on the mend

Hospital Discharge Services and the Role of Home Improvement Agencies

A Guide for Service Commissioners and Providers

Published by Care & Repair England

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Comment

I can tell you from my personal experience about the difference that help with housing problems can make to the lives of people like me.

I came to England from Jamaica in 1963 and trained to become a cook with the London Bus Company. I am 71 now and I have lived in my small townhouse in Hackney for over 30 years. My kitchen and toilet are the only rooms on the ground floor.

After a stroke this year I could only go home from hospital because my bed was brought down to the kitchen. The carpet on the floor was old and frayed and I kept falling. I couldn't go upstairs to my living room, bathroom and bedroom except by crawling there and then I fell. I had a bath once a week when my daughter took me to her home in Dagenham.

I was so upset that I might have to leave the home I loved so much.

All that worry has gone now with the help of Peter, the caseworker from the Hospital Discharge Project. He got me a grant for a new carpet downstairs and handrails and then arranged with social services for a stair lift and walk-in shower to be fitted.

Now I can wash whenever I want and sleep in my own bedroom.

Peter also discovered that I wasn't getting my rightful benefits and when I claimed them my weekly income went up by £78 per week and I no longer have to pay council tax. You cannot imagine the difference that has made to me. I was then put in touch with Sharp End Centre* where I go for exercise and some company.

My home is so important to me and I want to stay here for as long as I can. I feel so comfortable that I have someone like Peter and my home care worker alongside me.

I hope that other people like me wherever they live will also will be able to get this help because I know how much this has meant to my life.

by Mrs Evelyn Wood,
about her experience of the Hackney Staying Put Hospital Discharge Service

* Sharp End was one of the first Healthy Living Centres and provides exercise, alternative therapies and counselling for older people.

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Foreword

Upon leaving hospital, most people return to a decent, comfortable home and are cared for by relatives and friends. But for many older and disabled people this is not the case and going home from hospital can be a difficult time. Help may be needed with basic day to day tasks which most of us take for granted; getting washed and dressed, cooking, cleaning and shopping suddenly become major hurdles.

Trying to manage all of this in a home which is cold, damp, draughty and unsafe is even harder. For people who are leaving hospital coping with reduced mobility or a new physical impairment, adaptations to their homes can make or break efforts to live with dignity and regain an independent life.

This is why the work of home improvement agencies to help people who are leaving hospital is so valuable.

'On the Mend' is particularly welcome at a time when at a national policy level there is a strong commitment to enabling people to live in their own homes for as long as possible through provision of services which support independence.

In our work on the National Service Framework for older people we have sought to produce a comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people. It is a 10 year programme of action linking services to support independence and promote good health, specialised services for key conditions and culture change so that all older people and their carers are always treated with respect, dignity and fairness.

We have recognised that services may fail to meet older peoples' needs –sometimes through discriminating against them or by failing to treat them with dignity and respect. The National Service Framework sets out a programme of action and reform to address these problems and deliver higher quality services for older people.

The value of hospital discharge projects, as described in the following pages, to meeting key national objectives is clearly demonstrated. The dramatic difference such help makes to the lives of individuals is brought home over and again through the case studies and I am sure that this guide will inspire service commissioners and providers across the country to look very seriously at the development of a hospital discharge service in their area.

Professor Ian Philp

National Director for Older People, Department of Health

Part 1: Setting the scene

1. Context

1.1. The process of discharge from hospital can be particularly problematic for older and disabled people who need personal care and support as well as medical care. Good inter-agency co-operation and co-ordination between health and social services are essential if the needs of people leaving hospital are to be properly addressed.

1.2. The Audit Commission has examined the particular difficulties arising at this interface of health and social care in a number of studies. The issue of responsibility for funding the care and support of individuals has been identified in some cases as contributing to poor hospital discharge practices. Efforts have been made to address the root of this problem through the pooling of some health and social services budgets and in the longer term more fundamental reforms are planned, including the creation of Care Trusts.

1.3. The difficulties around hospital discharge often go beyond the financial. In *'The Way to Go Home'*, the Audit Commission recommended a whole systems approach towards practice development in this field. Fundamental overhauls of discharge systems are necessary in some areas to improve both the way that a range of professionals work together to ensure that patients and carers are fully involved in the discharge process and a smooth transition is achieved.

1.4. There is an ongoing concern in Government and health circles that people remain in hospital for longer than is medically necessary due to the shortcomings of hospital discharge arrangements, hence there is a wasting of health sector resources caused by 'bed blocking'. On the other side of the argument, is the belief that some people are discharged from hospital too soon, without due care paid to either the care systems put into place, or adequate support for carers, and that this can result in re-admission and the 'revolving door' syndrome.

1.5. There are also concerns, often expressed by those in the housing sector, that too little attention is paid to addressing the housing needs of people being discharged from hospital and that in putting together a discharge plan, not enough is done to assess the suitability of a person's home, or identify suitable alternative arrangements.

1.6. A recent study by Carers UK demonstrated shortcomings in hospital discharge practice, particularly with regard to the position of carers. It concluded that there had been little improvement in services since their previous study in 1998, and there had been a deterioration in some aspects of provision.

1.7. Most people who leave hospital with an ongoing health problem or disability return to their own homes, rather than institutional care. Ensuring that their homes are both fit and suitable for their needs is therefore critical if Government objectives of enabling more older and disabled people to live independently is to be achieved.

1.8. Aids and adaptations are often as important as care packages in enabling a person to live safely and independently in their own home. The Audit Commission concluded that equipment services *'have the potential to make or break the quality of life of many older or disabled people' (Fully Equipped, The Audit Commission, April 2000)*

1.9. The national study carried out for the Joseph Rowntree Foundation, *'Money Well Spent: The effectiveness and value of housing adaptations'*, found that *'minor adaptations.. produced a range of lasting, positive consequences for virtually all recipients'* and ' *major adaptations in most cases had transformed people's lives'*. It went on to suggest that *'an investment of health resources to increase over-all funding for adaptations could well be justified'*.

1.10. The installation of aids and adaptations can cause particular problems for people waiting to leave hospital. The legal and financial framework for the provision of adaptations is complex. Reaching agreement over the assessment of what a person needs and which of the various funding streams meets the cost of the necessary aids and adaptations can further contribute to unsatisfactorily slow discharge.

1.11. A review of the adaptations process, *'Meeting and Managing the Need for Adaptations'*, is currently being undertaken, jointly commissioned by the Department for Transport, Local Government and the Regions and Department of Health. The outcome of the project will be statutory guidelines on the adaptation process (expected in 2002).

1.12. With most people now living in homes which they own (69% of households), with the majority of unfit housing being found in this sector and with the likelihood of a person living in an unfit home increasing significantly with age (see below), many older and disabled people leaving hospital are returning to homes in need of repairs as well as adaptations.

1.13. It is against this backdrop that home improvement agencies (HIAs) have become involved in the field of hospital discharge.

Many of the people who live in the country's poorest housing cannot tackle their repair and adaptation problems alone because of poverty, frailty, disability or lack of information about what help is available.

- *There are one and a half million unfit homes in the UK – one home in every 16,*
- *The majority of these unfit homes are owner occupied*
- *75% of the people living on the lowest incomes in the worst housing are of pensionable age.*
- *1.7 million people need adaptations within their homes*
- *The tendency to live in poor housing conditions increases with age, particularly after 80, and lone older women are more likely to live in unfit housing.*

2. Home Improvement Agencies and Hospital Discharge

2.1. Most people wish to stay in their own homes for as long as possible but need assistance to address the problems of old or unsuitable housing. Home improvement agencies, often called Care and Repair or Staying Put, provide the help necessary to enable older, disabled and other low income homeowners to tackle their housing repair and adaptation problems, thereby enabling them to remain in their own homes in greater comfort and security.

2.2. Clearly, HIAs have a great deal to offer anyone living in an unfit home or one which is no longer suitable for their needs due to a physical disability, whether or not they are being discharged from hospital.

2.3. The process of carrying out repairs and adaptations funded through the local housing authority grants system can be slow. With a discretionary system of such grant aid for repairs, availability of help for low income homeowners varies very considerably from one area to another and such grants do not usually provide a 'quick fix' solution.

2.4. Consequently, the existing systems used by HIAs to access funds to carry out repairs and adaptations for low income householders are often not speedy enough for hospitals keen to discharge patients, or for that matter, quick enough for the patients waiting to return home after their stay in hospital.

2.5. Around the country HIAs have looked for new ways to work with patients and hospital staff to address these issues and a range of ideas and ways to work have emerged.

What do Home Improvement Agencies do?

Home improvement agencies help the people living in the worst housing with the least resources. Most services are targeted at low income older and disabled people in private sector housing.

