Hospital to Home .. and hopefully not back again

Kate McAllister: Senior Consultant
40% of the NHS budget is spent on caring for people over the age of 65 and older people represent the main in-patient group, at any one time occupying more than two-thirds of acute hospital beds.
Hospital and community services spend for 75+ is 3 x that of 30-40 year olds.

Result per The Nuffield Trust  £34bn - £54bn deficit in the NHS by 2021/22
Total NHS budget in 2010/11 was £107bn
Source: Lords Select Committee on Public Services and Demographic Change “Ready for Aging”
• Emergency admissions account for 35% of all admissions to hospital but take over two-thirds of in-patient beds as people admitted in an emergency tend to stay for longer. More older people are admitted in an emergency than any other group.
The NHS spends an estimated £600 million treating people every year because of poor housing.

The current financial cost of dementia is £23 billion a year to the NHS, local authorities and families and the cost will grow to £27 billion by 2018.

By 2025, almost 1.5 million people aged 75 or over will be unable to manage at least one mobility/daily activity on their own.
Home to hospital ....

• Pick a number between £850m - £1.5b per annum
• Included & some unknown additional costs
  – delayed hospital discharge & returns
  – admissions to A & E
  – repeat GP visits
  – other emergency interventions eg asthma, cold homes, homelessness, end of life
  – prescription costs incl loneliness, anxiety, stress......etc
“We must provide a seamless service focussed on the individual within their own home. A big part of this will be working to ensure that we avoid crises in people’s care which too often result in hospital admissions. This should always be regarded as a failure. If we can do better at preventing deterioration of health then we know that fewer people will end up in hospital. Instead they will receive the right care, when and where they need it”

National Collaboration for Integrated Care and Support: May 2013
And not back again?

- 2015/16 spending review introduced £3.8 billion pooled budget for health and social care with aim of delivering more integrated services
  - Includes £2 billion to improve adult social and join up services and £350 million for property adaptations - responsibility for delivery with Health and wellbeing Boards
Does health get housing?

• Recent (July 13) NHF GP survey found that 70% of GPs felt that housing support services are crucial to patient health but 8 out of 10 are unsure how to commission support services that can keep older and vulnerable people out of hospital
Does health get housing?

_In theory - but not so much in practice – why?_

- Pressure to manage crisis & acute needs
- Planning & commissioning decisions often reverting to reactive short term solutions
- Funding short term
- Good relationships forged at a very local level
- Rhetoric often fails at point of delivery
Positive practice

• An independent evaluation of one British Red Cross hospital discharge scheme offering personalised, flexible support found that only 3% of service users were readmitted in the six months following discharge, compared with NHS Trust’s figures showing a 12% readmission rate within 28 days for the same period.
Positive practice

• Whiston Hospital has ward-based discharge coordinators who liaise with community-based professionals and families about discharge arrangements.
  – The Home improvement Agency at St Helens Council works with the hospital to improve the discharge process. HIA employees helped to write the hospital's discharge policy and take part in quarterly 'discharge' meetings.
  – They commit to carrying out essential adaptations such as grab rails and access ramps within 2 working days of a request being made, so that patients can be discharged in a safe and timely manner.
Positive practice

- A Rapid Emergency Assessment and Care Team (REACT) provides assessments on mobility, activities of daily living, cognition and social support. Over a three month period, 126 admissions were prevented at a saving of £105,000.
  
  – Selly Oak Hospital reported in OTN May 2010 p30.
Ways forward

• Providers and commissioners need to develop cost-effective, community-based services, which can both prevent the need for hospital admission and safely reduce length of stay for older people.

• Some sheltered and extra care schemes are offering intermediate housing with care options, such as short stay accommodation, to support rehabilitation and reablement.
Rhetoric to Reality

Chartered Institute of Housing: www.cih.org
source of information, support and professional membership

Hospital 2 Home resource pack
www.dh.gov.uk/health/2012/10/hospital-2-home/

Integrating Housing Help into the Hospital Setting
‘If only I had known...’ www.careandrepair-england.org.uk] – Cost benefit evaluation and ‘how to’ info

Housing LIN www.housinglin.org.uk/
Medical professionals

• Ask the right questions about patients’ housing situations on or before admission;
• plan with the patient for their return home, or to a more suitable residential environment, with the support they need, alongside clinical planning;
• Find out about the kinds of housing and support that is available locally;
• adopt pooled health/care budgets dedicated to covering costs on both sides of the hospital door
• understanding the range of temporary and permanent re-housing options available and being able to advise patients.
Providers

• Get to know about local ‘Home from Hospital’ services:
  – Familiarise yourself with key agencies offering statutory and non-statutory housing and support services and with what they do and how they can assist you in providing your residents with tailored support on leaving hospital.

• Publicise your service offer: Make sure that local social and health care professionals know about your service and what you can offer.
• If possible, take part in case conferences and needs assessments about your residents. This will enable you to participate more fully in the discharge process and to be better prepared for their return home. At the least, ensure that you know when your residents are due to be discharged. Aim to get hold of their discharge date as early as possible so that you can prepare in advance of their return home.
Scheme managers

- Make sure someone is there to meet and greet your resident, if possible. It is particularly important that those residents who have few family and friends close by have someone to welcome them home, make sure they have sufficient food and warmth and to help them with small ‘settling in’ tasks. If the scheme manager is unable to be present, a local voluntary agency may be able to field a volunteer who can help
Thomas, aged 76, will shortly be discharged from hospital following an emergency admission.

He had a stroke 2 days ago that has reduced his capacity to get around, although he can still walk. He has a history of mental illness for which he has received treatment in the past and the stay in hospital has made him more depressed than usual.

He lives by himself (with his dog) in his own terraced house that is not in a great state of repair. He enjoys fishing and a pint in the local pub.

What would you do?

1. Outcomes
2. Thomas’ role
3. Options for Thomas
4. What has worked in the past?
5. What will you do – differently?
Thank you

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