support, and that a majority of the support provided is housing related in a broad sense.

79% of clients are over 75 years old.

Clients helped by the housing options caseworker are slightly younger on average, though the age banding data collected varies and prevents direct comparison across partner agencies.

Outcomes based on the caseworker's recorded assessment suggest success in speeding up discharge, keeping clients more independent and preventing re-admissions.

Information is available for 384 patients helped during the first 15 months of the partnership.

Referrals came from a range of hospital wards and staff. Over the most recently assessed 6 months the three highest referrers are the Community Care Team (22%); Occupational therapists and physiotherapists (17% of referrals) and the Discharge Planning Team (7%).

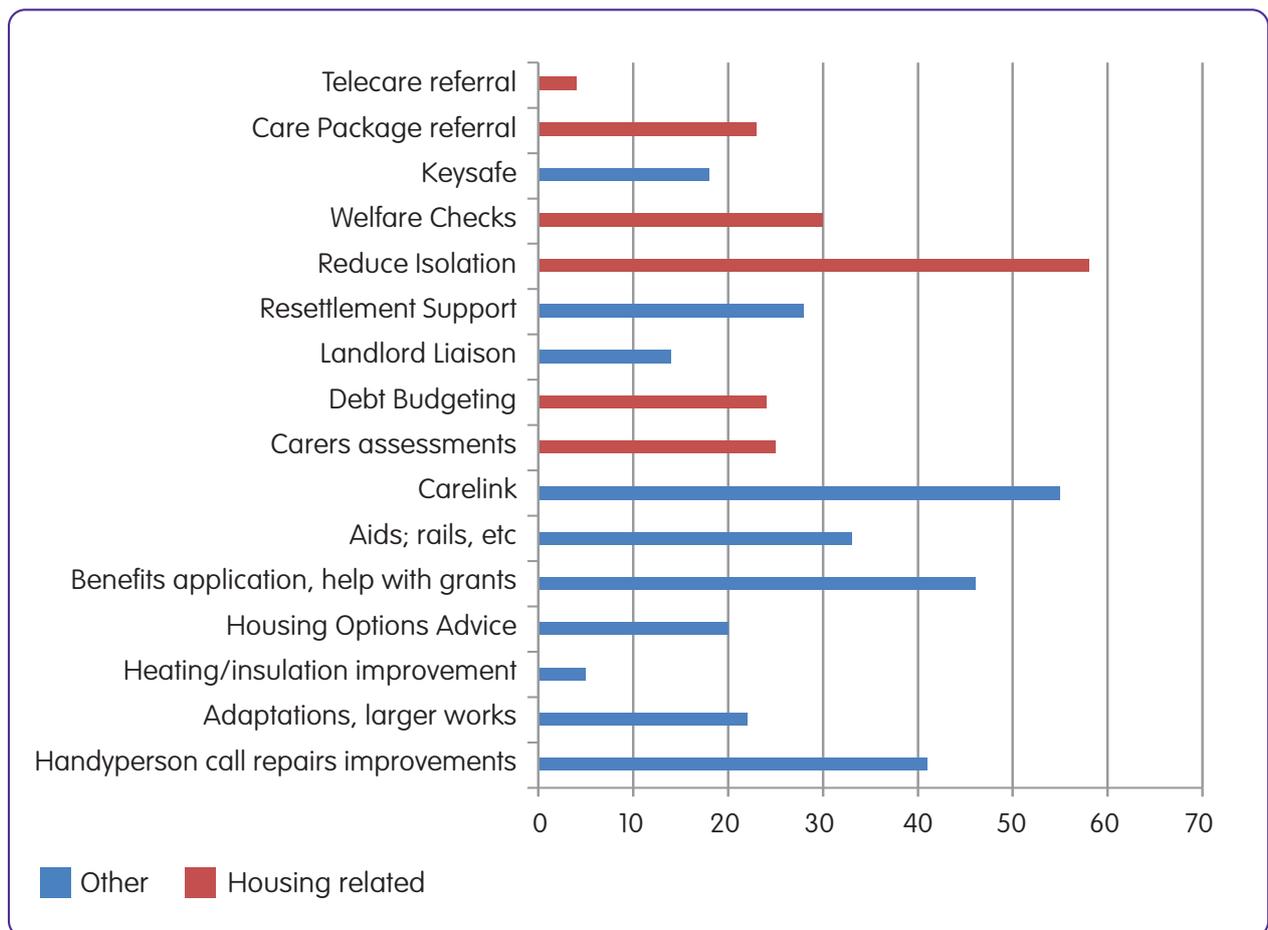
The number of referrals can fluctuate; there has been a steady increase as the partnership has become more established.

Referrals for the first 15 months of the project (up to the end of Sep 2011)

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept
No. Referrals	9	11	16	11	18	12	21	19	16	19	19	40	22	23	35

The graph below shows that of the services provided over the first 15 months of operation, over 60% are housing related.

Referrals over 15 months from the North Somerset Home from Hospital partnership



Care and Repair records show that during this period 137 handyperson referrals and 35 casework referrals came from information picked up in hospitals. It is not possible to analyse whether this was specifically from a Home from hospital pack, a general leaflet, or where a hospital worker may have passed on the phone number to a patient or carer. Data is available for 34 of the patients assisted.

Age of clients

Under 60	18%
60-69	18%
70-79	30%
80+	33%

Housing tenure:

Twenty three percent of clients lived in private rented accommodation, twenty per cent had a social tenancy and the rest were owner occupiers or living with owner occupiers (eg a family member).

Services delivered:

(Percentages add up to more than 100 as many clients used more than one service).

Help with finding a new home and moving home	59%
Repairs including providing emergency heating	21%
Adaptations/equipment	21%
Financial help and/or benefit checks	23%
Help with tenancy problems	12%

Outcomes recorded by project officer

These are relatively subjective. Percentages add up to more than 100% as some clients could have more than one outcome.

Faster hospital discharge	13% [of all clients]
Delays entry to a care/nursing home	3%
Makes it possible for client to remain living independently at home	58%
Reduces risk of re-admissions to hospital	39%

This is based on outcome data for 31 clients (one client died so no outcome is recorded; no outcome recorded for three others).

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