Rapid Response Hospital Discharge: Evaluation of the Dolphin Service in Bristol

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THE ROLE OF DOLPHIN FUNDING

The Dolphin Society is one of the oldest philanthropic organisations in the Bristol area, focussed on helping older and disabled people on low incomes live independently and safely in their own homes. They have supported WE Care Home Improvements to install minor adaptations, walk-in showers, ramps, or repairs to heating systems.

Helping WE Care innovate

Dolphin has played a significant role in financing the piloting and evaluation of new and innovative services. This has allowed WE Care to be agile and adapt to a constantly changing policy and practice environment. For example, in 2015/16 Dolphin funded a complex casework team to help declutter and deep clean the homes of vulnerable patients to allow them to be safely discharged from hospital. This service is now well established, is a core part of the WE Care offer and receives Bristol City Council funding. In 2017/18 Dolphin funded the pilot of an occupational therapy and handyperson project to prevent falls at home.

The new Dolphin Hospital Discharge Service described in this report has been funded since April 2019. It allowed WE Care to adapt to meet the needs of local hospitals to get people home faster. This report is an evaluation of the first year of that rapid response service.

ACKNOWLEDGEMENTS

We would like to thank all the people who have helped with this project.

We would particularly like to thank staff at We Care Home Improvements including: Kevin Snowball Chief Executive; Linda Gudgeon, Operational Lead (Bristol); Pete Bryant, Home from Hospital Technician; Ian Trigg, Project Manager; and Nessa Sobey, Finance and Revenue Administrator, for all their support in providing information and data for the evaluation.

We would also like to thank all the staff in Health and Social Care hospital discharge teams who talked through discharge procedures and provided detailed material for the case studies.

EXECUTIVE SUMMARY

Why the Dolphin service was set up

- In response to challenges faced by the NHS in Bristol, in April 2019 the Dolphin Home from Hospital service was introduced to support the Health and Social Care 'Home First' fast track pathway. Patients admitted using this pathway should be assessed within 24 hours and returned home within 72 hours.
- The Dolphin service means that work can be completed to make the home safe within 48 hours allowing the patient to return home within the 72-hour target.
- This type of rapid response service requires dedicated capacity. It was not possible to deliver as part of the standard WE Care Handyperson service where work is timetabled in advance giving little room to operate in a fast and flexible manner.

How the service evolved over the first year

- In the early stages it was important to promote the service in person to raise awareness. At the beginning, the Dolphin technician was running the service end to end, including promotion, receiving referrals, carrying out the jobs and recording the data.
- As the number of referrals increased, administrative tasks were taken over by other WE Care colleagues to increase the resilience of the service and to free more time for completing work in people's homes.
- In recognition that relationships with the hospital and intermediate care teams needed to be broader than a single person, a second technician was trained, who joined the Dolphin team in January 2020.

What the Dolphin service delivered

- There was an upward trend in jobs completed per month as hospital and intermediate care teams became more aware of the service.
- Over 12 months the Dolphin service completed 461 jobs supporting 246 discharges which equated to 17% of all We Care Handyperson hospital activity.
- It exceeded the original target of 440 jobs.

- By Jan-Mar 2020 an average of 78 jobs per month were completed, which is four per day.
- A third of jobs were completed in within 24 hours.
- Most jobs involved fitting grabrails, stair rails and keysafes.

The benefits of the service

- The service delivered significant benefits. It decreased the time that patients medically fit for discharge waited to return home, and the work completed allowed reablement and care to take place in the home. However, it is only one part of the discharge process and lack of capacity in care and reablement services or a change in a patient's medical condition can cause delays.
- Health and Social Care staff appreciated being able to work collaboratively with a service that they valued for its speed, flexibility, trustworthiness, reliability, and their ability to deal sensitively and effectively with patients and families.

Cost savings

- The service generated savings of a minimum of one bed day per client which **equates to savings for Health and Social Care of nearly £100,000 per year or £2 for every £1 invested.**
- From case study interviews we know that in at least three instances the work carried out prevented the loss of big care packages, saving over four weeks in hospital per person. This would result in savings of £11,000 person or £33,000 from just these cases alone.
- There was also £10,000 per year in savings in staff costs as hospital and intermediate care staff did not have to take time out to visit the home.
- **Overall savings are more likely to be £3 for every £1 invested.** This excludes the broader cost savings for Health and Social Care from patients enabled to remain safely at home rather than going into residential care.

Getting local and national recognition

Over the past 12 months Dolphin Society supported Hospital Discharge work has begun to get greater recognition as being a key part of regional and national hospital discharge processes:

- Inclusion in the Local Government Association High Impact Changes Model as an example of emerging best practice.
- In December 2019 the policy team of the Ministry of Housing, Communities and Local Government visited We Care to learn more about the role of housing in hospital discharge and heard about the Dolphin fast track service.
- In January 2020 King's College London ran a series of events on improving transfers between hospital and home and We Care were invited to present the hospital discharge models, including the Dolphin fast track service.
- Most significantly, in February 2020 the We Care home from hospital service and Dolphin fast track service were presented to the NHS Urgent Care Oversight Board for inclusion in Winter Pressures recommendations for 2020/21.

Impact of Covid -19

- Although We Care did not experience a large increase in referrals during the Covid-19 crisis there have been several developments that will have a long-term beneficial impact. The Dolphin project is now a proven model for the future and has already been implemented in Bath and North East Somerset, where the council funded two Handypersons to be on standby for urgent discharges during the peak weeks of Covid-19 admissions.
- New ways of working between Health, Social Care and the voluntary sector during the crisis have established new communication networks that have worked well and will become 'business as usual'. WE Care are now involved in the recently established Integrated Control Centre in Bristol. This will reduce, although not remove, the need to constantly promote the service as the Dolphin service is now recognised as being a key part of the wider discharge system.
- The Health and Care service is having to adapt to a new normal of treating Covid-19 patients whilst maintaining other NHS services which have been suspended in recent months. The huge backlog in elective surgery will ensure that rapid hospital discharge will remain a priority for the future and the WE Care service will play an important role.

- It is recognised that WE Care will need to continue to raise awareness amongst Health and Care professionals because of the high number of individuals and teams involved and the regular turnover of staff in the wards.

Recommendations to increase impact

Any new service takes time to become established, but it is particularly difficult in complex systems such as hospital discharge where there are numerous staff, wards, and discharge hubs involved in the process. The Covid-19 pandemic has introduced changes to the discharge system in which the voluntary sector is more firmly involved, but this is still evolving:

1. For the Dolphin service to receive funding over a longer period, ideally three years, to allow it to become fully established as a key part of the Bristol hospital discharge system.
2. That the capacity of the Dolphin service is looked at once a more settled pattern of hospital discharge has been re-established – this may involve using the existing hospital discharge handypersons in a more flexible way to provide support.
3. Continue to develop the relationship with the Integrated Control Centre and Sirona, the community care provider, to ensure that the referral process works effectively.
4. Broaden and deepen the relationship with the Red Cross, the other main provider of hospital discharge services from the VCSE sector.
5. When the WE Care IT management system is upgraded ensure that the NHS number and dates of hospital admission and discharge are included to be able to better evaluate the impact of all WE Care hospital discharge services, including Dolphin. It is also important that staff can easily input data remotely.
6. Continue to review and streamline the WE Care internal referral communication pathway to ensure that referrals are dealt with effectively by the most appropriate person
7. Work with the Health and Social Care discharge teams to collect information on customer satisfaction with all parts of the discharge process, including the Dolphin service.

Contents

INTRODUCTION

Hospital discharge policies have changed considerably over the past decade. Rather than patients staying in hospital for extended periods, the aim is to get people home as quickly as possible. Studies show that after 10 days of bed rest even healthy older adults lose 14% of leg and hip muscle strength, and 12% of aerobic capacity, which is equivalent to the loss of 10 years of life. For older patients there is a significant reduction in the performance of everyday activities with 12% of patients aged 70 and over having a decline in their ability to bathe, dress, eat, move around and get to the toilet, and the extent of deterioration increases with age.[1] Older people are also more likely to pick up infections than younger age groups, and those with cognitive impairments can get very confused in hospital.

However, reducing delays must not result in patients being discharged before they are medically ready, particularly as many live alone. Getting this balance right can help people remain living independently at home rather than entering residential care prematurely. The Government goal, cross-cutting all policy areas, is to "ensure that people can enjoy at least five extra healthy, independent years of life by 2035, while narrowing the gap between the experience of the richest and poorest".[2] Ensuring that people can return quickly from hospital is part of that overall policy.

In Bristol, the co-location of health and social care staff in discharge hubs in the main hospitals has allowed the discharge process and provision of care to be much better coordinated. To improve outcomes many people now leave hospital with a short-term reablement package, with their longer-term health and care needs reviewed once they are settled back in familiar surroundings. Getting people home fast also helps to prevent cross-infection which has become even more important during the current coronavirus pandemic.

To provide support for Bristol hospitals and clinics, from April 2019 WE Care added a rapid response hospital discharge handyperson service to complement the suite of hospital discharge services it already offered. The new service is funded for three years by a local charity, the Dolphin Society. An experienced technician with a fully equipped van provides a response within 24 to 48 hours, five days per week. This ensures that, as soon as a patient is declared medically fit to leave hospital, they can return to a home that is safe and set up for them to manage either independently or with any required care and support. The work typically includes making space for a bed downstairs, fitting rails to help people get around, and installing a keysafe to allow entry for carers.

This report evaluates the first year of the new service, from April 2019 to end of March 2020, looking at the caseload, referral patterns, work carried out and speed of service. Case studies show how hospital discharge teams used the service, the type of patients referred and how it helps with discharge planning.

As with any new service there was a learning curve, for the Dolphin Technician, the team at WE Care and the hospital discharge teams, to ensure that the new service

[1] National Audit Office (2016) Discharging older patients from hospital. https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf.
[2] Centre for Ageing Better (2019) Industrial Strategy Challenge Fund Healthy Ageing Challenge Framework, London: Centre for Ageing Better.

was understood and utilised effectively. The main aim was to decrease the amount of time that patients medically fit for discharge wait to return home. The Dolphin service demonstrated that it was able to work fast and flexibly, and it helped save considerable numbers of bed days in some cases. However, it is only one part of the discharge process. Not all patients return home immediately due to the nature of their medical conditions and the availability of care and reablement.

