An Evaluation of the Dolphin Society Funded WE Care & Repair (Bristol) Home from Hospital Service

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Contents

The Dolphin Society exists for the relief of older or disabled people who are or have been resident in Bristol and who are in need, hardship or distress. Their funding is targeted to help their beneficiaries maintain a high quality of life and independence by such means as are appropriate, including assisting and supporting them to live in their own homes;

The Society raises funds annually and distributes them in order to fulfil its purpose.

WE Care & Repair is a local, independent home improvement agency and a charitable community benefit society. They support people to repair, maintain and adapt their homes using contractors and experts they can trust. The quality and safety of their services are endorsed by local authorities.

1. Introduction

WE Care & Repair (WE C&R) works across three local authority areas: Bristol, Bath and North East Somerset and North Somerset. This report looks at the service the agency provides to facilitate timely hospital discharge in the Bristol City Council area, which includes two major hospitals: The Bristol Royal Infirmary (BRI) and Southmead Hospital, and a number of smaller rehabilitation hospitals.

WE C&R has provided a service to help people return from hospital for many years but demands on the service have been increasing. Demographic change means that higher numbers of older and vulnerable people are being admitted to hospital. Many live on their own and have no one to help them when they return home. They may not have been coping before they were admitted, or have not known where to turn for help. Without support these people remain in hospital for longer than they need to be or have to be discharged to a care home or nursing home when they might actually be able to live independently. Given the high demand for hospital beds there is the possibility that some people may occasionally be discharged home without the right support being in place.

Usually, all that is needed to enable people to return home safely is for the property to be cleaned, hazards removed and heating and electrical systems repaired. This is easy to arrange if someone can pay for the work themselves. However, people on low incomes or those with frailty, mental health problems or dementia are often unable to find the resources. This is where hardship funding is so important. It enables small jobs to be paid for to enable people to return home quickly and safely to carry on living independent lives. This frees up hospital beds and saves time and money for health and care services.

A programme has been running since April 2016 which has used Dolphin Society funding to pay for minor works to homes to facilitate timely hospital discharge. This report examines the increasing need for these types of services and provides details about the way the Dolphin Society funding has been used. It assesses how the intervention of WE C&R has affected the length of stay in hospital and freed up the time of hospital and social care staff. The report concludes by looking towards the future and how the service might continue to grow and develop if funding can be assured.

2. The need for home from hospital services

Pressures on hospital and care services

Home from hospital services are becoming increasingly important as the population ages. There are considerable pressures on hospital and care services as the following table shows.

Table 1 The impact of the ageing population on the health service[1]

20% increase in 10 years	in number of people aged 65 and over (compared with 8% for all age groups)
18% increase in five years	in emergency hospital admissions of older patients
62%	of hospital bed days occupied by people aged 65 or over
40%	of NHS's budget spent on people over 65
31%	increase in delayed transfers for older people 2013–2015
£820 million	estimate of gross cost to NHS of older patients in hospital beds no longer in need of acute treatment
£180 million	for comparison – the estimated cost of providing care either at home or in a more appropriate care setting

Bristol hospitals have been particularly hard hit by these issues. In the last ten years the North Bristol Trust has experienced a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75. There has been an increase in the complexity of patient's conditions and each year there has been a continuous increase (2.6% p.a.) in urgent readmissions within 30 days of discharge from hospital[2].

Delays in people leaving hospital once they are ready for discharge are a particular problem and both Bristol hospitals have experienced more difficulties with transfers of care than other hospitals across the region and nationally[3]. These delays restrict admittance for new patients and are costly for both the NHS and care services. Any increase in the length of stay in hospital means that older people are more likely to acquire hospital infections, they lose muscle strength and their ability to do everyday tasks such as bathing and dressing may reduce, potentially increasing the level of care needed at home.

More people than ever need care at home but a third of delays in leaving hospital are caused by problems accessing social care services; either waiting for an assessment

or for a care package to be put in place at home. A contributing factor has been a 10% fall in local authority spending on adult social care over the period 2009/10 to 2014/15 (£16.3 billion to 14.6 billion)[4]. There is clearly a need for health and care services to be integrated more effectively and resources allocated in different ways. There is an ambitious strategy for services to be joined together by 2020, with plans for integration to be in place by 2017.

Housing and other contributory factors

The type of housing that people live in, the type of household, their mental state, and their capacity to pay for services all impact on their ability to return home after being in hospital.

- **Housing:** only 4% of people aged over 55 live in specialised housing, the majority live in ordinary, mainstream homes. Few homes have basic accessibility features and increasing numbers of older people are in homes that have falls hazards or which are inadequately heated[5].
- **Living alone:** about a third of people aged 65 plus, and over half of all those aged 75 plus, live on their own.
- **Isolation:** about 20% of older people feel mildly lonely and another 8–10% are intensely lonely. Surveys show that 17% are in contact with family, friends and neighbours less than once a week and a further 11% less than once a month. Around 9 % say they feel cut off from society[6].
- **Sensory impairment:** significant sight loss affects 1 in 5 people aged 75 plus and half of those aged 90 plus. More than 70% of people aged 70 plus have some form of hearing loss.
- **Dementia:** there are about 676,000 people with dementia in England which is expected to double by 2040. Diagnosis rates are increasing, but around a third of those with the disease may be living in the community unaware that they have the condition. One in four admissions to hospital is a person with dementia, although dementia is rarely the main reason for admission[7]. A survey in 2014 found that 85% of people would want to stay living at home if diagnosed, rather than be admitted to a care or nursing home[8].
- **Mental health**: treatment has suffered from a lack of resources which means that large numbers of people may be living in the community without adequate support. People with a mental illness tend to die15-20 years earlier than the rest of the population[9]. Depression affects around 22% of men and 28% of women aged 65 and over, but around 85% of older people with depression receive no help at all from the NHS[10].
- **Caring**: there are 1.2 million carers aged 65 and over, many of whom have long-term health problems themselves. Nearly half (45%) of carers aged 75 and over are looking after someone with dementia. The number of carers aged 85 and over grew by 128% in the last ten years and 59% of carers over 85 are male. Over half of those aged 85 and over provide more than 50 hours of care a week[11].