Agency staff help people through the entire process of deciding what repairs or adaptations are needed, arrange the finance, organise the building work and supervise the work from start to finish. Jobs range from the very small, such as minor plumbing repairs, to major renovations such as renewing a roof and windows or building an extension for a specially designed bathroom and kitchen for a disabled person.

The agency caseworkers provide detailed advice and support on housing options and their implications, legal entitlements, financial matters and any other support services which the householder may need to help them remain in their own home. The building work is specified and overseen by the agency technical staff and undertaken by vetted contractors.

Tackling repairs and adaptations is a complicated business. Home improvement agencies liaise on the person's behalf with a wide range of professionals including environmental health officers, occupational therapists, architects, surveyors, social workers and benefits agency staff.

"It's not my job to take over but to help them (the service users) get back the control of their own lives which has been slipping away because of falling income, diminishing savings, a home that is deteriorating around them and a body which can no longer get in the bath or up the stairs without assistance.

Repair without the care is only half the story, and often the repair is the easy bit. The skill of the home improvement agency is to combine the two so that the clients have some choice and independence which after all, is only what we wish for ourselves."

Agency manager

Source: Making the Links, publ. Care & Repair England. 2001

3. Policy Framework

3.1. The Government has set out its vision for the delivery of health, social care and related housing services in a series of policy documents (see below). All make it clear that one of the priorities for service development is to support initiatives which encourage independence and provide support at home.

TABLE 1: KEY POLICY DOCUMENTS DRIVING FORWARD CROSS SECTORAL WORKING	
1997	- The New NHS; Modern and Dependable (DoH) - Better Services for Vulnerable People (DoH)
1998	- Home Alone (Audit Commission) - Partnership in Action (DoH) - Modernising Social Services (DoH) - Supporting People (DSS) (initial consultation) - Modernising Local Government: Improving local services through Best Value (DETR)
1999	- With Respect to Old Age – Royal Commission on Long Term Care - Local Government Act
2000	- Housing Green Paper: Quality & Choice: A Decent Home for All (DETR) - The NHS Plan (DoH) - Supporting People (various related consultation papers from the DETR) - The Way Forward for Housing (DETR)
2001	- Quality & Choice for Older People's Housing (DoH/DETR)

Source: Making the Links, publ. Care & Repair England. 2001

3.2. Further analysis of the policy context relevant to hospital discharge services can be found in the Care & Repair England report, *Making the Links*.

3.3. In the NHS Plan (2000), the Department of Health (DH) pledged a phased introduction of new money for intermediate care, rising to an extra £900 million by 2004 – around the same as current local authority spending on home care for older people.

3.4. The DH defined intermediate care services as those that promote independence by:

- *Reducing avoidable admissions to acute beds*
- *Facilitating timely discharge from acute beds*
- *Promoting effective rehabilitation and minimising premature or avoidable dependence on long-term care in an institutional setting.*

> *"What I liked about it was that it was the client who was treated as the central person in the process. The caseworker's attitude is 'it's the clients home. They are the people I must speak to'. There was a direct approach, no fuss. It would have been very much more difficult for us to run around finding someone to do the work – and the client had no money either so that was a problem."*
>
> Hospital Social Worker, Bristol

3.5. One of the Government's stated aims is to support new services which prevent older people being unnecessarily admitted to hospital and to keep more people out of long term care.

3.6. In *'Building Capacity and Partnership in Care'*, (DH, Oct 2001) the Department reiterates the principles underlying its policies;

- *The support and promotion of independence*
- *Social inclusion and equitable access*
- *Rights and choices for people using services and their carers*
- *Better care and higher standards*
- *Care at, or closer to, home*
- *The need for a whole spectrum of care options*
- *Delivery through integrated working, unimpeded by organisational boundaries and supported by harmonised budgets*

3.7. The report also states that *'adaptable, safe and suitable housing is an essential component to independent living and good quality of life. Commissioners should consider the contribution to be made by home improvement agencies'* (Section 4.3). Development of hospital discharge services which address repair and adaptation would make a valuable contribution to meeting the above objectives and delivery through HIAs is clearly being put forward as an option.

3.8. Another key financial framework currently being developed which is of major relevance to hospital discharge services is the *Supporting People* funding system. Under these new arrangements for meeting the costs of housing related care and support, housing benefit will continue to meet the costs of the 'bricks and mortar' of housing provision but a new, locally managed Supporting People Fund will finance the cost of related support services. This system will operate partially from 2002 and be fully implemented by 2003.

3.9. Current DTLR funding for HIAs is being transferred to local Supporting People Funds from 2003.

3.10. How far the new Supporting People funding framework will address prevention and support services, particularly for people living in the general housing stock, or how far the provision of special needs housing by the social rented sector may absorb the majority of resources of this funding system is not yet clear.

3.11. However, there is an opportunity here for the funding of services crucial to meeting the support needs of people who wish to live independently in their own homes, including those being discharged from hospital. Commissioners and planners in the health and social services sectors have the chance to influence such developments in local Supporting People Fund priority setting, the framework for which was set out in Administrative Guidance published in October 2001.

Case Study

Mr & Mrs Suker are an elderly couple whose first language is Turkish. They were referred to the hospital discharge service by the hospital wheelchair service a few days after Christmas. Mrs Suker had been discharged from hospital over Christmas after an admission for pneumonia. Their central heating had broken down and they had no money to pay for the repair. The hospital discharge service arranged for a central heating engineer to call the same day and carry out the repair, temporarily meeting the cost from a hardship fund whilst letters to charities were considered. They also helped the couple make a successful claim for attendance allowance and other benefits, thereby increasing their income to enable them to afford to use the heating and meet future repair costs.

"If we raise the money for installing central heating to improve the person's health, this is only useful if we then sort out their benefits so that they can afford to use the heating."

Agency manager

4. Conclusions

4.1. These are rapidly moving times in the fields of health and social care – the first Care Trusts are due to be up and running in 2002/ 2003 and Supporting People will come into operation over the same period. These changes will start the transformation of the whole field of social and health care for older people.

4.2. Whilst there are concerns that at an operational level the medical model of care could take precedence over social models, and that the importance of housing, preventative and environmental services such as home safety, aids and adaptations schemes will be given a lower priority, this is clearly not the intention at a national policy level.

4.3. As the case studies which follow demonstrate, if people are to be enabled to live independently in their own homes for as long as possible, ensuring that that those homes are warm, dry, secure and adapted to people's needs is critical if Government policy objectives are to be met.

Case Study

Mrs Black has both mental difficulties and physical problems which meant that getting in and out of her home up a flight of steps up to her front door was extremely difficult. Whilst the adaptation to the steps was only a small job (final cost £400), the policy of the local authority meant that the only way that they would meet the cost of the adaptation was through a disabled facilities grant. This was mishandled over a two year period during which time Mrs Black was admitted to hospital a number of times, with the worst instance of falling down the steps resulting in the loss of her front teeth. Within a week of referral to the hospital discharge service, the work was completed, paid for through charitable funds, and the caseworker is now helping Mrs Black with claims for welfare benefits.

4.4. This guide highlights services which have been developed by HIAs to address the housing and, in some cases, the associated care and support needs of older and disabled people returning to their own homes after discharge from hospital.

4.5. It offers ideas to service providers and commissioners about issues to consider when assessing the need for a hospital discharge service and includes examples of models which can be locally adapted to make it easier to set up a service.

4.6. The guide does not set out one specific model of a hospital discharge service; local situations are far too varied for such an approach. However it does seek to highlight areas of good practice and the limitations of some models compared with others.

Part 2: What is a Hospital Discharge Service?

1. Overview

1.1. There is a whole range of services being referred to as 'Hospital Discharge' or 'Home from Hospital' services.

1.2. In their report *'Hospital Discharge Schemes And Other Aftercare In England'*, Help the Aged defined the aims of hospital discharge schemes as follows:

- *To assist in the smooth transition of people from hospital to home.*
- *To help ensure that people do not remain in hospital longer than they need once medical and nursing requirements have been met.*
- *To help prevent re-admission to hospital because of inadequate home support.*

1.3. At the time this study was undertaken (1994), 32 hospital discharge schemes were identified (23 Age Concern plus 9 British Red Cross). Today Age Concern list 80 services, British Red Cross run 40, and 35 HIAs reported running a hospital discharge type scheme in 2000.

1.4. Such broad aims can clearly be met in a number of ways and a critical first step for anyone thinking of commissioning or running such a scheme is to be clear both about its aims and also about what specific services will be provided to meet these aims.

Case Study

Mr Jones is a young man with a serious respiratory complaint. He has to make continuous use of an oxygen machine and sleep wearing an oxygen mask.

His home is very cold and damp. The only heating is a gas fire which much of the year is used day and night. The wiring is unfit and the roof leaks, resulting in part of the upstairs ceiling collapsing.