The report looks at the lessons learnt and provides recommendations for the further development of the service. However, it has not been a typical year. The Covid-19 crisis at the end of the evaluation period meant that admissions were restricted while existing patients were discharged fast to clear wards. Referrals to WE Care's hospital discharge teams initially decreased but have since returned to normal levels.

It is still too early to understand the longer-term impact. Hospitals may have even greater need for a service that can respond fast to help prevent admissions or get patients back home quickly after treatment. WE Care will need to monitor activity levels over the coming months to see how they should respond as services slowly return to a 'new normal'. However, working relationships developed during the crisis are likely to be long-lasting and a new Integrated Control Centre in Bristol means that the Dolphin service is already becoming a more established part of the discharge process.

BACKGROUND

National hospital discharge policy

The number of NHS hospital beds for general and acute care has reduced by 34% over the last decade, partly due to increased use of day surgery but also the result of a fall in the number of beds for the long-term care of older people. The average length of stay in hospital has fallen by more than 40% from 8.4 days in 1998/9 to 4.5 in 2018/19.[3] This has allowed more people to be treated with fewer beds, but it depends on people being discharged promptly once they are well enough to go home, as bed occupancy rates are now over 90%. Five principles have been established for reducing long stays in hospital:[4]

1. Plan for discharge from the start
2. Involve patients and their families in discharge decisions
3. Establish systems and processes for frail people
4. Embed multidisciplinary team reviews
5. Encourage a supported 'Home First' approach

The NHS long term plan published in 2019 set out to redesign patient care to reduce pressures on staff and funding, deal with increasing inequalities in health, and cope with the growing demands of an ageing population.[5] The aim is to provide more care in the community, focus more on prevention, keep people living independently at home and reduce premature entry to residential care.

Additional resources have been provided to improve care outside of hospitals. To mark the 70th birthday of the NHS in 2018, NHS England received a 3.4% annual increase for the five years to 2023/24, when the budget would be at least £4.5 billion higher than in 2019/20.[6] The increase included additional funding for GP services and community care.

However, big disparities remain between the way social care is funded compared to the NHS, with the former provided by local authorities and mean-tested, while the latter is funded by central government and free at the point of use.[7] Demand for care is increasing and costs rising. Although authorities were allowed to raise council tax by a limited amount and there has been an injection of additional funding to cope with the Covid-19 crisis, there is still no long-term solution to the social care funding problem.[8]

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[3] Ewbank, L., Thompson, J., McKenna, H. and Anandaciva, S. (2020) NHS hospital bed numbers: past, present, future, London: Kings Fund. https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers.

[4] NHS England, Reducing long stays: Where best next campaign. https://www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/reducing-long-term-stays/.

[5] The NHS (2019) Long term plan. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/.

[6] Charles, A., Ewank, L., McKenna, H, Wenzel, L. (2019) The NHS long-term plan explained. https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained

[7] House of Lords Economic Affairs Committee (2019) Social care funding: Time to end a national scandal, 7th Report of Session 2017–19 HL Paper 392.

[8] Bottery, S., Varrow, M., Thorlby, R. and Wellings, D. (2018) A fork in the road: Next steps for social care funding reform, London: The Health Foundations and the Kings Fund. https://www.kingsfund.org.uk/sites/default/files/2018-05/A-fork-in-the-road-next-steps-for-social-care-funding-reform-May-2018.pdf.

Hospital discharge in Bristol

In Bristol, the two main hospitals, Southmead and Bristol Royal Infirmary, admit up to 400 people per day on normal weekdays.[9] Prior to 2018 the city was performing badly on measures of delayed discharge of care. A high proportion of people were ending up in long term residential settings which is costly and not the desired outcome for most people.

Hospital discharge processes have since been transformed. Integrated discharge hubs were set up in both the main Bristol hospitals using co-located health and social care staff. There is better communication with patients and family, a co-ordinated discharge pathway and fewer assessments in hospital.[10] In 2018 the process of planning, buying and monitoring healthcare across the region was further reorganised when the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups joined to form a single organisation (BNSSG).

A new Home First service started operation in November 2018 which is designed to settle people back into their homes as soon as they are medically fit and assess them for ongoing care and support within the first ten days. The service is available to anyone who is unable to return home to live independently immediately following discharge.

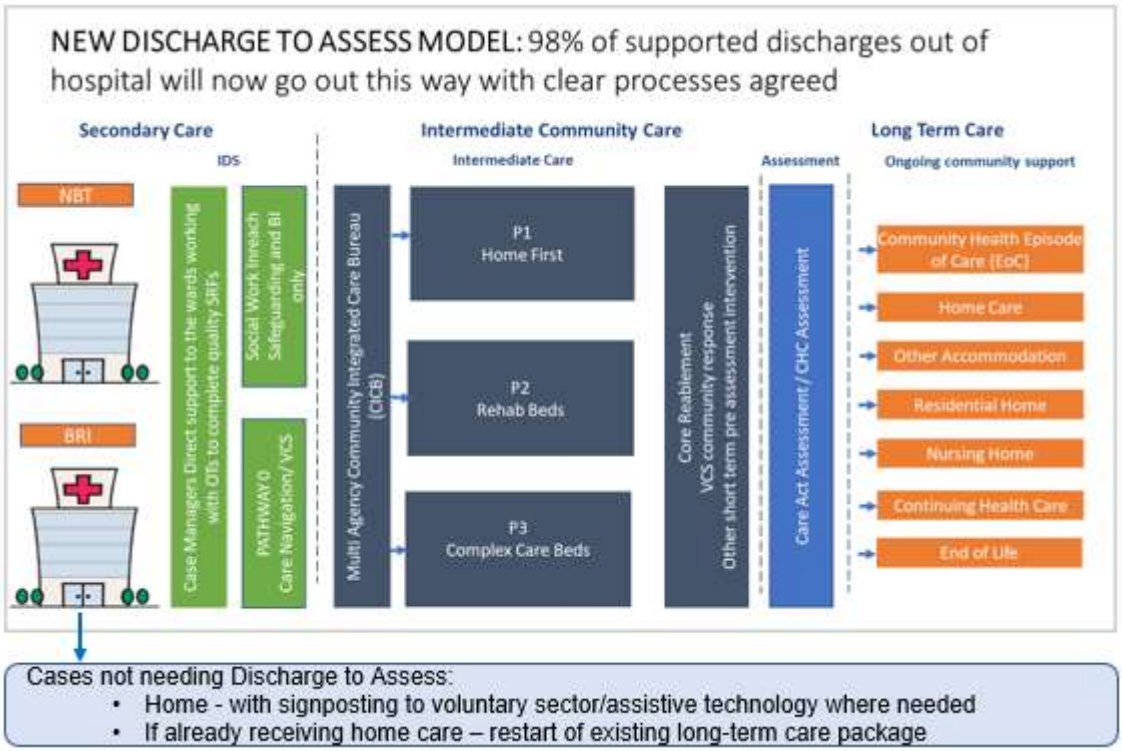
As part of this process there is a Home First fast track pathway. Patients admitted using this pathway should be assessed within 24 hours and returned home within 72 hours. The Dolphin rapid response service plays a key role in making homes ready so that people can leave hospital fast.

Other people may be discharged with a more intensive reablement package. This helps people relearn basic tasks like getting around their home, dressing, washing, cooking and other day-to-day activities. The average duration of reablement nationally was four weeks in 2018.[11] It is often the first contact people have with social care services and around two-thirds have no further homecare needs after receiving this service. Where people discharged with Home First do not make the progress expected within the first ten days, they may be referred to the reablement service for further support at home, prior to a final assessment of ongoing need.

In April 2020 Sirona began operating the community health service across the BNSSG area which should join up services more effectively. Figure 1 shows the discharge pathway in Bristol. The improved pathway should also enable better use of voluntary and third sector organisations to provide additional support.

[9] NICE (2019) Supporting best patient outcomes through a joint Discharge to Assess, Home First service. https://www.nice.org.uk/sharedlearning/supporting-best-patient-outcomes-through-a-joint-discharge-to-access-home-first-service.
[10] NICE (2019) op cit.
[11] NICE Intermediate care including reablement https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-use-of-nice-guidance/impact-of-guidance/niceimpact-adult-social-care/intermediate-care-including-reablement.

Figure 1 Discharge to assess pathway for hospitals in Bristol



Since 2018 there has also been a Rapid Assessment Emergency Care Team working with people arriving in A&E departments at Bristol Royal Infirmary and Southmead. Where possible the aim is to prevent hospital admissions and instead refer people directly into community healthcare services to provide clinical care at home.

Although Bristol's hospital discharge process has improved considerably, it is still struggling to reach national targets. Funding for social care in Bristol has not been able to keep pace with increasing levels of need or rising costs.

In Bristol in 2019/20 the rate of delayed days per month was 614 per 100,000 adults, almost twice the overall rate for England which was only 354 per 100,000 adults.[12] Nationally, the wait for home care is the biggest reason for delayed transfers with waits more than doubling over the past six years.[13] In Bristol almost half the delays in 2019/20 were attributable to social care, while just over a quarter related to the NHS and a further quarter was a combination of both.[14]

[12] Local Government Association (2020) Review of delayed transfers of care for Bristol compared with all single tier and county councils in England. https://lginform.local.gov.uk/reports/view/lga-research/quick-view-dtoc-summary-delayed-days-for-a-single-authority-1?mod-area=E06000023.
[13] Baker, Karl (2020) NHS Key Statistics: England, February 2020 House of Commons Library Briefing Paper No. 7281, London: House of Commons Library.
[14] LGA (2020) op cit.