Ability to pay for services: almost 40% of people 65 plus are deemed to be in poverty compared with around 30% of those under 65 (disposable income below 60% of the national median, adjusted for household size and composition)[12]. Women over 75 living alone have some of the lowest incomes. A fifth (19%) have incomes below the poverty threshold of £134 a week and 30% have no savings[13].

Home from hospital services that have employees and volunteers with the right skills, empathy, time, knowledge, access to resources and networks can facilitate timely and safe discharges from people in all of these circumstances.

Developing polices to deal with delays

There are a number of policies being developed to try to reduce the demands on acute services. The BRI and Southmead Hospitals have both reorganised their discharge planning process and have recently developed integrated discharge hubs with multi-disciplinary teams so that discharge services are better co-ordinated. Southmead has just installed a new computer system that allows them to collect more information relating to discharge.

There is a focus on earlier identification of discharge needs, starting at the point that someone is admitted to hospital. If there are significant problems with the home often the ambulance service will alert hospital staff. There may also be professionals already working with people in the community who would have already identified issues, but many patients have had no previous contact with statutory services.

Conversations are held with families and carers soon after admission. However, some patients may be too ill at that point, or have no family to speak for them. Sometimes people are only able to start talking about the problems they are experiencing at home later in their hospital stay. Discharge planning teams are trying to have this conversation when a patient's temperature is down and they are taking their first steps out of bed, rather than at the point of discharge.

Currently people wait in an acute hospital bed for an assessment of their need for care and support before discharge. A new strategy being piloted in Bristol is called 'Discharge to Assess'. There are three pathways:

1. **Home with support** provided they are physically and cognitively safe to do so
2. **Community step down facility** with rehabilitation for those not safe to go home
3. **Nursing or care home** for people with more complex or long term care needs.

Full assessment will take place when people are more settled and in a more suitable environment for care planning than an acute hospital ward. The pilot is only affecting a few wards in the BRI and Southmead at present but it may increase the need for work to be done to the home before discharge. The hospitals are also developing complex assessment and frailty units to reduce the length of stay of accident and emergency cases.

Summary

The context in which the WE C&R Home from Hospital Service is operating is therefore one of increasing numbers of people in hospital who are classed as medically fit for discharge but who are older, live alone, have dementia or mental health problems and who cannot return home without practical and responsive (paid for) services capable of making their property ready for them.

3. The Dolphin funded WE C&R home from hospital service

Early in 2016 approval was given by the Dolphin Society for WE C&R to use previously underspent budgets from Dolphin Hardship Funds to deliver a hospital discharge project in Bristol that would speed up safe discharge and free up much needed hospital beds. This service began in April 2016 and the project started with a fund of £23,866.

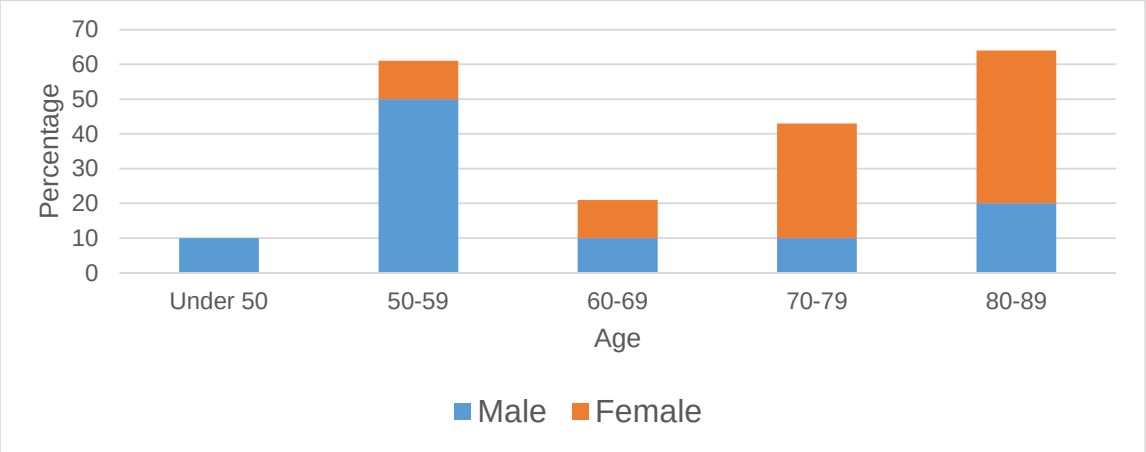
This evaluation examines cases completed by WE C&R between April and the end of July 2016, a period of four months. To make sure that the hospitals were aware of the project talks were done for staff and a leaflet and posters were produced for the discharge hubs. Two caseworkers have been assigned to the service who regularly visit the hospital discharge hubs to make sure that staff are aware of the service and know where to refer people. The caseworkers now spend about 40% of their time on home from hospital work and they get 2-3 new cases per week.

By the end of July 2016 27 cases had been completed which is slightly under the agreed target of 33 cases, but more are in the pipeline. It is expected that a total of about 50 cases will be able to be completed with the funds available.

