Improving homes, Changing lives

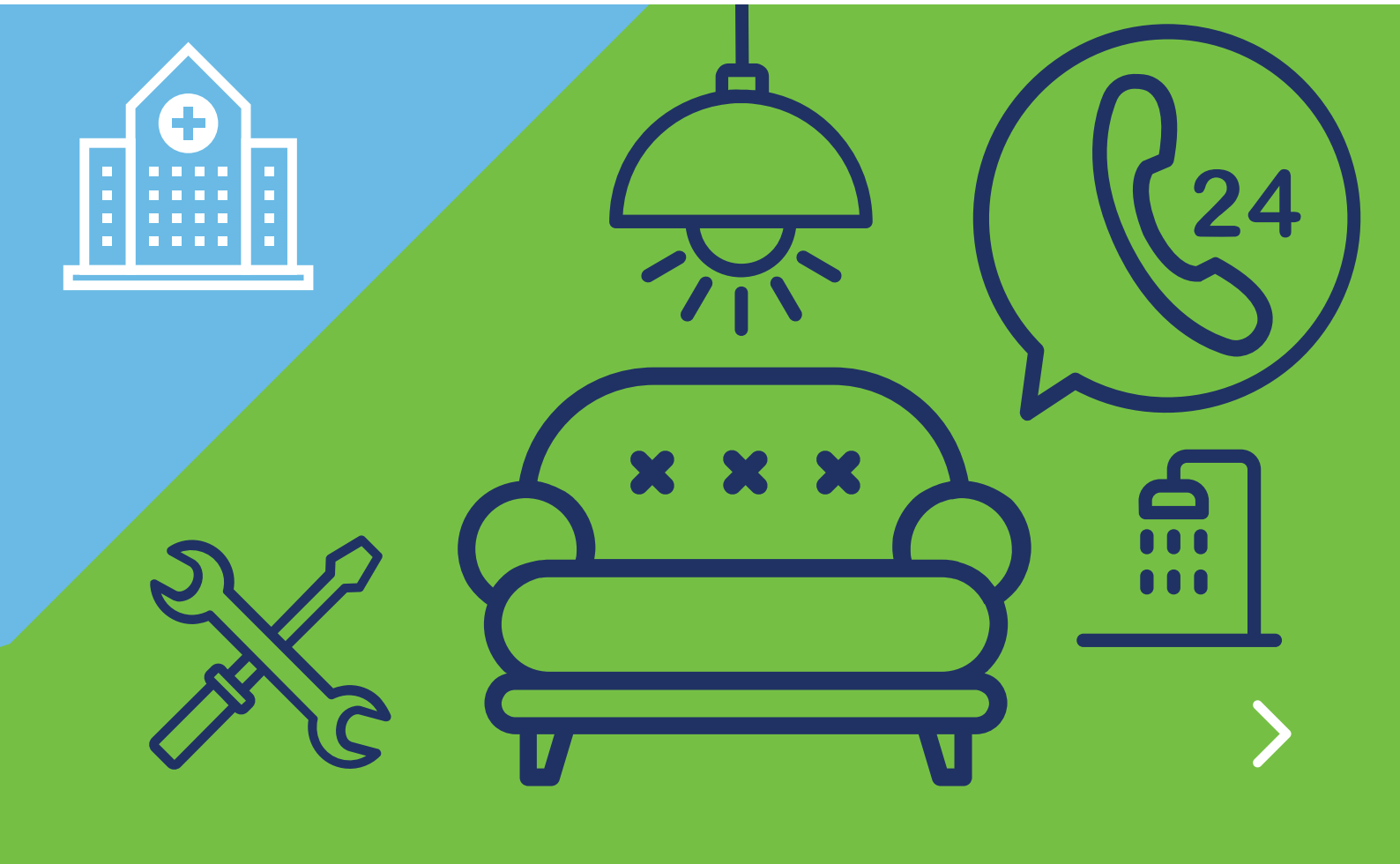
Care & Repair
Gofal a Thrwsio

Bridgend County Care & Repair

Hospital to Home service

Linking health and housing:
Better outcomes for older people

May 2018



We're always here to help

Bridgend County Care & Repair is an independent home improvement agency with charitable objectives and is not-for-profit. It is core funded by Welsh Government and funded locally by Abertawe Bro Morgannwg University Health Board and Bridgend County Borough Council.