The situation is particularly dangerous as the oxygen should not be used near a naked flame. The hospital discharge scheme has put together a package of funds (totalling just over £5,000 including home repairs assistance grant and charitable funds) to install central heating, fix the roof and the ceiling and rewire the home. This will dramatically improve Mr Jones life, and could prevent a very serious accident.

1.5. Below are outlined the main types of scheme currently being delivered by a range of providers. Highlighted are a number of more detailed profiles of schemes currently being provided by home improvement agencies. In the latter case there is a particular emphasis on addressing the issues of adaptations and essential repairs to ensure that the home of the person being discharged is safe and sound.

2. BRITISH RED CROSS HOME FROM HOSPITAL SERVICES

2.1. This initiative was first established by the British Red Cross in 1992. The local services focus on the provision of short term practical help and emotional support for people when they return to their homes from hospital. This help is delivered by trained volunteers and the programme organised by paid co-ordinators, usually hospital based.

2.2. The evaluation of the programme, undertaken by the Nuffield Institute for Health (publ. 1996) found that the majority of people helped were older people who lived alone, and most of the support was practical rather than personal. The model emphasised the importance of a one to one relationship with each volunteer having their own clients, and that this was particularly valued by clients. This contrasts with the way that some statutory services are increasingly delivered in an impersonal way by a series of different staff.

2.3. The study concluded that some purchasers saw the service as a particularly useful way of providing help to people who may not meet the eligibility criteria for statutory services, but who were vulnerable immediately after hospital discharge. However, it also pointed out the danger that Home from Hospital could be used as a substitute for statutory services as resources became more stretched.

2.4. Since that study, British Red Cross have gone on to develop further Home from Hospital Services and there are now over 40 schemes in the UK.

3. AGE CONCERN HOSPITAL AFTERCARE SCHEMES

3.1. Since the 1980's local Age Concern Groups have developed services which help with immediate practical needs in the days following discharge from hospital. In their 1992 guide to running an aftercare service Age Concern England list a wide variety of tasks which local schemes could undertake including; *light housework, shopping, personal care, help with financial arrangements, sorting out pensions and benefits, liaising with statutory authorities*.

3.2. Such help can either be provided by volunteers or paid staff, and the underlying principle is to help people carry out tasks themselves, rather than do it for them, in order to encourage rehabilitation. As with the British Red Cross services, the help provided is time limited, usually lasting from 3 – 8 weeks.

3.3. There are around 80 local Age Concern Groups running such services.

4. OTHER RELATED SCHEMES

4.1. Projects similar to the above may also be run by voluntary organisations such as volunteer bureaux. Specialist organisations such as local Mind groups may run hospital discharge schemes to assist people returning home after a stay in hospital as a result of a mental health problem. Common to all schemes is the emphasis on offering support for a very short period of time, with a handover to other services to meet ongoing, long term support needs.

4.2. A new way of helping people in the community which is well established in the USA but is just getting started in the UK is the idea of 'time banks'. When people help out in their local community, for example, visiting older people who have just come out of hospital, fetching shopping, running community transport or carrying out small DIY jobs, they earn electronic credits for doing so. They can then spend these credits on similar help for themselves when they need it. The first UK pilot in the health sector is operating from a GPs surgery in Lewisham.

4.3. Local authorities and primary care groups are developing initiatives which link to the hospital discharge broad aims. The London Borough of Hammersmith and Fulham Social Services Department, and the Hammersmith and Fulham Primary Care Group has been piloting a 'Keep Well at Home' initiative. The aim of this work includes reducing inappropriate admissions to hospital, residential or nursing homes and facilitating timely and safe discharge. This is done by identification of the risk of functional decline among the over 75's and improving their living situation in order to maintain their health and independence at home. The scheme operates with participating GP practices.

4.4. The project has identified many older people living in homes without central heating (or even without any heating), no hot water and some without an inside toilet or bathing facilities, plus many who need adaptations and smaller repairs. The scheme is currently being evaluated by the Imperial College School of Medicine.

"I was 75 when I had a number of mini strokes. I was like a child when I came home from hospital. I had to rely on Staying Put to help me get through this time as I learnt to fend for myself and regain my independence.

They helped me through all the paperwork that I had to do. They gave me loads of time to listen and talk through the decisions I had to make so that I could stay in my home. Love and compassion in your own environment is a great healer.

With their help I have had handrails fitted, a panic chain, and lever taps because of the lack of mobility in my arms, and a number of energy saving installations They also contacted a Stroke project, 'The Hot Shop', which is teaching me to regain my mobility. Without the support of Staying Put I wouldn't be here."

Mr O'Mard

5. IN - HOUSE HOSPITAL DISCHARGE AND ADMISSION PREVENTION TEAMS

5.1. In response to pressure on acute beds, health authorities have sought to develop a range of initiatives to speed up the process of hospital discharge and/or to reduce the admission of people into hospital when short term domiciliary or residential care would in fact meet their needs.

5.2. Services such as 'Rapid Response Teams' often deal with cases where an elderly person, or their carer, is taken ill and there is no-one to look after them at home, or they have been treated in Accident and Emergency and could be discharged if personal care at home could be arranged. Rather than be admitted to hospital and wait for the normal process of assessment and arrangement of the necessary services, the rapid response team will organise services immediately thereby avoiding hospital admission.

5.3. Some rapid response teams have a more medical focus, providing assessment, diagnosis and immediate medical treatment wherever the person is living (including special needs accommodation such as residential care or in people's own homes).

6. HOME IMPROVEMENT AGENCY HOSPITAL DISCHARGE SERVICES

6.1. The hospital discharge services provided by HIAs usually aim to help people who are unable to leave hospital and return to their own homes until an essential adaptation or repair is carried out. Most agencies help mainly older people living in owner occupied or private rented accommodation, though some work across tenure and age groups.

6.2. The actual help provided to achieve this broad aim and the extent of the service varies significantly. Some small scale schemes are literally fast track adaptations services whereby hospital occupational therapists (OTs) put through requests for the installation of a specified item (such as a handrail) which is then organised very quickly either via a group of contractors or an in-house handyperson or technician service.

6.3. In other cases the hospital discharge service is more comprehensive and undertakes all of the functions of the core HIA service but uses fast track methods to meet the person's most pressing adaptation and repair needs. The person can then return home and continue to live in the house whilst more major work is undertaken.

6.4. In a minority of cases the HIA hospital discharge service combines the repair / adaptation service with a more holistic package incorporating many of the tasks and support services noted in the Age Concern/ British Red Cross schemes above.

6.5. In the next section a series of project profiles are provided to illustrate this range of services. No one model is ideal – local circumstances will dictate the most appropriate service in a particular area, and one of the aims of the guide is to assist in the process of developing a suitable local model.

Part 3: Project Profiles

HACKNEY STAYING PUT HOSPITAL DISCHARGE SERVICE

Profile

First established in 1994, the Hackney Anchor Staying Put Hospital Discharge service seeks to deal with the needs of older people who are being discharged from hospital in a holistic fashion. The service is provided for older people who are in hospital and unable to be discharged unless essential work is carried out to their homes. It is also able to help people who are in danger of being admitted to hospital unless such work is carried out.

The team consists of caseworkers, technical staff, an administrator and handyperson. The building work undertaken ranges from handrails installed by the handyperson to major renovations and large scale adaptations. A dedicated fund for meeting the cost of small, essential repairs and adaptations is provided by the health authority and administered by the HIA. This enables the agency to provide a particularly fast and flexible service.

The caseworkers provide benefits checks and liase with a full range of service providers on people's behalf as necessary.

Mr Dunn is 90 yrs old. He lives alone in his own leasehold flat. Following several months in hospital after a fall, he was referred to the hospital discharge service when he was medically fit. The social worker felt that he could not be discharged to his unfit home and he was offered residential care, which he refused.

The hospital discharge scheme caseworker arranged a home visit with Mr Dunn and a care manager. The flat was extremely cluttered and dirty with no hot water in the kitchen, an inaccessible bath, broken lavatory and a large hole in the flat roof over his kitchen. With Mr Dunn's agreement clearance and cleaning of the flat was arranged and applications made for minor works grants for installation of a shower, a new lavatory, repairs to the roof and a hot water boiler. A community care grant was obtained for a bed, cooker and fridge. The care manager arranged for regular home care and Mr Dunn is now happily living independently at home.

Feature

One unusual feature of this service is the way in which the agency and occupational therapy (OT) service have worked together to streamline handrail provision. All of the team staff have been trained to measure up for handrails and OTs are no longer involved in this process. This has had a very beneficial effect as people no longer have to go on a waiting list for assessment just for a handrail. There has also been a benefit to other people who come to the agency for help with repairs. If any of the staff identify a safety issue and a need for a handrail to reduce a falls risk, they can organise for installation of this immediately. The project is also planning a 'One-Stop OT Shop' with an in house OT and grant officer.