Completed cases

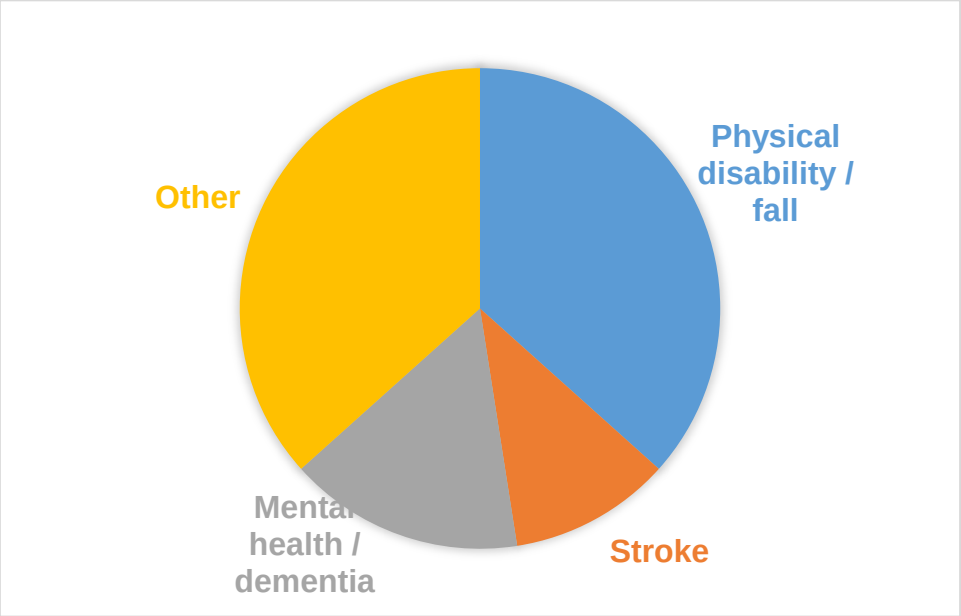
The majority of people helped by the service were over 50 years of age as is shown by Figure 1. Most of the younger cases were men, usually living alone. Many had mental health problems, although there was one with a heart problem and another with a degenerative condition. The people who were older were mainly women which reflects their longer life expectancy.

Figure 1 The age and gender profile of completed cases



Clients of the service had been in hospital for a variety of different reasons but Figure 2 shows that there were two main groups of conditions. Issues of physical disability, mobility problems, frailty, falls and strokes affected nearly half of the sample and another large group had problems with dementia or mental health. There were a number of other conditions such as COPD, heart problems and urinary tract infections. A number of people helped by the WE C&R service had had multiple conditions with dementia and mental health issues affecting about a third of all clients in total.

Figure 2 Reason for being in hospital



Note: diagram shows main reason for admittance but many clients had more than one health problem and in total a third had dementia or mental health issues

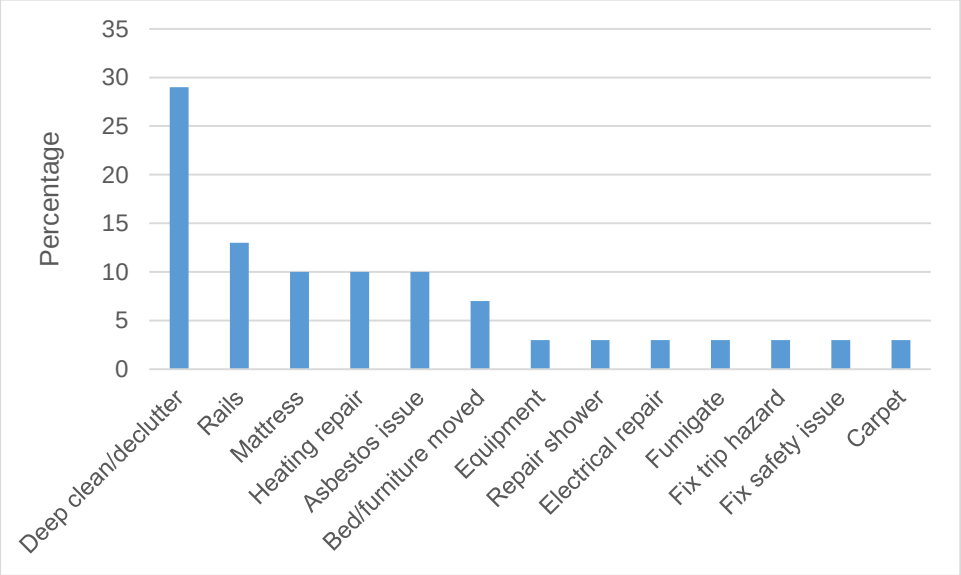
As several hospital staff pointed out:

"People will often spiral down for lots of different reasons, they lose partners or family members who at one time would have helped them keep on top of things".

"Older people have a history of not calling on services, have low expectations and it is only when we come to talk to them about being ready to go home medically or talk to their carers that we find out that they have been struggling and that their houses are in very poor condition".

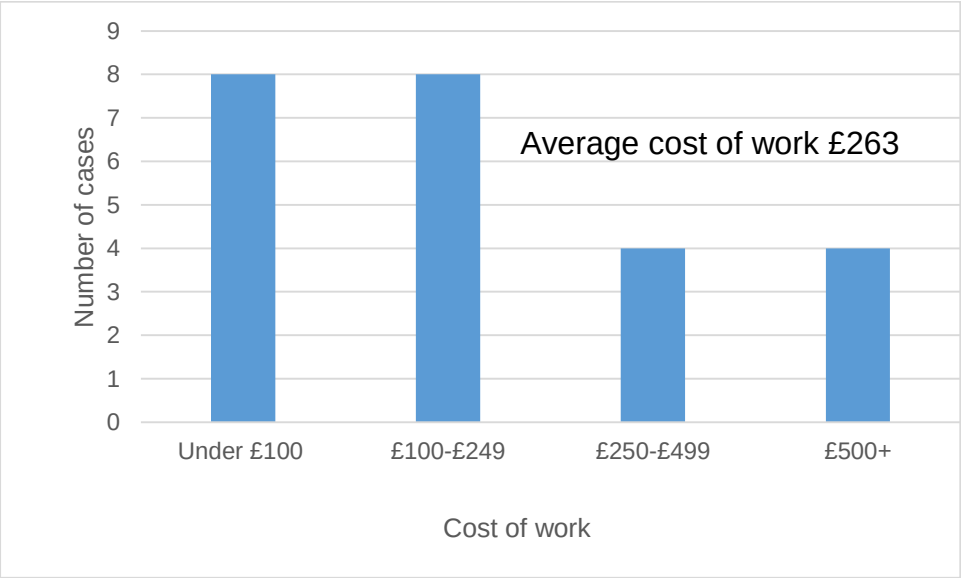
Most of the work financed by The Dolphin Society differed from the normal handyperson service and is detailed in (Figure 3). The predominant need was for deep cleaning, decluttering, and often the provision of a new mattress, all of which give an indication of the difficulties people were facing at home before they were admitted to hospital. Other, more typical handyperson work included fitting rails, moving furniture and doing minor repairs to make the home safe. There may also have been other minor work done at the same time paid from other sources which is not shown in the figures. This was mainly keysafes and the provision of equipment.