Bridgend County Care & Repair operates as a 'problem-led, person-centred' service through home visiting caseworkers who provide a Healthy Home assessment and a technical specification and supervision of home adaptations, repairs and renovation provided by qualified technical officers. Its in-house practical services team provides a trustworthy, good value and professional option for building work. In-house technicians are also trusted to assess and install for Telecare.

The agency also has an approved list of community-based safe contractors. The primary objective is to support older people to live independently in their own homes, with increased comfort, safety and security. The core values are based on dignity, respect and empowerment: providing a bespoke service that gets it right for the individual client.

The 'Hospital to Home' service brings this service ethos close to the hospital bed, easily accessible for patients, carers and family and widely understood in terms of its positive impact on health needs by clinicians, nurses and reablement professionals. Its USP is its co-located proximity to discharge planning, providing support for safe discharge, a rapid delivery, tailored problem-solving and the confidence of face-to-face agreement between NHS, patient/carer and housing services around long term wellbeing.

The Hospital to Home service provided by Bridgend County Care & Repair, operating out of the Princess of Wales Hospital in Bridgend has been in operation since 2014.

Patients Helped 2014 - 17
4,500

It has grown from a 3 hour a week pilot to a fully funded 5 day week service. It operates on a preventative, prudent healthcare basis, accepting that patients and clients are the same people. So, older people can be discharged safely and earlier; clinicians and nurses can do more for the wellbeing of older people; and Care & Repair can help them live independently.

Service cost and capacity 2016-17

- Senior Hospital Caseworker (F/T)
- Hospital Caseworker (P/T)
- Home Maintenance Officer (F/T)
- Discharge Support Officer (P/T)
- RRAP* Officer (F/T)
- Caseworker Assistant (F/T)
- In-house Occupational Therapist (P/T)

Revenue support: **£153,000**

Number of patients/clients helped: **1,272**

Number of patients/clients supported for safe discharge: **1,024**

Value of completed works: **£510,000**

Average cost of works: **£356**

Average cost of service per client: **£527**

Cost avoidance potential: **£2,987,560**

Social return on investment for bed days saved
£5.50 per £1 invested

Based on modest assumptions and a median approach to bed day savings, i.e. **6 bed days saved**, and cost avoidance principles if viewed as redirected investment potential could equate to a **16 bed ward** additional capacity.

*RRAP Rapid Response Adaptation Programme
RRAP Officer is part funded by WG grant

Service outcomes

- Greater appreciation of the environmental determinants of poor health
- Supporting a safe hospital discharge, speeding up discharge planning decisions and improving patient flow
- Improving opportunities for primary and secondary prevention
- Assisting older patients to return home quickly and improve rehabilitation & reablement
- Free up bed capacity for clinical planning
- Provide cost avoidance/redirected investment opportunities for the NHS

Preventative cost benefits

Considering NICE cost assumptions for readmissions, post discharge care and complex falls, i.e. hip replacement surgery; and the Chartered Society of Physiotherapists cost assumptions for quality of life costs, additional cost benefits could be:

- Total cost avoidance per patient discharged: **£5,800**
- Against total service costs there is an average preventative cost benefit of **£2,900** per patient discharged
- Cost avoidance, if a significant fall was prevented for just 2% of patients: **£3,079,764**

A total social return on investment per patient discharged
£9 per £1 invested

Mighty oaks from little acorns grow

"In 1989, before RRAP was funded in 2002, Bridgend County Care & Repair was part of the development of Home Safety, which in turn led to Emergency Pressures funding in 1994. Partnerships are built on 'trust', 'common goals' and a 'proven track record' over years.