Funding

As with many services, a complex package of short and medium term funding sources have been accessed over the lifetime of this hospital discharge scheme. It was first set up with 3 year funding from

the Department of Health. Winter Pressures money has since been accessed a number of times and the current funding sources include new 'capacity building' social services money, primary care trust funds, promoting independence grant, fees and charitable funds.

SEFTON HOME FROM HOSPITAL

Profile

The Sefton Anchor Staying Put Home from Hospital service was established on a small scale in 1996. It was a pilot project monitored as part of the Care & Repair England study into HIA diversification and is profiled in detail in 'Making the Links'.

The project has evolved into a comprehensive service increasingly integrated with the core HIA, with a caseworker, technical officer and administrative support. It helps older and disabled people who are waiting to be discharged from hospital, those who have already been discharged from hospital into homes which need repair and adaptation and people who would be at risk of hospital admission if such work was not carried out.

In the case of small adaptations, the hospital OT specifies the required work, the caseworker arranges for a contractor to carry this out and then visits the person's home after work has been completed to check quality of work, whether they are happy with the aid/ adaptation, to offer a welfare benefits check and to assess whether any other work/ services are necessary.

Case Study

Mrs Price is 87 years old and lives alone. She broke her arm and shoulder in a fall at her home and was admitted to hospital. The hospital OT contacted the home from hospital project one morning to say that Mrs Price was being discharged that afternoon and a stair rail was urgently required. The caseworker arranged for a contractor to go out that same afternoon to install the rail (the cost of the job was met from the social services minor works budget).

The caseworker then visited Mrs Price two days later to ensure that she was finding the rail helpful (she said that she would never have been able to manage without it). However, the visit revealed that the wiring in the property was at least 50 years old and in a very dangerous condition. A home repairs assistance grant was obtained to meet the cost of rewiring the house, thereby leaving Mrs Price in a much safer home.

This follow up visit is seen as critical by the agency if a holistic service is to be provided. It has been found that in over half of the OT referred cases further essential repairs and adaptations were identified and action taken (including emergency work such as gas leaks and defective wiring).

Feature

The project is able to respond rapidly to requests for small works (under £500) through access to a social services minor works fund and availability of a core group of reliable contractors who work to a schedule of rates.

Funding

Originally funded by Sainsburys Monument Trust, then co-funded by social services, The Housing Corporation & Anchor Trust (when part of the Care & Repair England pilot), and it is now jointly financed by health and social services (minor works budget plus prevention grant).

WARWICK DAILY LIVING SUPPORT SERVICE

Profile

This was also a pilot scheme for the Care & Repair England 'Crossing the Housing and Care Divide' programme and is profiled in detail in *Making the Links*. The service was developed by Warwickshire Age Concern Care & Repair as an extension of a project originally set up in 1997.

This service combines the provision of short term (6 week maximum) practical support services such as shopping and cleaning, with advice on equipment and installation of small adaptations through the agency handyperson service. The short term practical support is provided by paid sessional staff employed by the HIA. Wherever possible, the same individual provides the support for a particular person for the specified time period, rather than a number of workers. This enables people to develop a personal relationship with the support worker and is seen as one of the reasons for the high levels of satisfaction with the service.

A caseworker visits each person to assess their need for the care and equipment service, to check welfare benefits and identify related practical needs, such as referral to the core HIA service for repairs and major adaptations.

"My husband had died and I was very depressed, not eating or really looking after myself. When I fell and broke my arm I was in a terrible state – I don't know what I would have done if the hospital had not put me onto the Care & Repair people. They came out shopping with me, got me out of the house again, and helped me start to cook again. They put me in touch with Cruise [an organisation which supports widowed people] and built up my confidence so that now I feel a can carry on. It was so much more than help with a broken arm."

Mrs Stokes

Feature

The building up of positive working relationships with a range of ward staff has been critical to the success of this scheme in reaching people who would otherwise not receive the practical help and support that they need. Through this wider referral system, the service helps people who have not been referred by an OT for adaptations. Upon visiting at home after discharge many repair and adaptation needs are identified.

Funding

The pilot was funded by The Housing Corporation and Anchor Trust (when part of the Care & Repair England pilot) and it is now funded by the Primary Care Group.

LEEDS CARE & REPAIR HOSPITAL DISCHARGE SCHEME

Profile

This scheme is specifically focussed on providing a fast track minor adaptations installation service. It operates across housing tenure and ages. The agency holds a budget to pay for the adaptation work undertaken (provided by social services).

Hospital and community occupational therapists fax through a job sheet specifying what work is required for a person. The agency then passes this to a contractor who undertakes the required work (the contractor operates to an agreed schedule of rates). If more major adaptation/ repair work is needed the contractor refers the person back to the core Care & Repair team. OTs and other hospital staff may also make referrals to the core service.

Feature

One of the reasons cited for the success of the service is the exceptional quality of the contractor and her staff, both in terms of work quality, relationship with service users and speed of delivery (the majority of jobs are completed the same day or within 48 hours).

Funding

The service has been operating off and on (due to short term funding packages) since 1997, originally funded through winter pressures money. The service is funded by social services and whilst extra money was allocated to the service from the special extra government money for capacity building announced in October 2001, a key issue for the service is how to deal with the escalating demand.

"If I hadn't gone into hospital I would never have know about help with the house. I was always so worried about it [the house] – the work they have done made all the difference."

Service User

COVENTRY CARE & REPAIR HOSPITAL LINK DISCHARGE SCHEME

Profile

Established in 1998, the Orbit Care & Repair project in Coventry provides a fast track adaptations service to reduce delays in discharge and also home safety assessment to help reduce the risks of readmission into hospital as a result of poor housing. Caseworkers visit every person referred both in hospital and in their own home to carry out a full assessment of need (including a welfare benefits check), and a room by room home safety check.

Major and minor works of repair and adaptation are organised by the service.

Case Study

Mr Ball is 77 years old, has a severe heart condition and mobility problems which cause frequent falls. Following another fall and resulting hospital admission, he was referred to the Hospital Link Discharge Scheme. Upon visiting his home it was discovered that the downstairs WC was broken, there was no hot water, the rear external door was badly damaged from an attempted break in, the wiring was dangerous, the gas fire in the lounge and gas heater in the hall (the only heating in the property) were both defective.

All of these repair problems were dealt with and paid for through home repair assistance grants. A telephone line was also installed and a lifeline system is planned. Floors were bare (exacerbating the impact of the falls) so charitable funds were raised to pay for carpets. Following a check on welfare benefit entitlement, Mr Ball's income was increased by nearly £50 per week.

All of this work has made an enormous difference to Mr Ball's health and well-being.

Feature

A special arrangement has been reached with Orbit Housing Association, with regard to temporary accommodation in one of their sheltered housing schemes for people who do not need a high level of medical care input, but whose discharge from hospital is being delayed as a result of the need for home adaptations. The sheltered housing scheme is making available a large bedsit with en-suite facilities, adapted bathroom and lifeline link. In this way older people can be discharged from hospital and live independently whilst major works are undertaken in their own homes.

Funding

The cost of the service is met by Coventry Health Authority, including the cost of retaining a unit in the sheltered housing scheme (see above).

BRISTOL CARE & REPAIR HOSPITAL DISCHARGE AND ADMISSION PREVENTION SERVICE

Profile

Established in 1998, this service is provided for older and disabled people. This is a comprehensive repairs, adaptations and support service based on the model of core home improvement agency work with caseworkers, technical support and a linked handyperson. Accident prevention is an integral part of the service with a home safety check routinely offered to clients and remedial work undertaken.

Case Study

Mr Green is a retired man, living along in his own home. A leg condition was leading to increasing mobility problems, culminating in admission to hospital.

When the hospital discharge scheme caseworker first met Mr Green it was evident that he was desperate to return home so on the first home visit the handyperson also came along. He installed grab rails and handrails on the spot (as specified by the hospital OT), removed a stair carpet which was described as 'lethal', and secured other dangerous loose carpets in other parts of the house. Mr G had a dog, which was clearly a very important companion, and he was very keen to be able to go out into the garden with the dog. The handyperson returned to build low rise steps and install grab rails into the garden.

When the caseworker returned to carry out a benefits check (which resulted in Mr G claiming income support and increasing his weekly income), she described him as a 'changed man' very happy to be living independently again and happily moving around his home with the use of the aids and adaptations provided.

"It's the little things that are so important, too, for getting someone out of hospital. Take, for instance, a situation where the house is in a bad state after an illness involving incontinence. We can't let people go home to soiled carpets. Before the project was started, we would spend hours ringing around agencies getting quotes. The Care & Repair project will do all that for us."