Figure 3 Type of work carried out



The majority of jobs were quite small; most being under £250. The more expensive jobs costing £500 or over were for particularly extensive deep cleaning work, often with the provision of a new mattress. In all cases the expenditure enabled people to leave hospital, although one had to be readmitted due to additional medical problems and one client died during the period of the project.

Figure 4 Total cost of work including labour and materials



Note: Missing data for 3 cases where work not completed

Income levels

To ensure timely discharge there was no means-test to allocate funds for the Home from Hospital service which meant that clients did not have to fill in paperwork and produced documentation. It was difficult to draw conclusions about people's actual propensity to pay for work as only a limited amount of information on incomes was collected for people in the sample. Of the cases where income data was available (11 cases) four were on low income, three were on disability benefits and a further client was being helped to obtain attendance allowance. Only three clients appeared to have some savings. Of these, one contributed to the cost of work, another had been in a reablement hospital for a long time and needed a very small amount of expenditure (less than £100) to enable her to get home after a stroke. The final case was a man with considerable savings but who was scared to trust anyone. It was not until WE C&R had carried out some small jobs successfully that he agreed to pay back the expenditure and to schedule some more work. This is a good example of the gradual process that caseworkers have to go through to build relationships before more substantial work can be done to people's homes.

The service that the WE C&R caseworkers provide is holistic and so in addition the works detailed if Figure 3 in all cases they also checked for any additional problems that needed to be tackled once the person had returned home. In several cases the client or their family either carried out, or paid for, additional deep cleaning and decluttering. Another case was referred on to the WE C&R handyperson for locks to be installed. In the case of the man unable to trust outside help mentioned above, more extensive work costing about £7,000 was required. The property was structural unsound and had a huge amount of possessions accumulated over 45 years. In this case the client is going to pay for roof repairs, rewiring, heating and other works, although this will require him to take out a loan. Another client may have a level access shower installed in the future using their own funding.

The casework role

Home from hospital work involves a considerable amount of skill to liaise with and co-ordinate the various services to get results fast. It includes dealing with a variety of staff on the wards, in the discharge hubs, in the community hospitals and also social work and occupational therapy staff working in the community. WE C&R staff have to have good relationships with contractors and often have to be very resourceful to come up with effective solutions. They may also need to refer clients on to other services for additional care and support. Most importantly they also have to have the personal skills to be able to relate to the clients themselves who may be still be unwell and worried about their ability to manage at home.

A day in the life of a WE C&R Home from Hospital caseworker

My day typically starts by searching my emails for hospital cases as they take priority. I call the health professional who referred the case as they may have already seen the client's home and can tell me what essential work is required for discharge. If not, we may need to do a visit to work out a plan. Alternatively, if a family member is involved, I will arrange a visit with them as soon as possible.

Working with clients

A lot of our clients have struggled to manage on their own before they have been admitted to hospital and the house may have become very cluttered and unsafe so a large proportion of our work involves clearing accumulated possessions and deep cleaning. It's their home and obviously they want to say specifically what can go or what can be kept. If they are able to, they may come with us to the house. Other times I go to the property myself, take photos, then go back to the hospital to go through the photos so that they can decide what they want to get rid of. Some people don't want their things cleared so you have to be open minded and work with them to get a result that means they can be discharged safely.

When we are looking around a property we may find extra work. In one recent case the electrics and gas appliances were a bit outdated, but we felt it would not stop the person being discharged. I agreed to see the client once he was home to discuss what else should be done. A one size fits all approach just doesn't work. You have to be flexible and to see what happens once you get to the home. We often meet our regular contractors on site so they can get me a quote quickly. We can usually arrange a start in two working days and we make sure they block time out for us.

A typical case

A patient with diabetes could not be discharged as her bed at home was falling apart and giving her bed sores. She also needed a small fridge for her insulin. I ordered everything online, but the delivery needed to be co-ordinated as there was no-one at the property. The fridge was coming straight from the manufacturer via a courier, but the bed was coming on a different van from the warehouse. I got the earliest delivery slot for the bed and gave my details so they would liaise with me for the drop-off. I got in touch with the depot where the fridge was coming from and opted to have it delivered to a local shop. On the delivery day I got the keys from the social worker, picked up the fridge and went to meet the delivery driver at the house. Between us we took everything in, made sure it was set up correctly and the fridge plugged in.

It meant she could be discharged that day saving another night in hospital. Without WE C&R she would have been in hospital at least another week or two if not more. We know which suppliers have the best products at the right price, are most reliable and have the fastest delivery times. It is hard for social workers to do this type of work. It would have taken much longer and diverted their attention from other cases.

The rest of the day
That is just the beginning of the day. From then on its dealing with other things that come in, chasing up quotations and doing paperwork. I also have a caseload of self-funded repair work or less urgent jobs where we need to raise funds to get small repairs carried out.

During the day I also have to fit in more calls to hospital social workers. They are so busy that you have to take the chance to talk to them when you can to make sure a case progresses as fast as possible. There are also team meetings occasionally and I'm on the steering group of the WE C&R 'Making Space' project. This uses volunteers to help people deal with hoarding issues and start to clear their homes. One morning a fortnight I go into the hospital discharge hub to promote our service and make sure everyone knows what we can do to help them.

In the last 15 minutes of the day I plan the next day. I restructure the action list and think about what I need to do that is urgent tomorrow so I know when I'm going home that it is all planned out. As soon as I come in the next day I can get running with it.

What is the most satisfying thing about the job?
The primary thing is definitely doing something for the client, whether its fund raising, getting someone home or getting a repair done. If I can manage to get a client discharged within three days it's great for them, it's great for Dolphin because we've used the money in a really positive way and it's great for the hospital because they have got a bed free for that evening.

4. The difference Dolphin funding makes to people's lives

The Dolphin Society funding makes a huge difference to the speed of discharge and to people's ability to manage once they get back home as these case studies illustrate.