The importance of housing for health

Having a suitable home has always been essential for our health and wellbeing. If the home is safe and secure people can be discharged from hospital quickly and re-admission can be prevented. For those with long term conditions it allows care and support to be provided more easily. Conversely, unsuitable housing is linked to social inequalities and much poorer health outcomes.[15]

Housing is one of nine changes that can be delivered by the High Impact Change Model. This model was first developed in 2015 by strategic system partners, and was refreshed in 2019 with input from a range of partners including the Local Government Association, the Association of Directors of Adult Social Services, NHS England and Improvement, the Department of Health and Social Care, the Ministry of Housing, Communities and Local Government and Think Local Act Personal Partnership. [16]

It identifies actions that can delay, divert or prevent the need for acute hospital stays and statutory care. The original Dolphin funded hospital project is included as an example of emerging practice.[17,18] The aim is to produce a health and care system that is much more resilient year-round and not focused solely on winter pressures. Making sure that repairs and adaptations are carried out can maximise people's independence and help avoid hospital admissions.

The 2020 pandemic has shone a spotlight on the importance of the home. Patients have had to be discharged quickly to free hospital beds for Covid-19 cases, and people over 70 and those with existing health conditions have been confined to their homes for an extended period. To protect vulnerable patients, health checks and procedures formerly done in hospital or in GPs surgeries are now being done at home or via video link accelerating the trend towards more care in community care that is part of the NHS long term plan.

It is estimated that it costs £400 per day to keep someone in hospital and an average of £110 per day to pay for a residential care bed in Bristol. Services that can speed up discharge procedures, assist health and social care in providing services at home and adapt the home environment to help to keep people living independently are essential and likely to be very cost-effective.[19]

[15] Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity.
[16] https://www.housinglin.org.uk/Topics/type/Refreshing-the-High-Impact-Change-Model/
[17] Adams, S. (2017) Reducing Delayed Transfer of Care through housing interventions: Evidence of Impact, Nottingham: Care & Repair England.
[18] Local Government Association (2017) Housing Our Ageing Population: Learning from councils meeting the housing need of our ageing population, London: LGA.
[19] NICE (2019) op cit.

WE Care Home Improvements

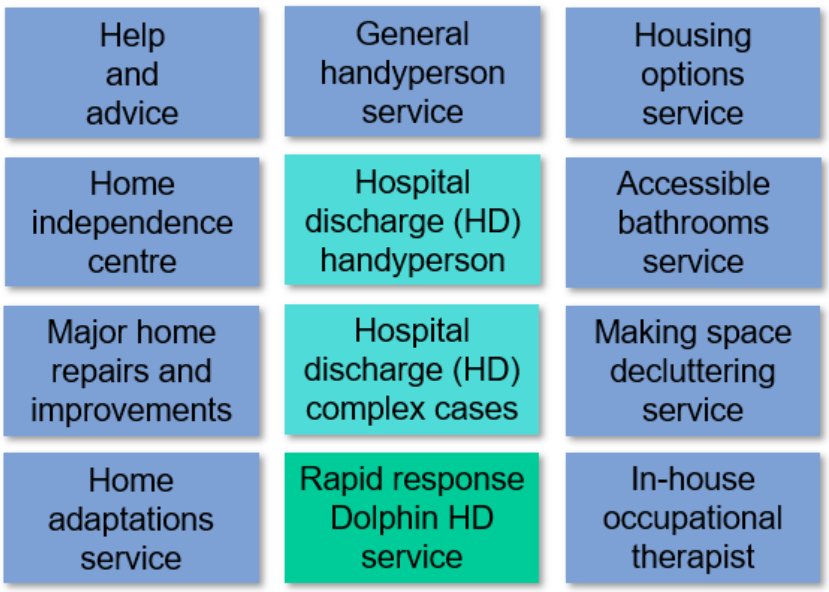
WE Care has been operating for more than 30 years and offers services across Bristol, Gloucestershire, and Bath & North East Somerset (BANES). It was formally known as West of England Care & Repair.

The aim is to help people to live comfortably and independently at home. The focus is on those aged 60 and over, disabled people of all ages, those on low incomes, and people coming out of hospital.

Local authorities fund some of their services, but others are either partly or fully paid for by customers themselves. Any surplus is used to support those on low incomes.

In Bristol there are three different hospital discharge services that are free to patients. Operational costs are mainly covered by Bristol City Council and, in the case of the new rapid response service, from the Dolphin Society.

WE Care services in Bristol



THE DOLPHIN SERVICE

With the support of the Dolphin Society, WE Care developed a new, rapid service to help Bristol hospitals, clinics and the Home First service meet hospital discharge objectives. The Dolphin funding covers the costs over three years of a technician and a customised and fully equipped van. It is branded and promoted as 'The Dolphin Home from Hospital Service'. The aim is to provide a much faster response to discharge teams than existing WE Care services.

Existing WE Care hospital discharge services

WE Care already has two effective home from hospital services: the Hospital Discharge Handyperson Service; and the Complex Case Service (see box). This is in addition to a general handyperson service available to homeowners and private tenants for a small fee. The existing hospital services aim to get work done within four to five days. They were not set up to guarantee a faster response. Staff diaries are normally fully booked with little flexibility to respond immediately, and if outside contractors are required (for example for deep cleaning) work may take longer.

WE Care handyperson and hospital discharge services

General handyperson service – this has been a core part of the service since the agency was first established 30 years ago and operates across the three local authorities that commission WE Care services. Any older or disabled person can contact the service directly or be referred by an outside organisation. It is a trusted service which provides help with a range of repairs and small jobs around the home. A fee is charged, although this is sometimes waived for vulnerable people or those on very low incomes. This service is used by people who are usually unknown to social care and often helps to identify those needing more help.

Hospital discharge handyperson service - referrals for this service go to the WE Care customer service team and are allocated to a team of handypersons. This service operates across Bristol and Bath & North East Somerset. Multiple hospitals, health clinics, occupational therapists and social workers use the service. There are no timescale targets within the contract, but the aim is for work to be completed within four working days from point of referral.

Hospital discharge complex casework team – this service was originally funded by Dolphin as a pilot but is now well-established and forms part of the local authority contract.[20] It helps patients with complex needs and difficult home circumstances. Many have mental health issues, addiction problems, cognitive impairment, are hoarders or very isolated. Their homes are often cluttered, dirty or unsafe. These cases require a holistic home assessment and often external contractors to do clearing and deep cleaning. The team aims to agree a discharge plan within one day and ensure the work is completed within a further five working days. It takes considerable skill to build trust with the patient and to get work underway. Without the service these patients can remain in a hospital or clinic for prolonged periods. After discharge, those who need it are referred for on-going support, e.g. the WE Care Making Space service.

[20] Mackintosh, S. (2016) An evaluation of the Dolphin funded WE Care & Repair Home from Hospital Service. Bristol: WE Care & Repair. https://www.dolphin-society.org.uk/sites/dolphin-society.org.uk/files/HfH%20Dolphin_WECR%20Final%20Report_%20130916.pdf.

All the handyperson services, including the Dolphin service, aim to reduce the risks in the home. The home from hospital handypersons are all trusted assessors who can carry out a range of work and notice issues of concern (see box).

WE Care work to reduce risks to patients returning home

- Identification of safety issues – e.g. trip and fall hazards, issues with flooring
- Infection risks, need for deep cleaning or infestation treatment
- Works to remove clutter and ensure safe passage of people with mobility aids
- Clear rooms and move furniture to make space for hospital bed and equipment downstairs
- Installation of minor adaptations - grabrails, mopstick rails, toilet rails - specified by an OT
- Help for carers and personal safety - keysafes and telecare
- Ensuring safe food storage and preparation - fridge/freezer, cooker/microwave, workspace, safe storage for medicines
- Provision of a bed and somewhere safe to sit
- Provision of heating, hot water
- Serious plumbing leaks, drain clearance, ensuring functional toilet and washing facility.
- Unsafe electrics, provision of sockets for essential equipment – hospital bed, hoist, etc.
- Security risks - repair/replace locks, doors, downstairs windows
- Address fire safety issues – smoke alarms, door openers
- Gas safety work, capping gas fires
- Note evidence of fuel poverty
- Identify/address other serious hazards, e.g. risk of structural collapse, falls from stairs.
- Note need for major adaptations such as showers, lifts or extensions and refer for DFG
- Co-ordination of trusted outside tradespeople where necessary e.g. for deep cleaning
- Refer for information and advice from trained case managers – e.g. on independent living
- Signpost/refer to other statutory, voluntary, charitable agencies for additional support.

Setting up the Dolphin service

To get the new rapid discharge service established required the appointment of a Dolphin technician with hybrid skills combining those of a caseworker, trusted assessor and handyperson. The person selected was a multi-skilled tradesperson experienced in the installation of minor adaptations, assistive technology and repairs in the homes of older and disabled people. The service can carry out holistic home safety checks, fit minor adaptations and community equipment, install Dolphin Telecare technology and complete larger repairs if necessary.

The experience of developing the WE Care Complex Case service shows that it takes a considerable time to get a new service known within NHS and Social Care. There are high numbers of people in the discharge and intermediate care teams, all in different locations, with many working part-time and with high turnover in the teams. In the first few months the Dolphin technician visited the hospital discharge hubs and wards to give talks to raise awareness of the new service. It was anticipated that there would be gaps in his diary until the new service was better known. He had to work flexibly at the start, with unused time slots used to support other WE Care services.

As the Dolphin service caseload developed a second technician was appointed in January 2020 in a timeshare post. This broadened the service, allowed continuity during holidays or periods of sickness and permitted the original technician to step back to three days a week to undertake further training as a caseworker.

EVALUATION

Aims

The aims of the evaluation were to demonstrate whether the service:

- Decreases the amount of time that patients assessed as medically fit for discharge wait to return home
- Allows care to take place in the home
- Reduces preventable hospital admissions/re-admissions
- Requires further resources to meet demand.