Hospital OT, Bristol

The pilot phase of the service was independently evaluated by M. Brenton in 1999. This report concluded *'It [the service] is comprehensive, offers a rapid response, mobilises the requisite resources with considerable ingenuity and sees through its tasks to completion within a very short time. …the project prevented any discharge delays and bed days were therefore saved'.*

The majority of the cases are referred by the hospital OTs. In some cases a joint visit will be made to the person's home by the OT and hospital discharge scheme caseworker. Occasionally, in more complex cases, the caseworker will attend a discharge meeting with other professionals at the hospital to ensure that the work required on the home is an integrated part of the discharge process.

Feature

In many cases, the service is able to effect repairs or adaptations within 24 hours if the handyperson can undertake the work. They are able to carry out many other repairs and adaptations within a week because of the rapid response system developed to pay for work. The hospital discharge service is provided with a budget for small adaptations by social services and the local authority makes available a ring fenced home repairs assistance grant budget, operated on a fast track system, for dealing with hospital discharge cases.

Funding

Initially a pilot project funded by winter pressures money, this service is currently funded by social services.

BURY STAYING PUT HOME FROM HOSPITAL SERVICE

Profile

The Bury Anchor Staying Put Home from Hospital Service was established in 1998 and helps people with a full range of repair and adaptation work through a caseworker, technical officer and administrator. The project is fully integrated with the core agency service. The agency employs a part time technician, who installs minor adaptations and carries out small repairs as part of the hospital discharge service. Social services meet the cost of small jobs (under £250) through payment for materials and the technician's salary.

Case Study

Mrs Long is 78 years old and lives alone in her own home. She was referred to the home from hospital service by the hospital social worker and OT who were concerned about the difficulty Mrs Long was having getting up and down stairs. A second stair rail was installed by the project technician within 3 day of the referral. When the caseworker visited she realised that Mrs Long's gas fire had been disconnected following a safety check. Funding applications were made to a number of charities and the money raised to repair and reconnect the fire. A successful claim for attendance allowance was also made.

Feature

As a way of monitoring one aspect of the cost effectiveness of the service the agency estimates the commercial cost of each job undertaken by the technician. At the end of the year it compares this estimated total with the actual cost of the technician service.
On this part of the service alone, the agency demonstrated a saving of over £18,000 in one year. Furthermore, the hospital occupational therapy service have reduced their visits on small aids and adaptations cases from 2 to 1 when the hospital discharge service is involved.

Funding

Initially funded by joint finance and then prevention grant. Social services meet the cost of the part time technician's salary.

WYRE HOME FROM HOSPITAL

Profile

This started out as a small repairs service with a handyperson employed by the HIA. However, it has evolved into a scheme akin to some hospital discharge projects because of the extensive use made of the service by the local 'Red Cross type' Home from Hospital project who make referrals for practical repair jobs on behalf of people being visited following their discharge from hospital.

Feature

This scheme compliments the social support work of an existing Home from Hospital service being run by another agency.

Funding

The service is funded by social services and the primary care group – clients usually meet the cost of materials used.

Case Study

Mrs Thomas is an elderly woman living alone. She fell through rotten floor boards in her kitchen and had to be admitted to hospital. She was not able to return home until these boards had been replaced – the work was completed by the handyperson service within 24 hours of the referral and Mrs Thomas was able to return home.

"I am ninety and retired as a lithograph printer almost thirty years ago.

So you see I have to be so careful with my savings as I want to be in a position to meet any unforeseen expenditure.

I was taken into hospital as an emergency after I had spent three days in severe pain. They admitted me as having hypothermia but I felt that this could have been avoided had I received medical attention when I rang my doctor on day one.

The hospital social worker suggested that Care and Repair might be able to help with the heating. Whilst I was still in hospital, they had a boiler and radiators fitted in the main rooms. Although I received competent medical attention I wanted to get to my own home as quickly as possible. I want to make my own decisions about what I do and I like to be self-sufficient.

I have no family now and it took some time to readjust. Since the installation of the central heating I enjoy greater comfort now.

There is some plaster coming off the ceiling in one of the rooms and Care and Repair's handyperson will be coming to fix it soon. I will only have to pay for the materials which it is a great help."

Mr O'Mard

ASSOCIATED INITIATIVES

CHESHIRE

There are 6 home improvement agencies operating at a district level in the county of Cheshire. Each employs a handyperson as an accident prevention officer to carry out small aids installation, minor adaptations and any odd jobs identified from a home safety check as putting the older person at risk. An Alliance of the 6 HIAs is being developed to produce a single broader project to address home from hospital/ accident prevention aims. The Alliance plans to apply to the primary care groups for funding for this work.

Each of the 6 HIAs operating in Cheshire have received 2 years funding from social services (modernisation followed by prevention grant) to offer an accident prevention/ handyperson service to people over 60 living in any tenure. They undertake a full safety audit of the property and carry out any small works identified as posing a risk to the person. Larger scale works are referred back to the core HIA service. The works carried out so far range from small aids and adaptations and small repairs to the removal of clutter, securing trailing wires and clearing moss from pathways. The Alliance is presently working with Age Concern Cheshire to widen the service to offer Falls Prevention Training and Awareness training. As this work meets the priorities of the National Service Framework for Older People it is hoped that the wider project will attract significant funding from the health sector.

Case Study

Mrs Smith is an elderly woman living alone. She had been admitted to hospital after falling over a loose carpet gripper in her home and fracturing her arm. Before discharging Mrs Smith, the hospital contacted the Accident Prevention Officer who (with the clients permission) visited her home to carry out a full safety audit as a result of which he refitted the gripper, secured trailing cables, re-fixed loose floor tiles in the hall and fitted a smoke detector.

A few weeks after discharge from hospital Mrs Smith contacted the Care & Repair agency because her roof was leaking. Grant aid was organised to pay for the necessary repair work.

GLOUCESTERSHIRE

A *Fast Track Adaptation Service* for *Older People* throughout Gloucestershire has been developed to provide a more efficient and cost effective way of installing small aids and adaptations. Funded by social services, the aims of the project are to reduce waiting times for small adaptations, give equitable access to preventative adaptations and equipment, alleviate the risk of falling and reduce accidents in the home, decrease reliance on family or other care services, increase the confidence of people living independently at home.

A key impetus for development of the scheme has come from the Gloucestershire social service's study of their adaptation waiting lists, combined with the demonstrable benefits of the small adaptation service which has been operated by Stroud Care & Repair for a number of years. The study revealed that 12% of people referred required a simple adaptation and that most of these, after OT assessment, received the adaptation they originally requested. Some people waited for up to eight months for an OT assessment. It was also noted that as most people only asked for help when it had become imperative, the long wait was putting them at high risk of falling or having an accident.

The HIAs in the 6 districts are working in close partnership to deliver the new countywide service co-ordinated by Stroud Care & Repair. Referrals come through Care Direct Customer Service Officers. Upon contacting Care Direct, people requesting a minor adaptation are screened and if they are not identified as needing an OT assessment they are given the option of coming straight through to the *Fast Track Adaptation Service for Older People*, as well as being offered a further range of measures to enhance safety at home.

Each Care Direct referral is routed to Stroud Care & Repair who pass this on to the HIA in the relevant district. There is a £250 maximum job cost for each case with a specific menu of available items. Work is priced at agreed rates and the budget is held by Stroud Care & Repair who also keep details of all work on a database.

Whilst currently available to older people in private sector housing, the longer term plan is for the service to operate across all tenures.

MANCHESTER CARE & REPAIR

Manchester Care & Repair have run a falls prevention scheme for over 2 years. It is funded by health action zone money and some prevention grant and operates in certain wards in the city. Anyone can refer people to the service, or older people can request the service themselves. The HIA employs a prevention officer who advises the householder, carries out a full safety check and specifies the work to be carried out by the handyperson or a contractor.

This service is increasingly being called on by the health sector as an aid to hospital discharge. The hospital discharges require the prevention officers to re-schedule their own and the handyperson's work at short notice. Manchester Care & Repair find that the hospital discharge work, while valuable, is affecting their ability to deliver the falls project successfully. They will be discussing this with health and social services to see if separate funding for the hospital discharges can be identified

Part 4: Developing a Hospital Discharge Service

1. PLANNING

1.1. The impetus for starting a hospital discharge service is most likely to arise either from the provider of existing services for older and disabled people identifying the need for a scheme, or from the commissioners of such services in health or social services departments.

1.2. If examination of the local Health Improvement Programme and Joint Investment Programme does not indicate that a hospital discharge service would be a priority, a meeting with the planners concerned to discuss the idea should take place prior to carrying out a great deal of work. These plans do determine expenditure to a significant degree and a hospital discharge service will be more likely to be prioritised for funding if it is included in the plans.