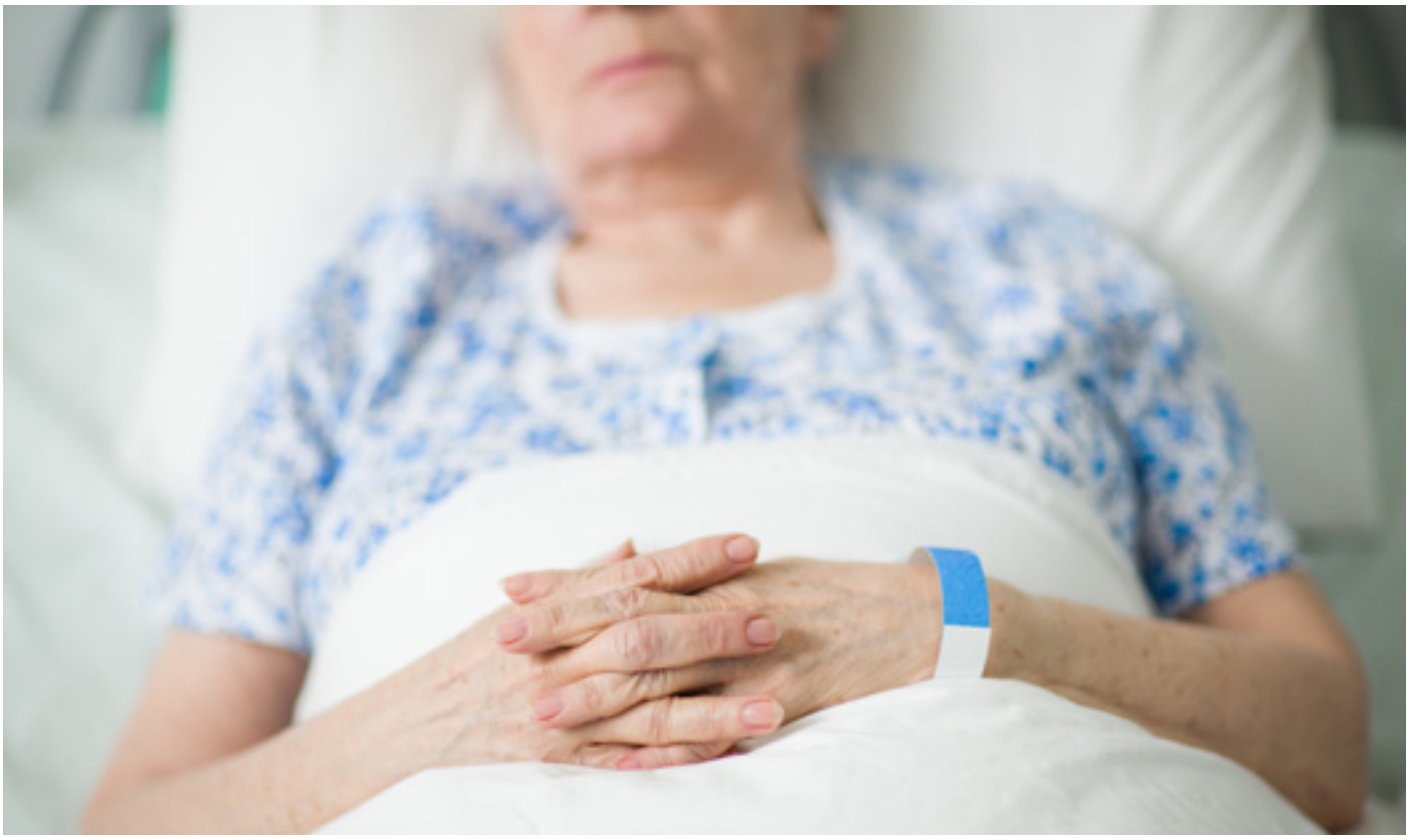
"We had been operating the emergency pressures initiative since 1994 to support the timely discharge of older people from hospital. However this service was very much based on a responsive, reactive service and so the contact with the patient was limited.

From client surveys I felt we were just scratching the surface in terms of helping these patients with their long term housing needs. There seemed to be a real gap in service provision for older people being discharged from hospital, hence the development of the Hospital to Home service.

Over the years the Hospital to Home service has really convinced the health board, local authority and health professionals that having Care & Repair staff working from the hospital alongside the clinical team can really make a difference in helping to speed up safe discharge, find the right solutions for patients, reduce readmissions and help to free up hospital beds quicker.

None of this would have been possible without the strong partnership arrangements and the forward thinking of the health board, local authority teams and NHS staff and of course the sheer hard work of our staff".

Rena Sweeney, Chief Officer, Bridgend County Care & Repair



Making a difference is brought about by being different

“I had been a Care & Repair caseworker for 15 years but working under the pressure of an acute hospital is different. Our service had helped patients get out of hospital in the past but we were always waiting for a referral and as much as we promoted ourselves to busy, rota-layered teams, communication took longer. Being part of the NHS culture and a discharge planning team but with a non-medical expertise brings real benefits.

I have access to older patients, their family or carers very early during ward rounds and so can resolve issues quickly and gain access to their homes without delay. We have been able to solve so many problems that would have held up safe discharge, some of which only emerge during conversations rather than being requested within a referral. Speed is a massive issue for NHS resources and I hear so many positive comments about our ability to improve patient flow which improves the morale of NHS staff. We have a new A&E emergency pressures pilot in the Princess of Wales Hospital and one example sums it all up; I recently took a query from A&E and within 2 minutes and a short walk I was involved in resolving an issue that helped resolve a bottleneck and improve the patient experience”.