Evaluation methods

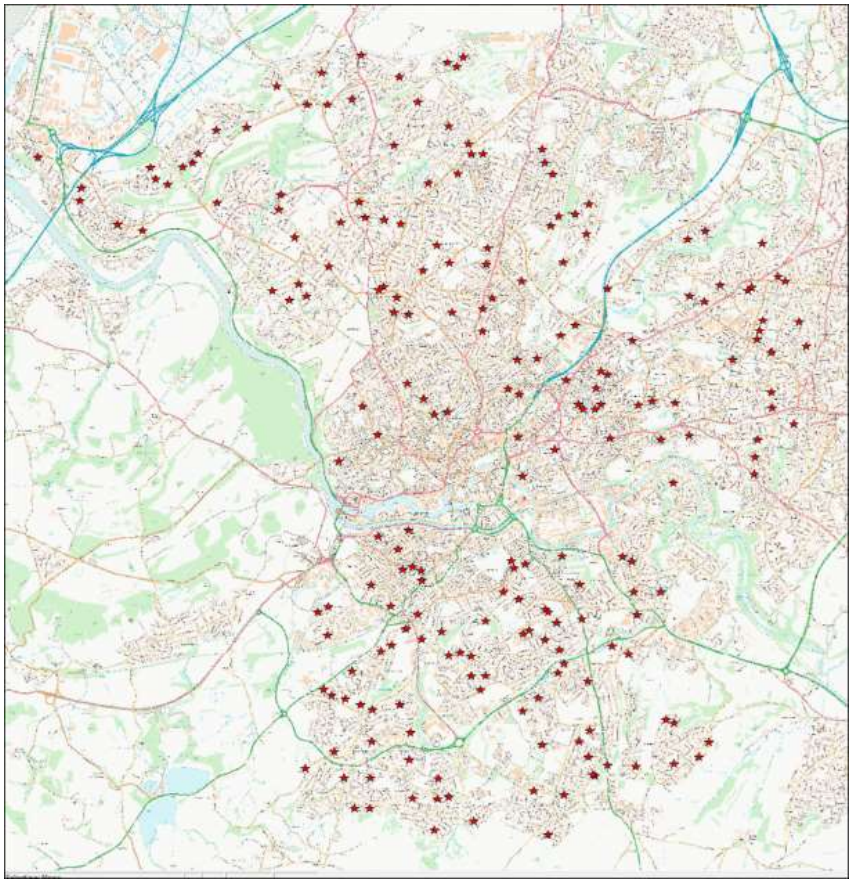
A mix of methods was used including data from the WE Care case management systems, interviews with discharge teams to gather case study information, feedback from Health and Social Care managers, and meetings with WE Care staff involved in the project. Knowing that the project would take time to develop, most evaluation tasks were carried out towards the end of the first year of operation, although some interviews with hospital discharge professionals took place in the autumn of 2019. Some further conversation with WE Care and Hospital discharge staff took place in May 2020 to determine the impact of the Covid-19 crisis. Details about the methodology and some of the limitations of the data sources are given in Appendix A.

EVALUATION FINDINGS

The WE Care management system suggests that the Dolphin service completed 461 jobs for 246 patients in the first year.[21] An average of two jobs were completed in each home, for example a keysafe and grabrails, or an extra stair rail and a rail in the shower. Cases were spread around Bristol in all areas of the city (Fig 2). The service has exceeded the original target which was for 440 jobs to be completed.

[21] Note: this is probably an underestimate of the number of jobs and cases – the evaluators screened out some cases where the information on the management system was incomplete or there were duplicate case numbers. The Dolphin Technician thought he had completed 285 cases.

Figure 2 The distribution of Dolphin cases in Bristol



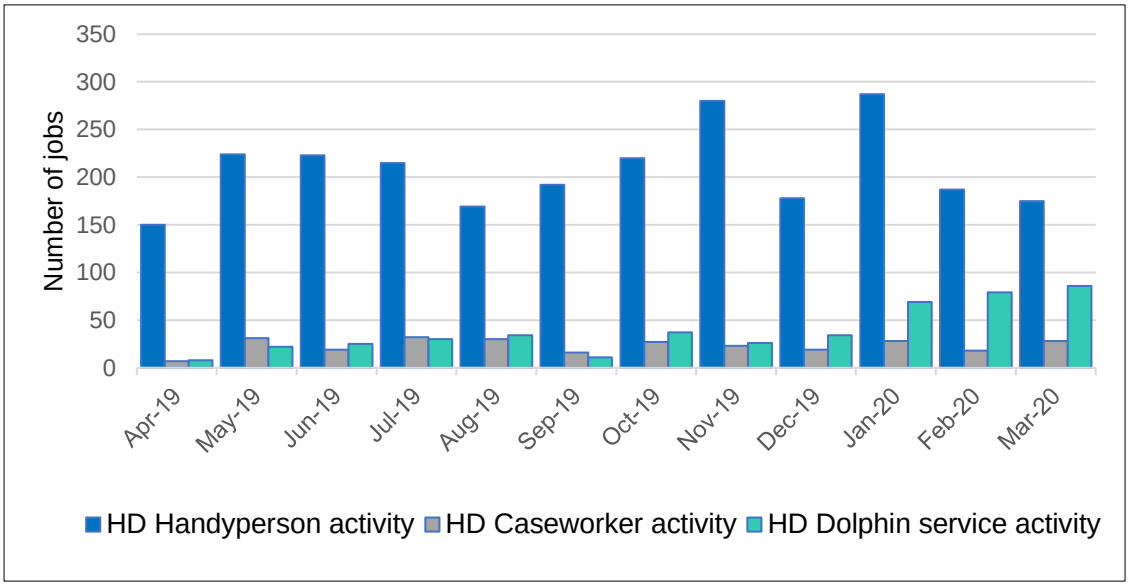
Referrals and jobs completed

Referrals took time to build up as might be expected. Figure x shows the upward trend in jobs completed over the year (Figure 3). There were fluctuations in activity for all WE Care hospital discharge services across the year, with a reduction in activity in August and December reflecting the main holiday periods when fewer people want to be in hospital. The Dolphin service also had a drop in completions in September 2019 when the main technician was off due to illness.

The first quarter of 2020 gives a better reflection of what the Dolphin service can achieve. This was the period when discharge and intermediate care teams had become more aware of the service. In Jan-Mar 2020 an average of 78 jobs per month were completed, an average of four per day.

Each Dolphin discharge averaged 1.9 jobs per case (461/246) compared to 1.4 jobs per case for the standard hospital discharge handyperson service (2039/1416) reflecting the more specialised nature of the service. The Dolphin service equated to 17% of all We Care hospital discharge handyperson activity.

Figure 3 Trend in jobs per month - all hospital discharge activity Apr 2019 to Mar 2020



The Dolphin Technician explained that if jobs are straightforward, such as fitting keysafes, it is possible to complete five to six jobs in a day for different households. On other days jobs take longer. For example, a house with three flights of stairs which all need mopstick rails fitted can take three hours. Distances and travel times within Bristol also limit the number of jobs that can be completed as crossing the city to get to the next job can take 45 minutes. However, it is not just about numbers. A banister reinstatement that takes all day is just as important as putting up 12 key safes if it prevents someone in their 80s falling through an open staircase and suffering catastrophic injuries.

One of the benefits of the Dolphin Service is that the van is permanently available for urgent discharge work which does not run to a set timetable. When there were gaps in the diary for the Dolphin service these were filled with other Handyperson work. As the year progressed Dolphin cases took up an increasing proportion of the Technicians' time rising from 39% in May 2019 to 60% in February 2020. The percentage fell back slightly in March 2020 to 52%, but this was not a typical month as it was when hospitals were cleared for Covid-19 cases. Over the whole period April 2019 to March 2020 62% of jobs were rapid hospital discharge and 38% were for other WE Care contracts.

Typical jobs have been fitting grab rails, mopstick stair rails or keysafes (Figure 4). Clinics and intermediate care teams such as South Bristol Community Hospital and have used the service more than each of the two main hospitals. Of the latter, UBHT has used the service slightly more than NBT (Southmead). The reasons for this may be greater awareness of the service in UBHT and the fact that NBT also covers South Gloucestershire where there is no WE Care service. Referrals have come from a mix of professionals but mainly from occupational therapists (Figure 5).

Figure 4 type of work carried out

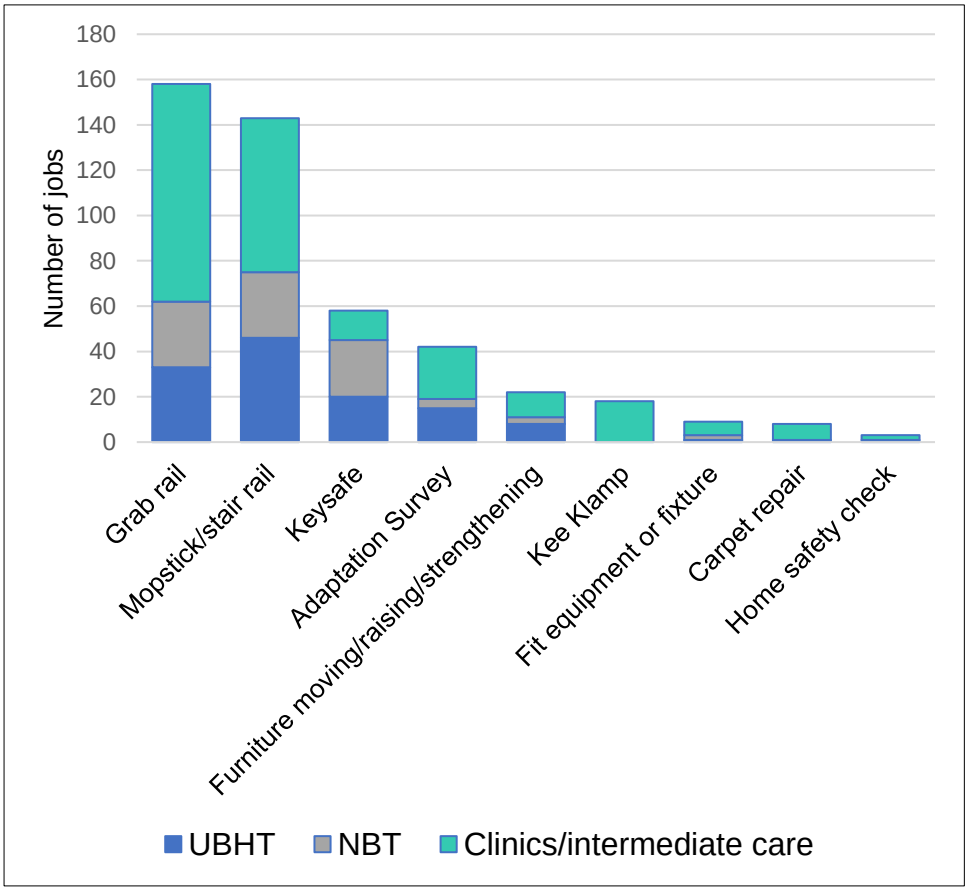
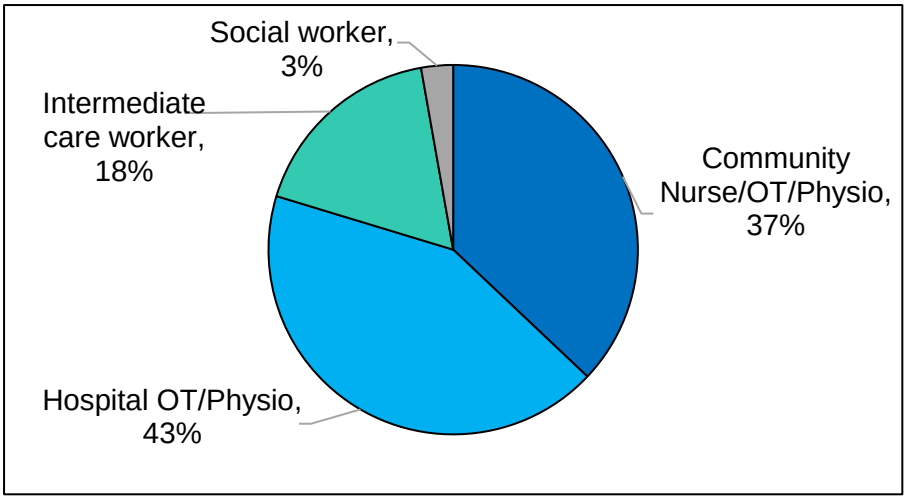