Case Study 1 - Making a house a home again

Mrs T was admitted to the BRI for inflammation of the gall bladder but could not be discharged home. She had lived in a three bedroom detached house for over 50 years, but recently had spent most of her time in a single armchair in a restricted space in her front room, which may have contributed to her ill-health. Each room was so full of possessions that she was unable to prepare food, keep clean or move around. It also affected her social life – she hadn't invited anyone home for more than three years. Even her family had not been allowed in her house. Her dog was in foster care as there was no room for it at home.

WE C&R arranged:

- Kitchen and front room made safe by clearing designated possessions (£300)
- WE C&R Handypersons mounted a mopstick handrail to the stairs (£70)
- WE C&R Handypersons to fix a leaking waste pipe and a trip hazard in the entrance
- Referral to 'Talking Money' to check her benefits as her DLA had been withdrawn despite her mobility and care issues
- Referral to the WE C&R 'Making Space' volunteer project which helps people clear unwanted items
- Referral to Social Services about care and meal issues
- Referral to local befriender/volunteer organisation.

Mrs T and her family are overjoyed with the result. The kitchen is now completely clear of empty cartons and rubbish and they are doing some simple cleaning to allow her to cook. The plan is to get Making Space involved as quickly as possible to help her clear the rest of the house. Once this is done WE C&R will fundraise for a deep clean throughout. The work done by WE C&R has not only made it possible for her to return home from hospital it is also reconnecting her with friends, family and her dog.

Cost of work including labour and materials = £370
Bed days saved (at £600 per day for a surgical bed[1]) = 14 (£8,400)

[1] The cost of an acute bed per day of £303 is based on the Department of Health, Reference costs 2014-15, published in November 2015 and used by the National Audit Office in May 2016
National Audit Office (May 2016) Discharging older patients from hospital, London: NOA.
https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf
Cost of a reablement bed per week of £400 taken from an OT lead at a Bristol reablement hospital (however, this is less than the figure used by the National Audit Office for non-NHS residential care which is £77 per day or £539 per week)

Saving in staff time = 1 (Without WE C&R the social work team would have had to deal with the case.
Other = The involvement of WE C&R fundraising services and Making Space volunteers will eventually enable her to regain the full use of her home.

Images from the property of Mrs T:

Trip hazard in hallway:

Bath full of clothes:

Unable to use her kitchen

Case Study 2 - Making a home safe for someone after a fall

Ms H is aged 73 and was admitted to Southmead Hospital after falling at home when collecting wood for her open fire. A visit was requested by the Discharge Facilitator on the ward to see what work was required to enable a safe discharge from hospital.

The WE C&R caseworker found the property to be in a poor state of repair and it was cluttered with piles of clothes, newspapers, magazines, old food and there was evidence of an infestation of maggots and flies. The radiators were on, the boiler was blasting out heat and the pressure was in the red. The steep stairs leading to the bathroom had no rails and the bathroom was also in need of safety rails.

The caseworker showed photos to Ms H to discuss what items could be removed and the caseworker drew up an action plan for clearing the property and letter of consent was obtained stating which items could be disposed of and what could be kept. The caseworker also established that Mrs H was on low income.

WE C&R arranged for a contractor to clear the property and deep clean the front room and kitchen. The handyperson put rails in the bathroom and fitted a handrail on the stairs. The boiler was checked by a contractor to get it working safely. A key safe, perching stool and toilet frame were also provided using a different source of funding.

Cost of work including labour and materials = £498
Bed days saved (at £303 per day in an acute hospital) = 4 (£1,212)
Saving in staff time = 1 day

Case Study 3 - Cleaning the home of a single man

Mr K is a 64 old man who was admitted to the Bristol Royal Infirmary. He suffers from mental health, jaundice and alcohol dependency issues. He was referred to WE C&R by the hospital social worker. The WE C&R caseworker went to the home to do an assessment of what was needed. There were faeces on the mattress, bedding, clothes and the carpet. WE C&R obtained a new mattress and liaised with the contractors to get the carpet cleaned. The social worker said that Mr K was now in touch with a local voluntary agency and his wellbeing has improved significantly more than in the past.

Cost of work including labour and materials £300
Bed days saved (assume £303 per day in an acute hospital) = 3 (£909)
Saving in staff time = 2 ½ days

Case Study 4 - Giving back independence to someone after a stroke

Ms J is 75 years of age and was admitted to Southmead Hospital due to a stroke on the right side of her body. She was then transferred to a reablement hospital. She spent more than three months in hospital in total. After the Occupational Therapist had done an assessment she contacted WE C&R requesting the handyperson to put in a mopstick handrail at the top of the stairs and to re-secure an existing rail to steel uprights fixed into the stair treads instead of to the hollow wall on the side of the stairs. Without the work it was going to be impossible for her to get upstairs and she would be confined to the ground floor which would mean loss of independence.

The work was completed within 48 hours and Ms J was ready to go home. It would have taken the occupational therapist far longer talking to the family, sorting out payment and organising the work herself. If Dolphin funding had not been used there would have been a further wait in hospital. The Occupational Therapist said "*it has saved us between two and four weeks further delay to get home*".