Meinir Woodgate, Senior Hospital Caseworker,
Bridgend County Care & Repair

Case study 1

Mrs X is 84 years old and lives alone. She was admitted to the Princess of Wales Hospital following a fall in her garden. Unfortunately, she was on the floor for 5 hours before a neighbour found her and raised the alarm by calling for an ambulance. The Hospital to Home service received a referral from the Occupational Therapist at the Princess of Wales Hospital requesting a grab rail by the side of Mrs X toilet and a Telecare Lifeline assessment. Without these in place, Mrs X was unable to be discharged.

The Hospital Caseworker visited Mrs X on the ward within an hour and organised for the Home Safety Officer to meet Mrs X's daughter at the property the following morning to install the grab rail and Telecare. As a result of the Hospital to Home service, Mrs X was able to be discharged home from Hospital 4-7 days sooner than would normally be expected.

Following her discharge, the Hospital Caseworker visited Mrs X at home to complete a full assessment. As a result of the visit it was identified that Mrs X was having difficulty negotiating the bath and accessing her garden due to the steps. Mrs X also had difficulty with her heating, her boiler was over 10 years old and was inefficient. A full benefits check was completed and it was established that Mrs X was not receiving her full entitlement to welfare benefits.

As a result of the Hospital to Home service, Mrs X received the following support:

- Telecare Lifeline System
- RRAP for a grab rail
- ICF Independent Living Grant for wet room
- Healthy Homes Assistance Grant for a handrail to the steps, security lighting and carbon monoxide detector
- Warm Home Prescription grant for new boiler
- Attendance Allowance award
- Signposted to Age Connects, Community Companions and Community Transport Scheme
- Assistance to obtain a Blue Disabled Parking Badge
- Assistance to register with the Refuse Assistance Scheme

Cost benefit	
Hospital discharge - Cost of hospital bed 7 days	£2,450
Cost of intervention by the Hospital to Home service	£450
Cost avoidance	**£2,000**

Prevention	
Cost of post - discharge care, rehab, further complex fall, readmission, quality of life	£171,908
Cost of intervention works	£8,400
Cost avoidance	**£163,508**

Case study 2

Mr J was referred to the Hospital to Home service during the ward round. He is 87 years old and lives alone and has no family living locally. He suffers with arthritis of the spine, emphysema and a heart condition. He was admitted to the Princess of Wales Hospital following an acute episode of breathlessness in the middle of the night.

Mr J was due to be discharged from hospital the following day but was unable to safely climb the stairs at home. The Hospital Occupational Therapist made a referral to the Hospital to Home service for a stair rail and Telecare to enable a safe discharge. The rail was installed that afternoon and Telecare the following morning. Mr J returned home as planned.

Within 2 days the Hospital Caseworker visited Mr J at home and carried out a full Healthy Homes Assessment. A full welfare benefits check was completed and an application for Attendance Allowance was submitted the same day. Following approval of the Attendance Allowance applications for Guaranteed Pension Credit and Council Tax Benefit were submitted and approved. In addition the Caseworker also identified that Mr J was encountering difficulty getting in and out of the bath. She arranged for a Community Occupational Therapist to carry out a full assessment and recommendations were put forward for a local authority grant to provide a level access shower.

Due to the changes in his benefits, arranged by the Hospital Caseworker, Mr J qualified for a full grant award. The shower was installed within 6 weeks and Mr J is delighted with the outcome. He feels more independent and no longer relies on carers for support with his daily care needs. In addition his income has increased by £252 per week which allows Mr J to leave the heating on longer and pay for taxis to visit friends and family. The Telecare gives Mr J and his family peace of mind that 24/7 emergency support is at hand.

Cost benefit	
Hospital discharge - Cost of hospital bed 7 days	£2,450
Cost of intervention by the Hospital to Home service	£450
Cost avoidance	**£2,000**

Prevention	
Cost of post – discharge care, rehab, further complex fall, readmission, quality of life	£171,908
Cost of intervention works	£2,450
Cost avoidance	**£169,458**

Hospital to Home 2016-17

Patients helped
1,272

Average age
78

98%
with chronic conditions

1,024 or 80%
of patients were helped and supported for safe hospital discharge

Improved quality of life
100%
*patient/client survey

1,434
completed jobs at a total value of
£510,000

Home safety (falls)
578 falls
prevention outcomes

144 patients
helped to claim
welfare benefits worth
£341,557 pa

401 patients
received a Healthy Home Assessment

412 patients
received a Telecare package improving their personal safety

Reduced waiting time
for Community OT Assessment
for 110 patients/clients

Average speed of work delivered by Home Safety Officer

1.5 days

Partnership "opinion" in Discharge Team – **between 4-7 bed days** saved per patient discharged through Hospital to Home

NHS feedback: An anonymous 2017 survey of Princess of Wales Hospital staff

"The comprehensive service that Care & Repair provides enables smooth transition from hospital to home, reducing their length of stay in hospital and preventing readmissions".