Figure 5 Source of referrals



Referral process

The original aim was for the Technician to take calls directly from the wards and discharge hubs about patients ready for discharge. This worked well initially as it gave him first-hand information about the work required and, when additional jobs were identified on site, they could be discussed with the referrer over the phone and carried out while the Technician was in the property. Once the home was ready, the Technician was able to let the referrer know, potentially saving more time if the patient could be discharged immediately. If required, the Technician could also meet the referrer at the home, often at short notice to solve a problem.

> *"I'm getting a good relationship with some of the OTs…. they want to speak to someone with building experience."* Dolphin Technician

> *"They came to trust me to do extra work as well. If I got there and felt there was an issue on site I would phone them up and say 'do you realise that you've not asked for a grab rail in the shower and the person is coming home to be showered by Home First'. 'Oh, I forgot that, can you just do it for us?'* Dolphin Technician

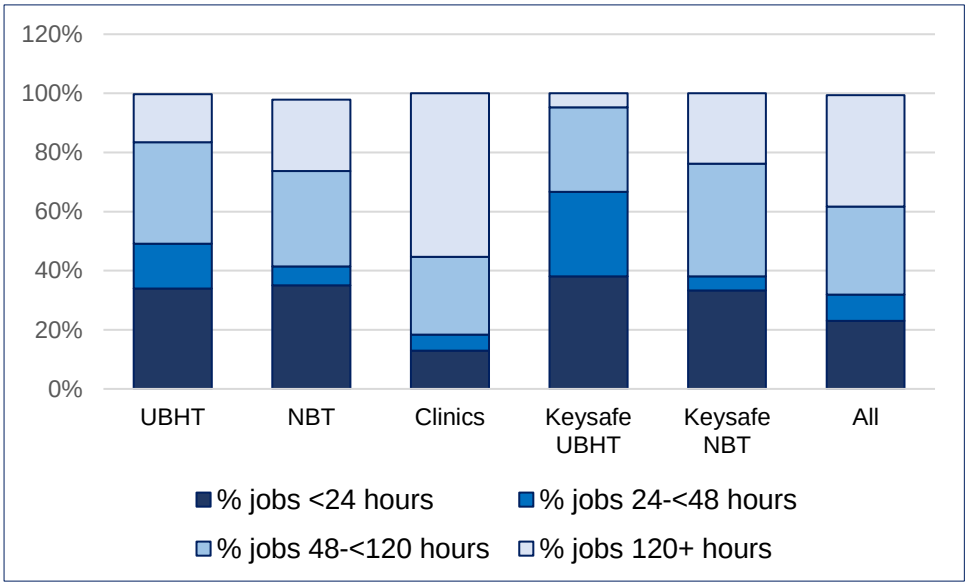
As the numbers began to increase, taking calls direct started to eat into the time available to do the work, and it was hard to talk on the phone if the Technician was in someone's home. The decision was made to route calls to the WE Care customer service team. The team is trained to take technical and medical details to ensure that comprehensive information is relayed to the Technician. He is able to call the hospital or clinic if anything needs to be clarified. He still lets the referrer know directly when work has been completed to ensure fast discharge.

Time to complete work

Overall a third of hospital referrals and keysafe work was done within 24 hours (Figure 6). However, a proportion took longer, particularly referrals from clinics and intermediate care. There were several reasons for this:

- Getting access to properties – this happened occasionally.
- Issues with the way data was entered - stopping after a job to input information into the management system was not always an option when the Technician was busy. As a result, data entry was often done by phoning through the information to the office team which may have led to some cases appearing to take longer. Proposed changes to the management system will simplify and speed the data entry process.
- The Dolphin service is not just about speed - what was also valued was the specialised service, ability to talk through more complex jobs like bannister reinstatements and having a guaranteed completion time, even if that was longer than 48 hours.

Figure 6 Time taken to complete Dolphin jobs



Case studies

The case study interviews revealed more detail about the nature of the patients referred to the project. Some interviews were carried out in the autumn of 2019, but the majority were conducted in February and March 2020. The later interviews were with professionals who were making a significant number of referrals and would have a greater understanding of the Dolphin service.

Information sheets were completed for pre-selected cases (anonymised for the evaluators) allowing data to be obtained for 18 cases from UBHT, South Bristol Community Hospital and St Peter's Hospice. All cases had been referred to the Dolphin service in the last six months of 2020/21 and most in the last quarter of the financial year.

- Of the 18 cases, three quarters were aged over 70 and half were over 80.
- Half lived alone, although most had at least some care from family living nearby.
- Fifteen were in hospital at the time of referral to Dolphin and most had been in for four weeks or more prior to discharge (Figure x). The professionals interviewed said that 13 patients would not have been able to go home if the work had not been completed.
- In three cases the rapid response service played a preventative role to avoid the re-admission of people who were already at home, either stroke patients admitted briefly then supported at home, or hospice patients wanting to be at home for end of life care.
- Two of the cases were done in conjunction with the WE Care Complex Casework Team.

- The most common medical condition was cancer, followed by strokes and dementia but others had diabetes, Parkinson's, and COPD. Several were frail or had multiple conditions and four had fallen prior to being admitted.
- Most patients had been very ill or frail, but most returned home successfully. However, despite the Dolphin work being completed, two people died before discharge, another went into a nursing home and a further patient was discharged but fell at home almost immediately, was readmitted and then went into residential care. One person went back into hospital for a short stay but was able to go straight back home as everything was in place.
- In 12 of the 14 cases where people recovered and were successfully discharged or enabled to remain at home, professionals said that the work completed allowed reablement or care (both formal and by the family) to take place at home.
- Due to the delays in discharge after Dolphin work was completed staff were only able to estimate bed days saved in four cases: in one case three days were saved as it prevented admittance to an acute ward from A&E, in two others it was estimated to save weeks as that is how long it would take to get another large care package commissioned, and in a final case where work was done fast they estimated four weeks of savings had the person been able to be discharged, but unfortunately he had another stroke and died in hospital.

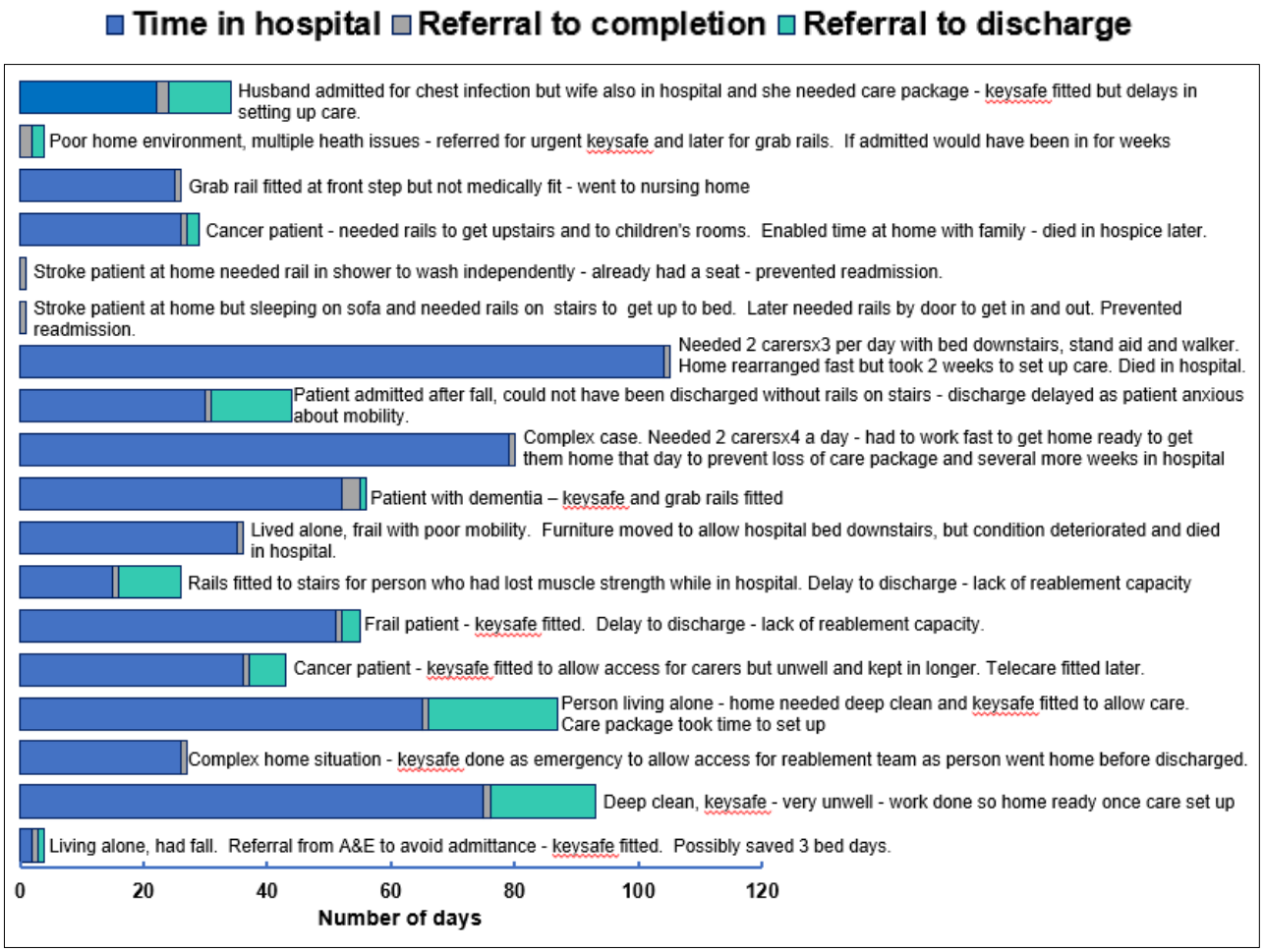
The sample was small, but it revealed that people's medical conditions were often complex and problems with their home environment and family circumstances meant that discharge was seldom straightforward. It also showed that the Dolphin service is only a small part of the overall discharge process and delays in other parts of that process meant that people did not always leave hospitals or clinics immediately after work was completed. It therefore made it very difficult to calculate savings in bed days.