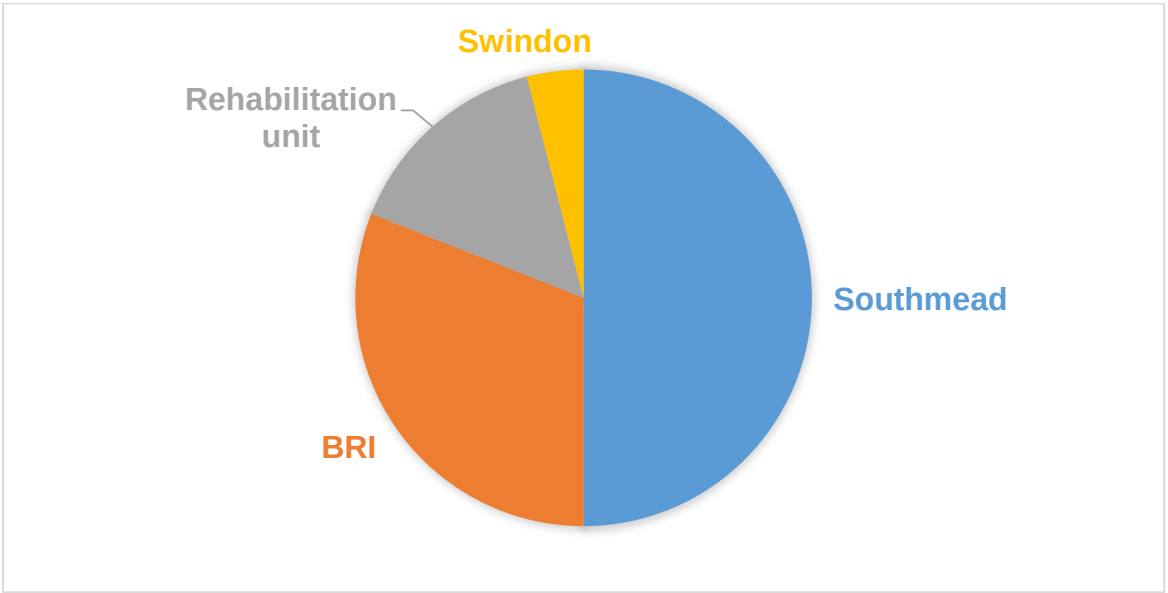
Cost of work including labour and materials = £92
Bed days saved (assume £400 per week in community hospital) minimum = 2 (£800)
Saving in staff time = 5-7 hours of OT time

5. The difference Dolphin Society funding makes to hospitals

To determine the qualitative impact of the Dolphin Funded interventions interviews were conducted by the independent evaluator and the Community Marketing & Promotions Officer from WE C&R. There was some overlap in the interviews to enable additional material to be collected by the independent evaluator. In total over 20 different staff were interviewed from Southmead, the BRI and the South Bristol Community Hospital. Most were people working in the Integrated Discharge Service Hubs in the two main hospitals, but there were a small number of interviews with staff who worked on the wards, particularly dementia care staff. Staff were in a mix of occupations, mostly social workers but some were occupational therapists and nursing staff. Most were employed by the NHS but a few were from Bristol City Council reflecting the integration of health and social care services that is beginning to take place in the discharge hubs. Some of the interviews were to obtain information more generally about how the discharge services in the different hospitals were working, but others sought to obtain details about the cost and time savings for specific cases. This section details the findings from the interviews:

Referrals

Referrals for the service came predominately from Southmead and the BRI, but there were a few referrals from the various rehabilitation units in the city and one from Swindon Hospital which related to someone who lived in Bristol.



Discharge planning

It was clear from the interviews that discharge planning is changing and beginning to be more effective. One of the team managers for adult social care in the BRI hub felt it made discharge planning much easier *"when you are sitting side by side you can find out the small things that need to happen in order for that discharge to go ahead".* A social care practitioner really valued being in the same office with the rest of the discharge team saying that *"referrals are done the same way, but before we were all in different offices and we weren't all talking and problem solving together".* It is clear that discharge planning is beginning sooner and this may affect future referrals.

Knowledge of WE C&R

WE C&R is already very well known by social workers and occupational therapists and there were positive responses about the service from everyone we spoke to. The service is generally felt to be very fast and responsive. Typical comments were that communication is good and "*they always do what they say they are going to do"*, *"they give a tangible benefit"* and that *"it's a really valued service".* There were only a couple of cases where there were felt to have been delays and neither of these was the fault of WE C&R.

Although WE C&R staff had done everything possible to make the different teams aware of the new Dolphin-funded service it took some time for the knowledge to spread. Some discharge staff only became aware that WE C&R could do deep cleaning a few weeks after the service had started. The people interviewed agreed that the discharge teams now all know about the service, although some of the ward staff may be less aware of it. The caseworkers continue to go into the hubs on a regular basis to make sure everyone is kept informed.

Those interviewed said that the cases they really value the help with are the ones where someone has no family or friends, where they have a rather chaotic lifestyle and are probably not already engaged with any services. The hospital social work teams do not have access to a budget for the type of things that WE C&R do like deep cleaning, moving furniture and doing repairs to the home.

One of the dementia care matrons said that deep cleaning and decluttering cause the longest delays as they cannot get anyone to agree to pay for it, or go in and do it, but it often gives the best chance for a safe discharge. These cases can be very time consuming for a social worker who does not have the time to go to the property to get quotes, agree a price or let in contractors. One team leader said that *"if WE C&R wasn't there it would be a complete nightmare to be honest*". When WE C&R have a hardship fund it makes it so much quicker because social workers do not have to negotiate with the person about payment or find the funding.

Another team manager working for Bristol City Council appreciated the fact that WE C&R caseworkers listen to what the service users want and are very reassuring. They understand that making big changes is not always possible and that you

sometimes have to do it a step at a time and wait until people are settled before making the bigger decisions. However, completing that small piece of work and getting someone out of hospital fast increases the chance of maintaining their independence. Delays can mean a patient becomes so dependent that there is no chance of them returning home and they end up in residential care. In this respect WE C&R is much more responsive than the community occupational therapy teams which have long delays for their minor works service.

There seemed to be very little overlap with other services. Staff interviewed were clear that the Red Cross Home from Hospital service (which was equally valued) was very different as it focussed on befriending, shopping, getting prescriptions and other tasks that are not to do with the physical fabric of the home.

Saving staff time and health service costs

The interviews revealed just how much time the Dolphin service can save for social work and occupational therapy staff. Several staff explained that they previously had to go and meet cleaning firms at the property and sometimes be there to supervise. This took up time that they could have used to assess other patients.

Another interviewee said that it halves the time a social worker has to spend on a case if they can share out the tasks with the WE C&R caseworker. If the social worker does not have that support and is unable to sort out the home, they often have to find an interim bed outside of the acute hospital. There are very few community bed spaces that are covered by the NHS; most have to be charged for by social care services. The NHS beds have the same time constraints as in hospital – people have to be discharged quickly. Before someone takes up one of these beds staff need to know that the home is being sorted out and that there is an agreed date for discharge. Having the work agreed with WE C&R means these criteria can be met.

Several people said that just fitting something simple like a keysafe can save 2-3 days in hospital as it allows someone to go home safely without the risk that they might fall by trying to get out of bed or hurrying to get to the door to let their carer in.