"Our partnership with Care & Repair means that our assessments and our treatment plan can make a real difference to people's lives. It enables me to look after my patients in a more holistic way".

"The quality of service that I am able to provide within my specialist area would be considerably impacted without the Hospital to Home service".

"Having a designated caseworker within the hospital environment has also speeded up the response to queries which is essential when working with a fast paced caseload with patients with life limited conditions".

"The caseworker is extremely efficient at informing myself of when work is scheduled, this enables the planning of timely discharges".

Why is housing so important to health outcomes?

It is widely acknowledged that the lived environment has a significant impact on the health opportunity and wellbeing of older people. The King's Fund has estimated that £1.4 billion is the cost borne by the NHS in the UK attributed to poor housing. The Building Research Establishment (BRE) has calculated £67 million of this cost is to the health service in Wales.

''The Care & Repair service is essential to our intervention; the service plays an integral role in enabling us to discharge people home from hospital efficiently and safely. The comprehensive service that Care & Repair provide enables smooth transition from hospital to home, reducing the length of stay in hospital and preventing readmissions''.

Neil Abraham, Integrated OT Manager, Social Services

"At Pendre Day Unit (Falls clinic) we get referrals from multiple sources from within the hospital and within primary care from GP's, for patients who are vulnerable, frail and falling.

Our patients come in and they have an holistic assessment. The patients are visiting us within the hospital and whilst we try to build up a picture of what is happening at home it's not until you actually set foot in somebody's property that you can actually start to get an accurate assessment of how they are managing.

We've developed an excellent rapport with the Hospital to Home service and for a small team their response is always really quick".

Helen Evans, Unit Manager, Pendre Day Unit Medical Day Unit

“We didn’t have the reactive service that we’ve got now. Now it’s a completely different kettle of fish, I can do discharges within 24/48 hours and that’s because Telecare can be in place within 24/48 hours if I need it to be. Before the Care & Repair service we were looking at a wait of a week, if not more. We’ve slashed that time.

Welfare Benefits is another big thing “How am I going to pay for this care?” Our patients don’t always want to accept help because they worry about how much it will cost them.

Older people don’t need to be here in the hospital, not when there’s flu, not when there’s pneumonia, not when there are all the other germs going around. If they are left, you can guarantee within 1 week they won’t be going through that door. They’ve got something, they’ll have an infection, they are back on antibiotics and that’s the rolling thing. They get 1 thing and it holds them up. When they are medically fit, they need to go home. That’s where you go to get better. You are in hospital to get fixed but you go home to get well”.

Sharman Williams, Support at Home Organiser, Community Resource Team Bridgend

‘One of the things we are so impressed with is the speed which we can now get adaptations completed in our patient’s homes. This allows us to facilitate someone’s discharge promptly, getting patients back into their own home environment. This, in turn, facilitates patient flow throughout the hospital.

It can take up to 7 to 10 days for a referral to be started, actioned and completed Now, working with the Hospital to Home service it can be done within 24 to 48 hours if needed.

Working in the emergency department and acute medical wards we need equipment and adaptations for our patients to be installed as soon as possible to allow speedy discharge. We let Care & Repair know the date we anticipate a patient will be discharged so they can action the work or adaptations needed, and this is often done within 24 – 48 hrs.

If we can facilitate a speedy discharge home from the ward it means other patients can be transferred from the emergency department onto the ward and from the community into the emergency departments. Without that there would be a massive backlog at the front door with patients waiting to be seen in emergency departments and waiting in the emergency department for a hospital bed on the ward, and that’s not good for patient care or the patient experience.