Figure 7 shows the time the 18 patients spent in hospital, the time taken for Dolphin work to be carried out, how long it took for patients to be discharged and some details about each patient and the work carried out. In nearly all these cases the Dolphin work was done in 24-48 hours. Despite the work being done quickly, in over a third of cases there was a delay in discharge. This was either due to difficulties in setting up a care or reablement service, complications with the family situation or a deterioration in the patient's condition.

The case studies indicate that the service fulfilled another aim of the project which is to enable care to take place at home as this was achieved for 12 of the 14 cases where people were successfully discharged or enabled to remain at home.

A further aim of the study was to look at whether the service reduced preventable admissions. This is very difficult to determine as there are so many factors involved. However, in the case of two stroke patients already at home it allowed them to get upstairs or to shower safely, preventing re-admission. Several other patients returned to hospital, but mainly because of a deterioration in their condition or due to a fall. There is nothing that the Dolphin service could do to prevent this. However, in one case it was clear that work carried out enabled someone who returned to hospital to be discharged quickly because the home was already adapted.

Figure 7 Stages in the patient pathway and outcomes



Some jobs were done in conjunction with the WE Care Complex Casework team. These were cases where homes need to be cleaned, decluttered and reorganised before a patient could return home. Being able to call in the Dolphin Technician to quickly fit a handrail, a keysafe or help move furniture speeds up these cases and prevents the complication of having to leave keys for someone else to call another day. It is not possible to use the normal handypersons for these jobs as their diaries are completely booked out in advance. The Dolphin flexibility helps the complex casework budget go further by avoiding having to use outside contractors and it often saves an occupational therapy visit and means a patient can go home the same day.

One example was case where the teams worked together to move furniture upstairs to allow a deep clean of lounge to create space for a bed. The Dolphin Technician also fitted a keysafe for the carers. Everything was in place in three days to make sure they didn't lose the large care package that had been arranged.

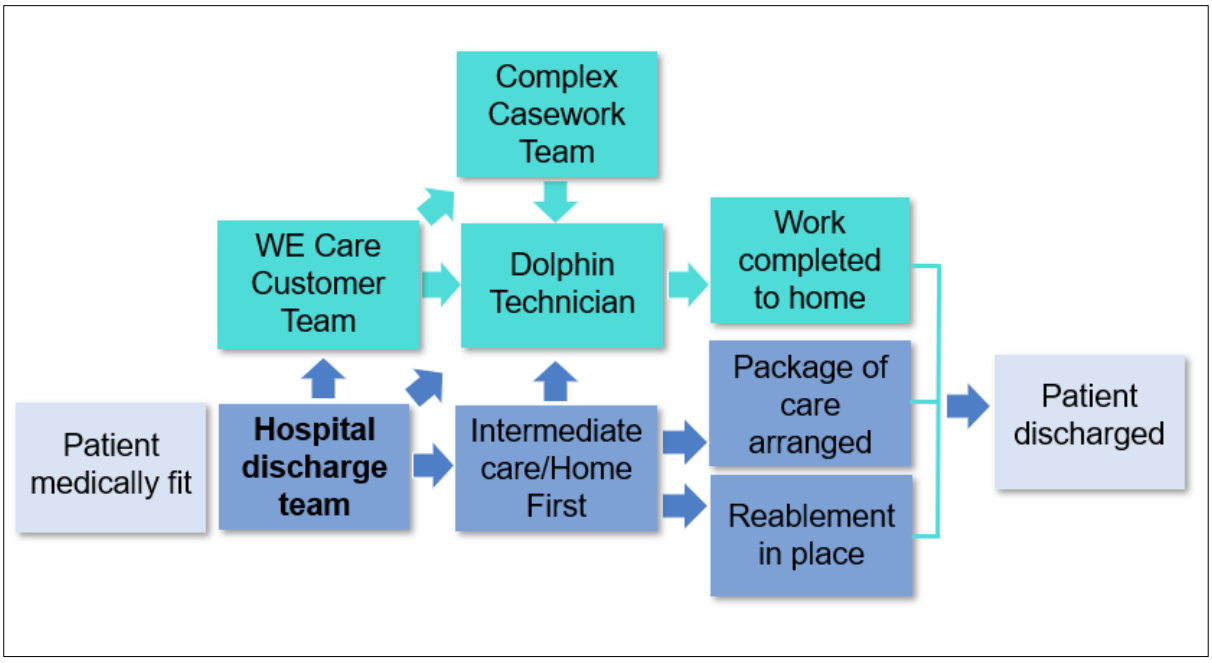
> *"I met [the WE Care staff] at the home with Medequip [the equipment supplier]. They were asked to move furniture upstairs to clear a space downstairs for a hospital bed and patient turner. It had to be a military procedure to create the space as the house was so small."* South Bristol Community Hospital OT

Summary of referral pathway

Figure 8 summarises the referral routes for the Dolphin service. Most referrals now go straight to the WE Care Customer Service Team from the hospital discharge team or intermediate care teams. If all that is needed is minor work to the home and the case is straightforward the Dolphin response can allow a person to go home the same day. However, in most cases patients need a reablement or care package which take much longer to set up.

Once care is in place, the fast pace of the Dolphin response means the care is not lost and the patient can go home. In other cases, getting the work done in advance means discharge can take place immediately the care is in place. In more complex cases where homes need cleaning, decluttering and reorganising the Dolphin technician and the Complex Case Teamwork work in tandem to ensure these cases do not suffer additional delays.

Figure 8 Summary of the Dolphin referral pathway



The benefits to health professionals

Discussions with hospital and intermediate care occupational therapists and social workers (in the autumn of 2019 and in Feb-Mar 2020) identified several benefits of the Dolphin service. These included: speed, flexibility, collaboration, trustworthiness, reliability, the ability to deal with patients and families, and the time saved for health and care staff in co-ordinating works and checking they have been completed (Table 1). Every professional interviewed had only positive comments to make about the service.

Table 1 The benefits of the Dolphin service to health and care staff

Speed: A fast service able to deliver results in 24-48 hours is invaluable, especially for those dealing with complex care packages. If the home is not ready the care can be lost. Dealing with simple issues like keysafes is also really important to make sure that carers and reablement staff can gain entry, that vulnerable patients do not injure themselves trying to get to the door and that patients with dementia are kept safe.	*"It is very hard to get such a comprehensive care package of four visits per day with two carers. She [the patient] could not have gone home without it. If the work had been delayed, we would have lost the care package. She would have been in weeks waiting for another care package."* South Bristol Community Hospital OT *"Keysafes are often done at the last minute when we realise that the family will not be there to let carers in, so it has to be a reliable service to ensure that care can take place."* South Bristol Community Hospital OT
Flexibility: The technician has control of his diary and has the flexibility to get on site fast to deal with adaptation and equipment problems discovered when an OT is at a property. This speeds discharge and prevents patients having to return to hospital.	*"Whilst at a patient's house yesterday we discovered that a rail needed removing to enable fitting of a free-standing toilet frame. The patient was for discharge today and needed bilateral support to get on/off the toilet. He [the technician] was able to come out almost immediately to remove the rail."* UBHT OT
Collaboration: working with health and care staff provides a better service which also saves money. Meeting on site with patients means that rails can be fitted exactly where required and tested to see that the patient is safe and able to manage on their own. If the technician hits a problem when the OT is not there, he can take a picture for the OT on the ward so that they can say what is needed.	*"So useful to all be in the same place at the same time. If he hadn't been there, we may have had to put in place more measures to ensure the patient copes at home like a commode downstairs and a carer to empty it. We would also have to consider whether the patient would actually manage the stairs to get to bed in evening when tired and if downstairs living needed to be set up - which could have meant the patient couldn't be discharged in first place."* NBT Community Physiotherapist.
Trustworthiness and reliability: most staff said they usually get an email or phone call to say the work has been completed. One team said that they have total trust in the Dolphin service and will now get a patient ready for discharge before confirmation - they know that the work will be completed.	*"Nothing but praise for them as they do things in double-quick time."* Southmead Social Worker *"Totally reliable, much better at dealing with patients and families [than the equipment supplier] and they always let medical staff know that the work has been done."* South Bristol Community Hospital OT
Saves time for health/care staff: several staff said that they did not know how they would get work done without WE Care and that it was one organisation they could not do without. The visit by the Dolphin Technician saves them considerable time as it means that they do not have to visit the home.	*"The referral to Dolphin comes at the end of the case, the point it is almost closed. "If we had to organise [the work] it would take so much time. It would result in a very different discharge service as we already have a long waiting list….. We are supposed to be based here [at the hospital]. For us to visit the home is usually half a day out. If we had to do this ourselves it would be a huge amount of work."* UBHT Social Worker

Demand for the Dolphin service

Developing referrals

The development of new WE Care services is dependent on WE Care staff doing the promotion work themselves, and it takes time to raise awareness. The discharge hubs are busy and there are so many staff involved it is hard to get messages across. The Complex Casework service has become very well-known but only by staff spending a lot of time in the hospitals, and they were only able to do that because there are several of them in the team.[22] In contrast, the Dolphin technician is working alone and trying to complete work fast which leaves little time for hospital visits.