The following two examples show how much time the Dolphin-funded service has saved discharge planning staff, in addition to releasing hospital bed spaces.

Case Study 5 - Saving acute bed days and staff time

Mrs O is a frail lady of 88 with dementia still living in her own home who was admitted to Southmead hospital with a urinary infection. When she was ready to go home they did a capacity assessment and realised she couldn't make decisions relating to money management and had to freeze her finances until someone could be appointed with power of attorney.

The social worker did a home visit and realised the home needed cleaning but there were no funds to pay for it. This was in April before the Dolphin funded service was well known. The social worker tried to sort the case out herself and spent 4-5 hours over a period of a week to ten days trying to find the funding and locate a contractor to do the deep clean. To get funding from Bristol City Council would have taken at least four weeks to sort out.

The social worker already knew about WE C&R but did not know about the deep cleaning service and the hardship fund. Once they heard about the service she said "*they were really good – excellent. Things happened really quickly when we got hold of them. I don't know what I would have done without them to be honestly. We weren't able to touch her finances so it was very useful".* Mrs O is now back home with carers going in four times a day. She feels safer and her health is improving. In future, a case like this may be assessed before the patient is ready to return home so that work can be done in advance to avoid delays.

Cost of work including labour and materials = £414
Bed days saved in acute hospital – up to 4 weeks at £303 per day = £8,484
Saving in staff time = 5-7 hours of OT time

Case Study 6 - Speeding discharge and taking pressure off a carer

Mr X is younger man aged 40 who has Huntington's disease, a neurological degenerating condition. He was on a specialist ward in Southmead hospital for people with complex discharge needs. He lives with his mother and WE C&R were asked to carry out an electrical repair to the shower and to fit a rail. The occupational therapist in charge of this case said that "*the mum had enough on her plate and was quite stressed at the time. It would have taken her ages to sort it out and it would have been added pressure. It's probably not my role but I would have taken time out to do it".* She thought it would have taken a couple of days of her time to find a plumber and liaise with the mum to get the work carried out. Due to the son's condition he could not go home until the shower was fixed and the rail was in place. That would have meant anything up to a week extra in hospital if WE C&R had not been able to use the hardship fund to do the work. She added that *"I think it is a brilliant service. It's really useful to have a service to go to who know about the difficulties people have in their own home and can deal with the issues that we can't deal with".*

Cost of work including labour and materials = £92
Bed days saved in an acute hospital 7 x £303 per day = £2,121
Saving in staff time = 4-5 hours of OT time

The potential cost savings

Table 2 on the following page summarises some of the cost and time savings from the case studies in this evaluation. Clearly costs are an approximation and the sample is very small so not a great of weight can be placed on these findings. However, it is indicative of the potentially huge savings that a practical and effective Home from Hospital service can generate for the health service. Most cases create savings simply in terms of reductions in the time spent by health professionals, let alone the cost of a hospital bed. The figures do not include the cost of care at home which was not included in this evaluation and they do not include the potentially high cost of clients having to go into long term residential care if they were unable to return home.

There is no other agency in the area that provides this type of deep cleaning, decluttering and small repairs service that is so patently needed. As health and care services become more integrated assessment should take place earlier avoiding some of the costlier delays. However, it is crucial that there is a service that discharge teams can turn to that can offer fast turnaround times for the type of cases that have often caused delayed discharges in the past to avoid the costs falling on social work and occupational therapy staff.

Table 2 Summary of potential cost savings[2]

Case	Home circumstances	Cost of WE C&R intervention	Potential cost savings
Discharge of client after a stroke from reablement hospital	Without work impossible for her to get upstairs - loss of independence and isolation	Rails fitted on stairs including special fixings to a stud wall Cost of work including labour and materials **= £92**	Saved two extra weeks in community hospital at £400 per week x 2 weeks **= £800** Savings in OT time - 5-7 hours **= £246**
Discharge of client with dementia from acute hospital	House was dirty and untidy	Deep clean Cost of work including labour and materials **= £414**	Bed days saved in acute hospital – up to 4 weeks at £303 per day **= £8,484** Saving in OT time -5-7 hours **= £246**
Discharge of someone with diabetes from acute hospital	Discharge not possible as old bed gave her bedsores and needed fridge to keep insulin cool.	Supply of new bed and small fridge to go by the bed = **£350**	Saved at least one week in acute hospital at £303 per day x 7 days **= £2,121** Saved in social work time - several hours **= @ £220**
Discharge of someone with Huntingtons from acute hospital	Needed to be able to wash safely to be allowed home	Electrical repair to shower and fixing of rail Cost of work including labour and materials **= £92**	Saved at least one week in acute hospital at £303 per day x 7 days **= £2,121** Saving in OT time 4-5 hours **= £185**

[2] The cost of an acute bed per day of £303 is based on the Department of Health, Reference costs 2014-15, published in November 2015 and used by the National Audit Office in May 2016
National Audit Office (May 2016) Discharging older patients from hospital, London: NOA.
https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf
Cost of a reablement stay of £400 per week taken from an OT lead at a Bristol reablement hospital (however, this is less than the figure used by the National Audit Office for non-NHS residential care which is £77 per day or £539 per week)
Unit costs of social work time is costed at £55 per hour and OT time at £41 per hour – see Cooper K, (2015) FistStop Advice for Older People: An independent evaluation of local services, London: EAC.
http://www.housingcare.org/downloads/kbase/3432.pdf

6. The future of the service

Developing the service

The need for a rapid Home from Hospital service seems very clear. Nearly all staff who talked about the new 'Discharge to Assess' scheme suggested that it was likely to increase referrals to WE C&R as they have to make sure the house is safe. However, the Southmead Integrated Discharge Service lead indicated that it had to be a fast service to be effective and help them get people on Pathway 1 and home quickly. Earlier identification of problems with the home through better discharge planning will obviously help to make sure the house is ready in time for discharge.

Possible changes to the service

There may be a need to increase the number of contractors doing the deep cleaning and decluttering. There seems to be reliance on a very small number. This might enable more competitive prices to be obtained and avoid delays.

There may also be a need to develop a 7 days per week service to match that being developed by the hospitals. This type of service is already in operation in some home improvement agencies such as Ealing.