1.3. Every health authority area is obliged to have a jointly (health and social services) appointed intermediate care co-ordinator and contacting this person would also be useful in terms of understanding local plans for intermediate care, including what the strategy is for improving hospital discharge and preventing unnecessary admission to residential care (a joint 3 year investment plan for intermediate care has to be drawn up and agreed by January 2002).

1.4. In some areas identifying a joint health and social services commissioner who is keen on the service and who would steer through the process of planning and funding will be the catalyst to developing a scheme. This would involve the least time input from a service provider in terms of fundraising and development. Involving the local health sector older people's champion would also be advisable.

1.5. Depending upon the response to the above and local circumstances, it may be appropriate to establish a broad based steering group to develop the idea for a hospital discharge scheme. This could involve representatives from local older people's forums, strategic planning officers from health, housing & social services, hospital OT managers and other individuals who are keen to improve the discharge process for people. Ensuring that the views of potential service users are integral to the development of the service is particularly important.

1.6. At a day to day operational level, a service developed with practitioners' active involvement is more likely to operate effectively than one which is perceived as 'imposed from above'. A one-off open event to present and debate the service idea very early on in the planning process is another option worth considering.

1.7. Whichever way the process starts, there are a number of key questions to be addressed:

- *Is there evidence that such a service is needed?*
- *Is everyone concerned agreed about the type of service required? (see Part 2 above)*
- *Which organisation is best placed to run the service?*
- *Are the financial and procedural systems (particularly in the case of repairs and adaptations services) in place/ achievable to enable the service to operate effectively?*

1.8. If the impetus is coming from a service provider such as a home improvement agency, some evidence of need/ demand/ viability will need to be put together. This could be commissioned as part of a feasibility study and might include some or all of the following:

- *Basic statistical analysis of the area to be covered: numbers (current and projected) of older and disabled people, tenure patterns, ethnicity of local population and issues arising from this (Census Data), local profile of disrepair levels and adaptation needs (local House Conditions Survey), numbers of older and disabled people being discharged from hospital (statistics from the health authority may provide useful data).*
- *A survey of the views of older and disabled people.*
- *The results of a consultation meeting held with older people/ existing service users (perhaps along the lines of the focus groups piloted by Care & Repair England and detailed in the publication, Learning to Listen, or from a meeting with an existing local older people's forum).*

> *"Where there are unsafe electrics – it's no-one's job to follow that up and it falls in the gap between OT and social services. We can get Care & Repair to do it."*
>
> Hospital OT

- *Case studies of people currently being helped by the HIA who could be classed as hospital discharge cases.*
- *Case studies to demonstrate inefficiencies in current systems and how a proposed hospital discharge service could help. Examine current discharge arrangements and put forward constructive ideas for improvement/ efficiency savings.*
- *A survey of national policy trends (use Part 1 above) and related local trends.*
- *Examination of local priorities set in the Health Improvement Programme (HimP), Joint Investment Plan (JIP), Capacity Planning Groups, Local Strategic Plans (if available), Health Action Zone (if applicable), social services/ housing strategies, any information available about needs projections and priorities from the local Supporting People Team.*
- *Examination of any other similar services already being provided in the area or nearby. There may be issues to consider in terms of boundaries – the health trust/ social services boundary might encompass a number of HIAs/ providers. Is there scope for these parties to work together? Also consider the range of service type options set out in Part 2 above and consider other possible partner organisations.*
- *Estimates of the resources needed, possible funding sources plus estimated outputs and any anticipated savings to the health sector.*

1.9. Whatever the route to development, clarity about the purpose and parameters of a hospital discharge service are critical. It can be a source of frustration to HIAs and other service providers if a commissioner only wants one small part of the service that they believe people want and need; such issues need to be resolved at the early stages of development.

1.10. For example, the HIA may wish to provide a comprehensive hospital discharge service – providing people with help with adaptation, repair, practical and emotional support, financial advice- but a commissioner may only wish to pay for a fast track adaptations service. The service provider needs to be clear how far they are prepared to compromise and also be clear about whether or not they can practically limit their service in the way required. Involving other key partners/ commissioners in the debate could also lead to compromise agreements if they too wish to see a wider service.

1.11. Tenure and age of service users may be an issue if the HIA core service is only for older home owners but the commissioner wants a hospital discharge service which operates across tenure and age. How the HIA will deal with cases on a day to day basis if this arrangement is entered into also needs to be thought through.

1.12. Clarity of purpose will be particularly important when negotiating a service agreement or specification. A sample service agreement is included in Appendix A.

2. FUNDING

2.1. The profiles in Part 3 above illustrate the range of income sources accessed by HIAs to date for the funding of hospital discharge services. These include;

social services (including mainstream grants, joint finance, partnership and prevention, promoting independence, capacity building), winter pressures programme, primary care groups, health authorities, Department of Health (special programmes)

2.2. Winter pressures money was the most frequently mentioned source of funding for HIA hospital discharge schemes. This is being replaced with specific funds from central government to enable local health and social services bodies to take a more strategic approach to capacity planning and move away from the 'stop – start' arrangements resulting from winter pressures money. This could open a window of opportunity for the funding of hospital discharge services.

2.3. Primary Care Groups are another possible source of funding, as are social services 'Promoting Independence' funds.

2.4. In the longer term, the new Care Trusts will be the commissioners of the majority of health and social care services for older people and would be expected to be one of the main funders of hospital discharge work, possibly along with Supporting People funds.

Case Study

Mrs Ash is an elderly woman who lives alone and had been admitted to hospital after a fall. She could not be discharged from hospital until a door had been fitted to stop her falling down a flight of cellar steps. She did not have any savings to pay for the work (£225) or anyone to help her. The hospital discharge service paid for this work from their hardship fund and it was completed within 2 days, enabling Mrs Ash to return home.

2.5. Precisely how hospital discharge services fit into the Supporting People framework is still to emerge. There seems to be no reason why such services should not be financed by the Supporting People fund. The extent of the use of these funds for preventative services which support people in the owner occupied sector is as yet unclear, but anyone planning this type of service would be well advised to discuss the idea with their local Supporting People team.

3. PRACTICAL CONSIDERATIONS

3.1. Having decided to pursue the development of a hospital discharge scheme and identified funding, the stage of more detailed implementation planning is reached. Plans should consider each of the following (if not already covered in the feasibility assessment):

3.1.1. Where should staff be located?

Even if the service is integrated into the HIA, perhaps a caseworker operating part of the time from the hospital is worth considering.

3.1.2. Where will referrals come from?

In developing a plan for promoting and publicising the service the following issues need to be considered:

- *Will older people be able to contact the service directly themselves or will the scheme be restricted to those referred by specified individuals in the hospital/ social services?*
- *How will the service aim to reach all sectors of the community?*
- *How could the scheme fit into the single assessment process being developed by health and social services?*
- *Will new referral systems and recording systems be required?*

Case Study

Mr Watt is a private tenant. He was unable to be discharged from hospital because his landlord refused to mend a dangerously broken banister. Discharge was delayed for 6 weeks whilst both social services and health sector solicitors were involved in negotiations with the landlord's solicitor. The hospital discharge service was approached and they immediately sent in the handyperson (acting upon Mr Watt's instruction) and the banister was repaired within hours, enabling Mr Watt to return home immediately.

3.1.3. How will the costs of repair and adaptation work be met?

An easily accessible budget (possibly held by the service provider) to pay for small works/ materials is invaluable in order to provide a rapid response to requests for help. Addressing the ways in which the current disabled facilities, home repair assistance and renovation grant system could be better administered/ prioritised for hospital discharge cases is important – note the examples in Part 3 above.

3.1.4. Rapid Response arrangements

Many hospital discharge services see the availability of a handyperson service as critical to their ability to deliver fast results. Access to a reliable panel of small contractors willing to work to a schedule of rates and respond rapidly to urgent cases was also cited as an important resource.

Liaison arrangements with related support services, such as home care, safety and security check schemes etc. need to be established.

3.1.5. Do the systems in the core service need to be revised?

Case prioritisation, recording systems and communication systems may all need to be adapted to enable the hospital discharge service to integrate with the day to day operation of the HIA. Ensuring that monitoring systems are in place which will provide service commissioners with the information required, whilst at the same time not resulting in duplication with core monitoring is particularly important *(See Appendix B)*.

4. SUSTAINABILITY

4.1. Any service has to be able to prove its worth if it is to be sustainable. Much of the health sector has an ethos of evidence based commissioning and if a hospital discharge service is funded to reduce bed blocking and increase discharge efficiency, efforts will have to be made to demonstrate that this is being achieved.

4.2. The issue of how to quantify the precise extent to which a particular intervention by a hospital discharge service has resulted in faster discharge, reduced readmission rates and prevented admission remains unresolved. A number of attempts are being made to quantify this at a local level, but there is no strategic study on a national scale. However, some suggestions for monitoring and evaluation are made in Appendix B.