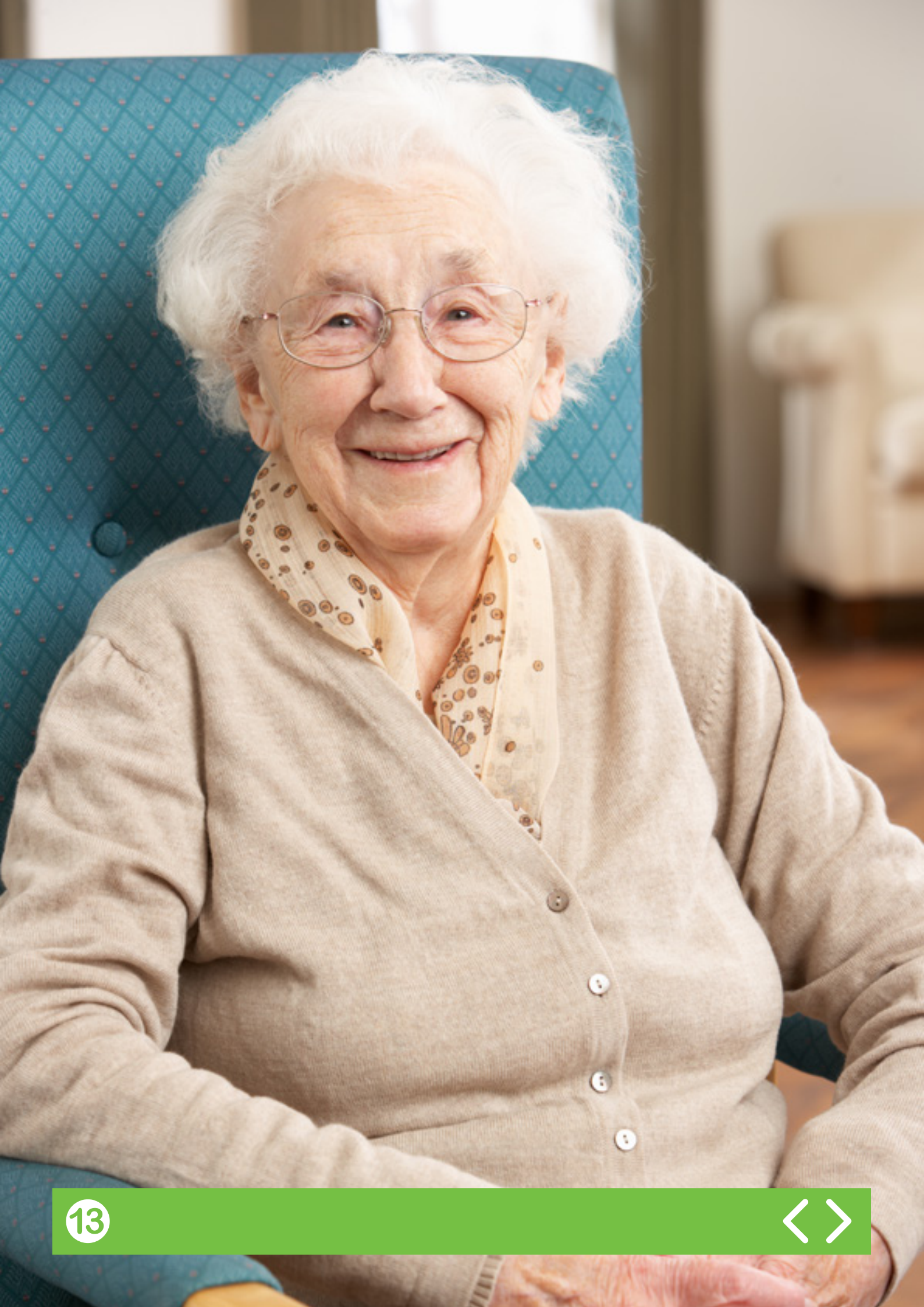
Anyone coming into hospital feels vulnerable and a lot of things are taken out of your control. Having a named OT and being able to have a conversation in the hospital with not only ourselves, but also with the people who are going out to do the adaptations, gives people the confidence and control to say “yes, that is what I want or no that’s not what I want”. It gives them the confidence to know they have a legitimate person going into their home to carry out the works needed. You cannot underestimate the value of that.

Before the Care & Repair Hospital to Home service was based in the hospital there was always a friendly voice on the end of the phone, but there is nothing like having that face to face conversation with someone on a daily basis.’

Rachael Gdesis-Evans, Locality Lead Occupational Therapist for Princess of Wales Hospital

We’re always here to help

Bridgend ‘Hospital to Home’ Digital Story



Care & Repair
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This service is dependant on annual funding arrangements. The cost avoidance assumptions are not derived from local NHS partners but uses research by NICE, Personal Social Services Research Unit (PSSRU), Chartered Society of Physiotherapy (CSP) and Age UK.

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