There is also an issue about services outside of the Bristol City Council area. Many of Southmead's patients live in South Gloucestershire and they need a similar rapid service. The key to expanding the service is to demonstrate clearly what can be delivered in Bristol over a longer time period and then go back to discuss this with the neighbouring local authority.

Written guidelines

Now that the service is well known there may also need to be some written guidelines to make sure that hospital staff know the parameters:

- **Type of cases** – if the service saves hospital staff time they may be tempted to refer cases which could have been funded from other sources, or where the client could afford to pay for the work themselves. There is no evidence that this has happened up to now, but it might in future.
- **Essential works** - it also needs to be clear to hospital staff that de-cluttering and deep-cleaning will be done to essential rooms only. In one case that was evaluated the hospital had not communicated this to the family who had thought the whole house would be cleared and cleaned with no charge.
- **Speed of response** - hospital staff are focussed on getting people out of hospital fast, but they have to be realistic about the speed of response e.g. there are a very limited number of good deep-cleaning contractors and if they are booked up there will be a delay. It is where advance notice through better

discharge planning would help WE C&R. Cases could be picked up much earlier.

Training

Hospital staff would welcome more training from WE C&R for hospital discharge teams about the Home from Hospital service and about specific issues. One occupational therapist was keen to have more training on fitting rails to make sure that they all recommend the right solutions. There may also be more demand for Healthy Homes training.

One call centre

Although staff were clear about the different roles played by the Red Cross and WE C&R there is potentially scope to have a single number for the two independent sector services and any others that are developed in future. There is high turnover of hospital staff; a single number could help ensure that new staff know exactly where to call to get a rapid response. It would also enable more overlap between the services to make sure that people who live in cluttered and unclean homes or dwellings in disrepair not only have work carried out, but are also easily referred for be-friending services to help reduce loneliness and isolation to prevent the same problems reoccurring. It is also extremely important that the phone is answered quickly. Sometimes due to the volume of demand for WE C&R other services there can be short delays in reaching the caseworkers when services are busy.

Future funding

At the point of writing the original allocation of funding from the Dolphin Society was 90% spent. WE C&R have been able to provide this responsive and effective service thanks to having the funding from the Dolphin Society. New sources of revenue and capital funding will be required to meet the growing need for the services as the population ages.

This evaluation has hopefully shown that a clear business case exists for additional and ongoing funding for a casework led service capable of co-ordinating small and fast repairs from handypersons and for the commissioning of minor adaptations, decluttering and deep cleaning support from trusted contractors.

It is clear from the interviews with health service and social care professionals that they cannot take on this type of work themselves without diverting their attention from their own caseload leading to further delays for all patients. WE C&R provides that vital co-ordinating casework role. They liaise between hospital staff, clients, handypersons and outside contractors to ensure that homes are made safe, warm and secure for people to be discharged quickly to remain living in their own homes in the community.

Appendix – Methodology

This evaluation was carried out by Sheila Mackintosh of Mackintosh O'Connor Associates a consultancy that specialises in work relating to home improvement agencies, home adaptations and the interface between health, housing and social care.

The evaluation involved the development of a standard form to capture data about each case. This information was collected by the WE C&R Community Marketing & Promotions Officer from case file information, from casework staff and from phone calls to discharge planning teams. The information collected included:

- Source of referral (hospital, ward, staff role of referrer)
- Urgency categorisation
- Patient characteristics (age, sex, ethnicity, disability, income, number of times in hospital, length of stay in hospital)
- Home characteristics (tenure, house type, household type)
- Number of cases where home safety check/home health check undertaken
- Type of work carried out
- Other assistance provided – advice on independent living, debt advice etc.
- Referral on to WECR for further work/type of work
- Signposting to other services/type of service/reason
- Cost and payment method – Dolphin funding, other funding, self-funding
- Cost of work - including labour and materials
- Speed of service - from first referral to completion
- Number of home visits and estimate of time spent
- Reason - if work was not completed

In addition to a large number of calls made by the WE C&R Officer fifteen interviews were conducted by the independent evaluator with staff involved with discharge planning at Southmead, the BRI and one of the rehabilitation hospitals. These interviews included staff in different roles:

- Interim Lead and Lead of the Integrated Discharge Service
- Social Work Team Leaders
- Senior Occupational Therapists
- Dementia Matron, Dementia Care Trainer and Lead Dementia Practitioner, Dementia/falls nurse
- Ward sister
- Social workers and social work practitioners
- Rehabilitation Lead, Community Hospital

Interviews followed a standard format and covered:

- How hospital staff find out about a patient's housing situation
- The point during the hospital stay that these conversations happen

- How people are identified who need help to enable them to go home
- How staff found out about WE C&R / extent of knowledge about the service
- How many times they had used the Home from Hospital service
- How the referral process works
- The type of work done
- The time taken to get the work done
- The details of specific cases - the impact on bed days, the savings in staff time
- What works well/what works less well
- How the WE C&R service fits with other services such as the Red Cross
- If information about the service could be better communicated
- Any other issues
- The 'Discharge to Assess' process – likely effect on WE C&R
- Any further changes in the pipeline

It was also hoped to interview a number of clients of the service to find out more about the work that had been carried out, the difference this had made to their health and wellbeing and to their capacity to remain living independently at home. However, in the limited time available for this study these interviews proved difficult to implement. The time between notification of the need for an intervention by WE C&R and delivery of the completed work was quite short. Clients were still in hospital at this stage. Often the caseworker did not meet the client but simply dealt with the hospital social work team who let them know what work was required. The client therefore had little knowledge of who had carried out the work.

Clients were also still not very well when they first returned home and quite a large number had mental health problems or issues with dementia. As a result, it was very difficult to arrange interviews and for those interviews to be meaningful. The most contact was with the clients whose homes needed cleaning and decluttering as the caseworkers had much more involvement. Telephone interviews were conducted with a small number of these cases, but only a limited amount of information was able to be obtained. Only a small number of cases were able to be followed up in any detail. The case studies included in the report have been put together in part from client interviews, but also from information obtained from caseworkers and hospital staff.

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