Despite the lack of publicity, the number of Dolphin cases continued to rise in the last quarter of 2019/20. How much further the caseload would have risen we do not know because of the interruption caused by the Covid-19 crisis. The caseload is increasing rapidly again, but the true level of demand is still unknown.

Reaching the right people

There may be many more cases that need a rapid service but are not yet being referred as the Dolphin service did not appear to be actively promoted in a strategic way by Health and Care themselves. There is potential to use the service for:

- Older and vulnerable people coming in for short stays
- During winter pressures when hospitals are on the highest levels of alert
- In A&E where it is important to avoid admission to acute wards.
- For other preventative work to keep people from being re-admitted.

At the end of the first year the pattern of referrals may reflect the level of knowledge of the service by certain teams rather than true levels of need. However, due to Covid-19 there are new discharge arrangements (discussed further below) which will mean that WE Care will have a higher profile as key partner in the discharge process. This is likely to a further increase in referrals.

The need for expansion

The upward trend in caseload, the potential for many more cases to be referred if there was more time for promotional work, and the problems juggling the different demands on the technician's time, indicates that there is potentially a need to expand the service. The whole premise of Dolphin is that the Technician should not have a full diary but be able to be on stand-by to react to hospital demands. There may be scope to use the existing hospital discharge handypersons more flexibly to provide additional support. They have already started to increase their speed of response to meet Health and Social Care requirements.

[22] Mackintosh (2016) op cit.

Satisfaction with the Dolphin service

The evaluation did not involve interviews with patients themselves. It is difficult to interview people who have just returned from a stay in hospital and as most never meet the Dolphin technician they would have limited knowledge of the service. Dolphin is only one part of the discharge process and patients would not easily disentangle which service provided what.

However, WE Care does a regular survey of 20% of their handyperson customers to look at outcomes. The findings of the most recent survey in 2020 is shown in Table 2. The customers of hospital discharge services are more likely than general customers to say that the work helped with daily activities, made their homes warmer, safer and more secure, made it easier to get around and they feel less likely to fall. However, numbers were too small to extract Dolphin cases on their own.

Table 2 Customer satisfaction with WE Care hospital discharge services in Bristol

Percentage who said 'yes' to the following:	**All WE Care services**	**Hospital discharge services**
Work has helped me go about my daily activities safely and independently	96%	98%
Work has made it easier to get around*	54%	65%
Work has made home warmer, safer, more secure	82%	88%
Feel more confident as result of the work	86%	80%
Feel less likely to fall as a result of the work*	51%	58%
Total number of respondents	**244**	**52**

Note: percentages are for the whole sample

* Includes cases that are not applicable

It would be useful for WE Care to get more direct customer feedback about the Dolphin service as people are coming out of hospital to find their home has been changed. There is potential to work with Health and Social Care discharge teams and the Red Cross (which helps people settle at home after a stay in hospital) to collect information on customer satisfaction with all parts of the discharge process.

Financial benefits to health and care

All agencies like We Care suffer from the same problem. It is very difficult to accurately assess the savings they create for Health and Care. They are working in complex systems where they are only dealing with a small part of the discharge process. Even when work is done quickly, there are delays due to the patient's medical condition, or the need for care and support, that mean people do not get discharged immediately.

There are also difficulties in getting the data to acutely measure the impact. WE Care records information to manage its part of the process, but there is no access to data from Health and Social Care. Scheduled changes to the WE Care IT system in 2021 will allow each patient's NHS number to be added in the hope that in future there might be better data sharing. At present WE Care is not able to record the date of hospital discharge as this would require someone spending time chasing each individual referrer for the information. It is therefore very difficult to calculate if WE Care actions lead to fast discharge. In this evaluation we have used case studies to supply missing data and to make some conservative assumptions about potential cost savings:

- **Minimum level savings -** adding up the annual costs of service provision and dividing by the number of cases gives an average cost per case of just under £200 (total cost of running the service is £48,000 divided by 246 cases in the first year). The cost of a hospital bed in Bristol is about £400 per day.[23]

  If each case saved just one bed day this is a saving of £100,000 per year for Health and Social Care or £2 for every £1 invested. Feedback received by the Technician indicates that 2-3 bed days were saved per case, so savings could be considerably higher.

- **Savings from preventing the loss of big care packages** - the case studies indicate that by acting fast to make the home ready for discharge in three cases the Dolphin service prevented the loss of big care packages. This can save patients at least a further four weeks in hospital. Four weeks at £400 per day is a saving of just over £11,000 per person or £33,000 per year for all three cases. This excludes the cost of the mental and physical deterioration people experience while confined to a hospital bed in an unfamiliar place, which means that they may need extensive physiotherapy or will go into residential care.

- **Savings in health and care staff costs** - occupational therapists and social workers said that using the Dolphin service saved them around half a day of work time (about 4 hours) as it stops them having to visit the patient's home themselves. We do not know how many of these home visits are avoided. A conservative assumption might be that this happens in 50 cases per year. At an average cost of £50 per hour[24] this would result in a further saving of £10,000 per year.

- **Overall savings for Health and Social Care are likely to be £3 for every £1 invested.**

[23] NICE (2019) Supporting best patient outcomes through a joint Discharge to Assess, Home First service. https://www.nice.org.uk/sharedlearning/supporting-best-patient-outcomes-through-a-joint-discharge-to-access-home-first-service.

[24] Curtis, L. and Burns, A. (2019) Unit Costs of Health and Social Care 2019, PSSRU, University of Kent. https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2019/.

The discharge teams said that it was not just about cost, they could not do this work themselves. If they had to take on this work, it would use up so much of their time and would mean that they would not be able to deal with their own caseload. With the Dolphin service they have the reassurance that the work will be completed within a guaranteed timeframe.

> *"If there is one organisation we couldn't do without it is them - the whole hospital discharge handyperson service is so valuable."* UBHT Social Worker
>
> *"Don't know how you would get this work done without WE Care & Repair"* Occupational Therapist, South Bristol Community Hospital
>
> *"The service is much more valuable to the discharge team than the statistics suggest."* UBHT Social Worker

Lessons from elsewhere

There are a range of home from hospital services operating in different part of England and Wales.[25] A few have done evaluations of outcomes and calculated cost savings (more details and references are provided in Appendix B).

- The County Durham handyperson service estimated that every £1 invested provides £2.64 in costed benefits.
- A pilot project in Norfolk reduced the average length of stay in geriatric medicine beds by 50% and the overall length of stay by 42%. The project saved £77,000 over the pilot period. If offered seven days a week over a 12-month period it would generate a saving to the NHS of £330,000.
- Figures from an evaluation by Care & Repair Cymru of a winter pressures pilot service run by nine Care & Repair services across eleven hospitals in Wales gave a minimum ratio of £1 of investment to £2.80 in savings, but the potential preventative cost benefits could be as high as £4.50 for every £1 invested.
- Care & Repair Cymru Rapid Response Adaptation Programme helps over 16,000 people a year. Quicker hospital discharge is achieved in 30% of cases and it is estimated that £1 spent on Rapid Response saves £7.50 for health and social care.
- Bridgend Care & Repair operate a home from hospital service. They calculated a social return on investment for bed days saved of £5.50 per £1 invested.
- A review of research findings by Public Health England determined that £1.00 spent on home assessment and modification for people who have had at least one fall results in savings of £3.17 in health and care costs by reducing accident and emergency demands and hospital admissions. If quality of life gains for the individual are included savings are even greater (£7.34 per £1 spent).[26]

[25] Foundations and Housing LIN interactive map – https://www.housinglin.org.uk/home-from-hospital/.
[26] Public Health England (2018) A return on investment tool for the assessment of falls prevention programmes for older people living in the community. https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning.

- A series of hospital to home pilots in Wales showed that some of the strongest findings came from qualitative interviews with a range of NHS staff, strategic and operational partners, caseworkers and patients.[27] Services similar to those offered by WE Care reduced pressures on hospital staff, prevented blockages to provide better patient flow, and minimised re-admissions by returning people quickly to safe, warm homes.

The savings calculated by other studies are similar or higher to the ones presented in this report which should provide confidence in our estimates. Handyperson services that provide a rapid response all add value and provide vital support for health and care services across the country.

[27] Care & Repair Cymru (2019) Hospital to a Healthier Home, Cardiff: Care & Repair Cymru.

THE CHANGING CONTEXT

WE Care and the Dolphin service have faced some significant obstacles in the past year. The first relates to the way hospital discharge services are funded which affected service delivery late in 2019, and the second is the Covid-19 crisis of 2020.

Funding pressures

The running costs of the Bristol hospital discharge services (excluding Dolphin) are funded by Bristol City Council, but the general handyperson service available to the public is largely self-funded.

Funding for the hospital discharge service in 2019/20 (excluding Dolphin) was based on a completion target of 1,560 minor adaptations and 200 complex cases. However, due to demographic trends, increased awareness, and a high level of trust in the service, demand has increased year on year (Table 3).