4.3. Some commissioners may focus on quantitative output targets – it may be useful to also include more qualitative measures in monitoring processes and be able to demonstrate 'added value'. How a hospital discharge service is to be monitored and evaluated needs be incorporated into the service agreement and systems for monitoring built in from the start. Such systems are also central to quality control and day to day service management.

4.4. Integration with existing forms of monitoring is clearly an issue and individual HIAs may need to seek specialist help to enable them to adapt their IT systems to cope with the requirements of new services in ways which minimise duplication.

4.5. Whatever the practicalities of the day to day monitoring system eventually adopted, the system has to be able to provide readily accessible information which enables managers and commissioners to;

- *Ensure quality of service.*
- *Evaluate the performance of the service against agreed criteria.*
- *Ensure that the views of service users are integral to the process.*

> *"It was a very good service. I'm getting along lovely. I would still be in hospital if these things hadn't been done."*
>
> Mrs Grey

Appendix B includes suggestions for data collection and use.

Part 5: What makes a good Home Improvement Agency Hospital Discharge Scheme?

HINTS AND TIPS FROM CURRENT SCHEMES

1. "Rapid access to money to pay for the work to the persons house is critical"

- A number of models of good practice have been identified for carrying out small jobs (approx. under £500):
  Direct employment of a handyperson plus holding a materials fund. Hospital discharge service holding a fund of money to pay for work undertaken by a panel of contractors using a schedule of rates. Social services holding budget for materials with a rapid processing arrangement. Lump sum allocation from health and social services given to hospital discharge service to pay for agreed range of work.
- For intermediate jobs (approx. under £3,000):
  Fast track home repairs assistance (HRA) arrangement with housing authority combined with ring fenced HRA grant allocation. Emergency fund provided by social services, held by hospital discharge scheme for medium size adaptations.
- For larger work:
  Local authority operates priority system for disabled facilities grants (DFGs) and allocates a specific part of renovation grant budget for hospital discharge cases.

> *"One of the really important things we do is to give people a sense of security and reassurance that there is someone that they can rely on if they need more help in the future."*
>
> Caseworker

2. "You need to be able to do small jobs very fast"

- *Directly employ a handyperson and hold a panel of reliable contractors. (High level of job satisfaction for the builders concerned was reported, and this helps to sustain a high quality of work).*
- *Fast acting contractor, working to a schedule of rates, ready to rearrange their general work programme at short notice.*
- *Ready access to money (as above).*
- *Establish team flexibility and prioritisation of cases– have to recognise overlap of core/ hospital discharge service and be flexible about 'core' staff taking on urgent hospital discharge referrals at pressurised times.*
- *Establish a better link between health/ social care policies and housing policy and practice. Good examples exist of flexible use of HRA grant for small essential works. Example of poor practice includes putting every small adaptation through the DFG system (a 30+ page for a job under £100 is very inefficient). Specific allocation and prioritisation of renovation grants (RGs) as well as DFGs helps.*

Case Study

Mrs Brown is 65 and lives with her 15 year old foster son in a small terraced house. Upon discharge from hospital, it was evident that she was no longer able to go up and down the stairs.

However, the social services assessment concluded that she did not meet their criteria for installation of a stairlift because there was a downstairs WC and shower and she was told that the living room could be turned into a bedroom and the very small dining room adjoining the kitchen was adequate as a living room.

Mrs Brown was very unhappy with this assessment for a number of reasons. They lived in a high crime area and the proposed bedroom was at the front of the house directly adjoining the street, so she felt very insecure sleeping downstairs. She also felt unable to supervise her foster son if unable to move around the house, and felt that the loss of a living room would also have a negative impact on their relationship and social lives.

The hospital discharge service successfully fundraised from charities to meet the cost of a stairlift.

3. "It is important to spend time developing positive working relationships with hospital staff to establish a shared commitment to making the service work for patients"

- *The idea of multidisciplinary teams is being developed in a number of areas to bring together grant officers and OTs from health and social services and involve a hospital discharge team caseworker.*
- *The stop/start nature of some schemes (eg because of short term winter pressures funding) has meant that HIAs have had to re-establish relationships with GPs, OTs and others every year. Even without this, staff turnover and internal reorganisation means that maintaining links with referrers is an ongoing process. Leaflets were only considered useful for promotion if backed up with personal contact.*
- *Better longer term planning for patients is needed to improve hospital discharge and the hospital discharge scheme can be a catalyst for this. Example given of case where doctors knew within 24 hours that a person would not walk again after an accident, but nothing was done to start the process of major home adaptation for many months.*

4. "A good hospital discharge scheme needs to demonstrate a flexible approach and be willing to innovate and change systems. The aim is to encourage a similar approach from statutory services."

   - *HIAs are based on an ethos of responding to people's needs and wishes and acting as their agent. Only being able to assist people who are referred by specified professionals because they have already had a fall/ been admitted to hospital, rather than taking a more preventative approach was identified as a problem in some cases.*
   - *Most HIAs are controlled by a managing agent. These bodies also have to look at their flexibility – how quickly they can respond and change to new demands and be open to reviewing their own systems and professional boundaries.*

"We spend a lot of time giving reassurance and support to people who are alone, anxious and confused and this is an important part of our service."

Hospital Discharge Caseworker

"We had helped Mrs Singh to get central heating installed after a spell in hospital following a stroke. She lives alone with no family. When water started to pour into her house from a major leak in the roof, causing the electrics to short, she called the fire brigade who turned off the electricity supply. She then called us in a very distressed state. Our technician was able to visit straight away, trace the fault, isolate it and restore the electricity to the rest of the house. A patch repair to the roof was organised and a grant application made to repair the roof properly and carry out a rewire."

Hospital Discharge Caseworker

Appendix A:
Service Agreement

A service agreement is an agreement between a funder and a service provider to deliver a particular service usually for an agreed price. Some service agreements are called 'service level agreements', or a 'memorandum of agreement'.

Service agreements vary a great deal in terms of detail and how they are interpreted with regard to legal status. In law they may be considered a contract as payment is being made in return for a service. Providers need to be clear about whether they intend to enter into a binding contract when they sign a service agreement for provision of a hospital discharge service and legal advice may be advisable if there are any concerns about the contract being proposed by a commissioner.

POSSIBLE HEADINGS FOR INCLUSION IN A SERVICE AGREEMENT

1. Introduction – names and details of the parties to the agreement, date/ duration of agreement, aims and objectives of the parties concerned in entering into the agreement, definitions of any terms or abbreviations used (eg HIA, LA). For example, the aim of a health sector body might be to 'Contribute to the objectives of the HimP by promoting the independence of older people in their own homes, promoting avoidance of hospital admission by contributing to the provision of a safe and appropriate home environment and facilitating prompt and timely discharge from hospital'.

2. Service Specification – this sets out the service to be provided. Examples in use range from the general to the highly prescriptive. Below are suggested items which could be included:

2.1. A statement of who the service is for and what it will do. For example:

2.1.1. The hospital discharge service (hereafter referred to as ' the service') will be made available to older and disabled residents of anytown who normally live in owner occupied or privately rented properties.

2.1.2. The service will facilitate timely discharge of older and disabled people from hospital and prevent the admission or re-admission of older people to hospital primarily through repairing and adapting their homes. This will be achieved through the provision of the following:

- *personal advice and support to people with regard to the options available to them for the repair and adaptation of their home, alternative housing options, advice on care and support services, financial advice and information on welfare benefits and the assistance available to meet the cost of the requisite repair and adaptations, help with obtaining such resources.*
- *technical advice and support to effect the repairs and adaptations, including preparation of specifications, schedules and plans, liaison with vetted contractors, supervision of building work through to satisfactory completion.*
- *a handyperson service to carry out small repairs and adaptations and safety assessments in people's homes.*

2.2. Standards of service to be provided. Note any quality assurance scheme to be utilised, policies required with regard to equal opportunities issues, confidentiality, data protection, complaints, personnel, financial administration, management arrangements.

2.3. Details of user involvement in service review and development (eg. satisfaction telephone survey, annual open event etc).

2.4. Service location / opening hours/ accessibility.

2.5. Any referral criteria or limitations – there needs to be clarity about the control of access to the service and appropriate referrals.

2.6. Details of charges for services (if any).

3. Obligations on each party

3.1. The contract management process (reporting systems, meetings, resolution of disputes).

3.2. Payment arrangements (frequency, method).

4. Monitoring and evaluation

4.1. Activity Targets – agreed outputs (see Appendix B for suggested data collection by service provider. Aim for limited specific targets in the service agreement and detail in an appendix to the agreement).

4.2. Agreed outcomes and how the commissioner will measure these (eg. faster safer discharge and decreased bedblocking, prevention of re-admission due to unsafe/ unhealthy conditions at home, service user satisfaction).

4.3. Reporting and review requirements eg. quarterly or biannual meeting between specified individuals/ major annual review.

5. Finance

5.1. Level of finance being provided by commissioner and details of any other funding affecting the provision of the service.

5.2. Any financial reporting or audit requirements.

6. Termination/ Resolution of Disputes Arrangements

6.1. A termination clause should only allow termination in very specific circumstances eg, insolvency, with mutual consent of all parties concerned, serious breach of agreement when attempts to resolve disputes has failed.

Appendix B:

Suggestions for Data Collection and Use

Because the hospital discharge services being run by home improvement agencies are so disparate, a single monitoring and evaluation system may not appropriate. However, it can probably be taken as given that most funders want evidence of faster discharge (as well as better quality, more co-ordinated discharge), and they want savings to be made through greater efficiency.

With this in mind, the following examples of data which could be collected and how this could be used to evaluate effectiveness in meeting these broad aims could be the starting point for a system which is then tailored to local use. *Some service may only require limited data collection – it must be emphasised that the following is not intended as a blueprint for all cases and aims only to illustrate the range of possibilities.*

QUANTITATIVE MEASURES

1. Referrals

- *Referral numbers and source (eg. hospital / community OTs, hospital social workers, social services care managers, self/ PCG/ other).*
- *Referral characteristics (age, sex, ethnicity, disability, tenure, household type, income, hospital history eg, number of times in hospital in last year, length of stay in hospital prior to referral, urgency categorisation)*

EXAMPLE of what this enables a hospital discharge scheme to report to demonstrate how well the service is reaching people in the greatest need:

This year Anytown hospital discharge service received 500 referrals, with 87% of these coming from the hospital based OTs. In 67% of these cases the referral was classified as urgent, ie. the person was ready to leave hospital but this work had to be undertaken prior to discharge.

All of those referred lived in either their own home or private rented accommodation and 16% of those referred were from black and ethnic minority communities.
82% of those referred were older women living alone, 98% were over 75yrs of age, 88% had a disability and 74% were in receipt of means tested benefits.

2. Outputs

- *Numbers of people referred who had work carried out to their homes.*
- *Number of jobs/ payment method/ speed of service.*
- *Number of visits.*
- *Type of work (major or minor adaptation, aid installation, small/ major repair, noting main categories such as stairlifts, bathroom adaptation, grabrail).*
- *Details / number of incidents where some of the work undertaken was not specified in the original referral .*
- *Number of cases where home safety check (or similar) undertaken.*
- *Outcome of benefit checks, number of cases where other help brokered to assist independent living.*

EXAMPLE of what this enables a hospital discharge scheme to report:

Of the 500 people referred to the hospital discharge scheme, 478 (96%) went on to have work carried out to their homes and 820 repair/adaptation jobs were carried out.

In 68% of cases the hospital discharge service identified urgent repair and adaptation work which needed to be carried out for the safety and comfort of the person (see case study).

Home safety checks were completed in 84% of cases and small remedial works to reduce the risk of accidental injury were carried out in every case.

The main type of work undertaken is shown in figure Y below. Adaptations to bathrooms and kitchens were the most frequently undertaken jobs, followed by the installation of grab rails to external doors.

Where referrals were classified as urgent, the service carried out the specified work within 48 hours in 74% of cases, and within 5 days in 92% of cases. In the remaining 8% of cases, the work took longer because of the time taken to process more complex disabled facilities grants or other finance.

This speed of service was greatly assisted by the finance systems introduced this year. Use of the rapid response fund and handyperson scheme met the cost of 72% of jobs. The cost of the work undertaken was met by the methods shown in figure X below.

The caseworkers made 765 visits and benefits checks were taken up by 76% of referrals. Successful claims for benefit were made on the behalf of 62% of those referred (310) resulting in an average increase in weekly income of £12.20. This amounts to a total of increased income for all clients of £196,664 pa.

Referral for other support services were made in 42% of cases (illustrate with case studies).

QUALITATIVE MEASURES

1. Service User/ Stakeholder satisfaction

- *Use of questionnaires, telephone survey or interviews with people discharged.*
- *Undertake sample survey of stakeholder views on impact of service.*

2. Impact on speed of discharge

- *Undertake quarterly case review meeting with hospital referrers and aim to estimate impact of service on speed of discharge. (From a small sample survey it may be possible to extrapolate).*
- *As part of this review, also look at current systems, eg number of visits, and scope for efficiency savings.*
- *Look at average cost per adaptation job before and after hospital discharge scheme as a one-off monitoring exercise.*

EXAMPLE of what this enables a hospital discharge scheme to report:

The hospital discharge scheme is very popular with service users:

76% of the people using the service returned the questionnaire and of these 82% said that the adaptation/ repair had enabled them to return to their home more quickly than would otherwise have been the case.

89% said that the adaptation/ repair helped them to live more independently.

82% said that they felt safer in their home as a result of the adaptation/ repair.

96% said that they would recommend the service to others.

98% said that they would contact the service again if they needed further help.

With regard to the professionals referring people to the hospital discharge scheme:

94% said that they were very satisfied with the service.

90% said that the service helped the majority of the people referred leave hospital sooner than would otherwise have been the case.

86% said that the service had made a positive impact on the safety of the person being sent home.

The aspects of the service which were most valued were speed of service (96%) and flexibility/ responsiveness (93%).

EXAMPLE of what this enables a hospital discharge scheme to report (continued):

The service has had a positive impact on discharge arrangements:

In 68% of cases hospital staff estimated that the hospital discharge scheme had enabled the person to be discharged from hospital at least 2 days earlier than would otherwise have been the case (in many cases much more than 2 days earlier).

This is equivalent to at least 680 nights at an average cost of £150 per night, representing an estimated saving of at least £102,000.

Furthermore, the system for OT assessment has been reviewed as a result of the hospital discharge scheme. OTs now undertake one home visit per client whereas previously they undertook 2. This has reduced waiting list times and increased throughput.

Prior to the hospital discharge scheme, the average cost of a small adaptation/ aid (those which met the criteria for under £500 jobs) as specified by the OT service and carried out by a private contractors was £498. Average cost is now £324.

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A précis of many of the Joseph Rowntree Foundation reports can be viewed at *www.jrf.org.uk*

on the mend

Care & Repair England's equal opportunities statement of intent

- *Care & Repair England believes that, in our society, certain groups and individuals are discriminated against.*
- *The grounds on which people are discriminated against include colour, class, creed, ethnic or national origin, sex, age, physical appearance, sexuality and disability. Care & Repair believes that such discrimination must be opposed.*
- *Care & Repair England is committed to taking action to counteract both direct and indirect discrimination. We recognise that passive policies will not in themselves provide equality of opportunities and that monitoring and evaluation of specific actions is essential.*
- *Care & Repair England recognises that conscious or unconscious attitudes influence the treatment of job applicants and service seekers. It recognises that unless action is taken, Care & Repair will perpetuate the discrimination against particular groups or individuals in society.*
- *Care & Repair England declares therefore that it will introduce specific measures in all areas of its operations to combat direct and indirect discrimination. This includes reviewing management and employment practices, public image/publicity material, development strategy, provision and delivery of services.*

on *the* mend

Improving people's health is high on the Government's agenda and ensuring that health and social care services support independent living is central to a raft of policy objectives. Developing the services necessary to enable people to live independently in the community, to live safely in their homes and, if a health problem does arise, to return home as soon as possible after a stay in hospital are all key priorities for health and social care planners.

On The Mend looks at the range of services broadly referred to as 'hospital discharge' or 'home from hospital' schemes and examines the policy framework in which these services are expanding and developing. It profiles in more detail those services which have a particular emphasis on ensuring that the homes of people leaving hospital are both adapted to their needs and also in a fit state for them to live in.

The majority of these housing related hospital discharge services are being operated by home improvement agencies, projects which for nearly two decades have been helping people in poor housing repair and adapt their homes. In their efforts to help older and disabled people live independently in their own homes for as long as possible, home improvement agencies have increasingly diversified into related service areas, including hospital discharge.

On The Mend demonstrates the valuable contribution that such hospital discharge services can make to meeting the broad aims of the national health and social care policy agenda by promoting independence and enabling people to remain in their own homes. It is also a practical resource for those interested in establishing such a service, providing step by step guidance to setting up a local project.

Care & Repair England hopes that *On The Mend* will encourage further development of innovative hospital discharge services that will fully address the housing and care needs of older and disabled people.

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Care & Repair England is a national charity established in 1986 to improve the housing and living conditions of older and disabled people. Its aim is to innovate, develop, promote and support housing policies and initiatives which help older and disabled people live independently in their homes for as long as they wish.

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