Table 3 Increase in hospital discharge cases 2016/17 to 2019/20

	2016/17	2017/18	2018/19	2019/20
Total	1619	1693	2123	2500
Annual increase	-	+5%	+25%	+18%

Approaching the end of the third quarter of 2019/20 hospital discharge completions were already above target levels with several months to go before the end of the year. All the services had worked hard to reduce discharge times resulting in 15% of all jobs being completed in 24 hours and 22% in 48 hours. However, this impacted on the time that handypersons could devote to fee-paying work, undermining the financial viability of the whole WE Care service.

Very reluctantly, WE Care had to reduce the response time for hospital referrals until further funding could be found. They were able to obtain NHS winter pressures funding (£50,000) and social care funding (£24,000) for the period Jan-Mar 2020 to cover the additional work.

WE Care and Covid-19

Accelerating discharge from hospitals

The learning from the Dolphin project meant that WE Care was well prepared to help with hospital discharge during the Covid-19 pandemic. By mid-March 2020 they had set up rapid response teams able to deliver fast-track services across Bristol, BANES and Gloucestershire and they stock-piled vital materials, such as mopsticks, to ensure that they could keep working as building suppliers closed.

Government guidance just before the lockdown that began on 23rd March 2020 (guidance that was repeated in more detail as people started to go back to work in May) said that tradespeople could still carry out repair and maintenance work in people's homes as long as: the worker has no symptoms; they increase the frequency of hand washing and surface cleaning; they keep the activity time involved as short as possible, and keep two metres away from household members.[28]

Most WE Care work is for people aged over 70 who were advised to self-isolate. Hospital discharge patients are more likely to be 'extremely vulnerable' individuals who need to be shielded.[29] Government advice was that no work should be carried out in these people's homes, however, emergency repairs to remedy direct safety risks were allowed. This should have enabled the WE Care rapid response team to keep on working and they were included in the emergency discharge pathways set up for local hospitals.

National guidance set out hospital discharge service requirements that had to be adhered to from 19th March 2020. It was clear that the voluntary sector was to play a role:

> "*Many systems already work with the voluntary sector to facilitate swift and safe discharges. In the current situation immediate consideration should be given to increasing the capacity of these services*." [30]

This included mobilising quickly, focusing on safety and positive experiences for patients, and enabling patients to feel supported at home. The guidance also mentioned providing a range of practical support to facilitate rapid discharge, including transport home and equipment such as key safes.

However, the virus was spreading quickly, and the news was showing Italian hospitals being overwhelmed. Acute and community hospitals had to discharge all patients as soon as clinically safe to do so. The aim was to free up to at least 15,000 beds nationally by 27th March 2020 to provide space for the expected surge in Covid-19 cases.

Impact on WE Care and the Dolphin service

WE Care produced a poster and flyer for the wards and discharge hubs to make sure that staff were aware that fast track WE Care services were available to help with rapid discharge.

However, the predicted spike in activity WE Care was expecting did not materialise as there was only one week to clear UK hospitals. Younger patients were discharged

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[28] HM Government (May 2020) Working safely during COVID-19 in other people's homes: Guidance for employers, employees and the self-employed. https://assets.publishing.service.gov.uk/media/5eb967e286650c2791ec7100/working-safely-during-covid-19-other-peoples-homes-110520.pdf.

[29] https://digital.nhs.uk/coronavirus/shielded-patient-list

[30] HM Government (Mar 2020) COVID-19 Hospital Discharge Service Requirements, Section 7 What are the actions for the Voluntary Sector? https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874213/COVID-19_hospital_discharge_service_requirements.pdf.

home, but many older patients went into residential care. For those who went home, it was often easier to provide equipment than fit a grabrail. So instead of a surge of activity, the end of March was very quiet. A member of the Health and Social Care senior management team responsible for hospital discharge commented that:

> *"COVID19 was new for everyone. In the end the numbers first modelled by Public Health England and NHSE did not materialise, especially in the south west which fortunately so far has seen the smallest numbers as a population in the country. That said I do think opportunities were missed."* Health and Social Care Senior Manager

The Dolphin service and the 'new normal'

Since the first rush to clear hospitals WE Care hospital discharge services have returned to near normal levels. The Dolphin service recovered strongly. Handyperson cases rose to 40% above target in April which is consistent with typical performance. Complex case management referrals were at about two thirds of usual rate in April, but in May increased to about 13% above normal referral levels (56% above target).

There is a potentially large backlog of cases that need minor adaptations and other WE Care services:

- Many people needing medical attention have had operations or treatment delayed. Hospitals are gradually admitting new non-Covid patients, some of whom will need help when they return home.
- Many patients were discharged abruptly, and possibly prematurely, into care homes and some will now want to return home.
- Others discharged into the community with equipment will need more permanent solutions.
- There may also be demand from people who have had Covid-19. It has been more likely to affect older people. Some will have poor muscle strength and sub-optimal heart and lung functions. Predictions are that nationally 45% will need low level medical or social input for recovery, and a further 5% will require more intense, ongoing rehabilitation.[31] Some will therefore need minor adaptations or other changes to their home.

From now on stays in hospital are likely to be shorter and people will need to be discharged quickly. Many more may be treated at home to minimise the risk of infection. If this is the case, the rapid response developed by the Dolphin service may assume even greater importance.

A member of the Health and Social care senior management team said there was a lot of change very quickly to comply with NHS England's hospital discharge guidance. Over the coming months he thinks that there will be less hospital delays but more community delays until new ways of working get established.

[31] Morris, J and Murray, A. (May 2020) Managing a covid-19 rehabilitation surge, The BMJ Opinion. https://blogs.bmj.com/bmj/2020/05/15/managing-a-covid-19-rehabilitation-surge/.

> *"What's certain is we will not go back. Assessments will wherever avoidable not be taking place in hospital anymore, they will happen in the community following a step-down pathway."* (for step-down pathway see Figure 1) Health and Social Care Senior Manager

WE Care has develop local protocols for working in people's homes based on Public Health England guidelines, and staff have been provided with personal protective equipment (PPE). The protocols have been made available to staff in discharge teams so that they can have confidence in WE Care services. We Care is also communicating effectively with patients to reassure them that WE Care is following guidance about safe working practices in their homes.

Occupational therapists and social workers are following up with patients who were discharged to see what support they need. Some conditions of the Care Act have been eased temporarily.[32] There is now much more reliance on conducting remote assessments rather than occupational therapists, social workers and physiotherapists visiting homes.

The Dolphin Technician was proactive and rang occupational therapists to let them know he was still available. In most cases he is getting a full assessment before visiting the home to carry the work, but if he is the first person to visit the home, he may have to consult the occupational therapist once he gets there if the situation is more complex than anticipated.

New networks and ways of working

New communication networks have worked well through the crisis and will become 'business as usual'. WE Care is involved in the recently established Integrated Control Centre (ICC) which now controls the discharge process in Bristol. The Dolphin rapid response service is now recognised as being a key part of the wider discharge system.

The ICC will reduce, although not remove, the need to constantly promote the service. However, WE Care will still need to continue to raise awareness amongst Health and Care professionals because of the high number of individuals and teams involved and the regular turnover of staff in the wards.

Sirona, the community care provider for the whole BNSSG area, is now responsible for all supported discharges out of hospital. WE Care and Sirona need to review how referrals are working, what the needs are, and to have formal processes to maximise what WE Care can deliver.

The other key voluntary organisation working in hospital discharge is the British Red Cross which runs assisted discharge services for Bristol Royal Infirmary and the North Bristol Trust. They take patients without family support home from hospital and get shopping and prescriptions for a period when they are back at home. WE Care is aiming to work more closely with the Red Cross and the ICC to ensure that the services

[32] Mandelstam, M. (2020) Coronavirus, social care, law and Occupational Therapists: a briefing note https://www.inclusion.me.uk/files/Briefing_Note.Coronavirus.Care_Act.OTs.30.4.20_V2_with_Forward_Final.pdf

provided by the voluntary sector are properly embedded in the new hospital discharge process.

The Health and Care service is having to adapt to a new normal of treating Covid-19 patients whilst maintaining other NHS services which were suspended in recent months. The huge backlog in elective surgery will ensure that rapid hospital discharge will remain a priority for the future and the Dolphin service will play an important role. Further monitoring of the Dolphin service is required to see how caseloads develop as hospitals return to more typical admittance and discharge patterns.

National and regional awareness of the service

The WE Care hospital discharge services are becoming better known and getting both local and national recognition:

- The Complex Casework Service was included as an example of emerging best practice in the Local Government Association High Impact Changes Model.
- The Ministry of Housing, Communities and Local Government policy team visited We Care in December 2019 to learn about the role of housing in hospital discharge and the Dolphin fast track service.
- We Care were invited to present the hospital discharge models, including the Dolphin fast track service, at an event run by King's College London in January 2020.
- The following month the home from hospital and Dolphin fast track services were presented to the NHS Urgent Care Oversight Board for inclusion in Winter Pressures recommendations for 2020/21.
- Finally, the learning from the Dolphin project allowed a similar service to be developed in Bath and North East Somerset to respond fast to the Covid-19 crisis when hospitals had to be cleared.

Services that help with fast discharge are becoming established across the country. WE Care and Dolphin are providing a blueprint for how these can effectively support Health and Social Care and provide patients with a safe route back to independent living in their own homes.

CONCLUSIONS AND RECOMMENDATIONS

The evaluation of the Dolphin service has shown that the specialised, rapid response handyperson service is valued by social workers and occupational therapists and that it saves health and care services time and money. The evaluation had four main aims - to demonstrate whether the service:

1. **Decreases the amount of time that patients assessed as medically fit for discharge wait to return home** - most work is grab rails, stair rails (mopsticks) and keysafes. In the majority of cases discharge staff said that patients would not have been allowed home without the work being completed. The service was able to do a third of jobs in 24 hours and the indication from the case studies is that even when work took longer it decreased the length of stay overall. It produced a substantial saving in bed days of up to several weeks in a small proportion of cases where large home care packages had been commissioned, and where delay would have resulted in the packages being lost. Overall savings to Health and Social Care services are at least £2 for each £1 invested and could be as much as £3.
2. **Allows care to take place in the home** - keysafes allowed access to the home for carers, and internal work such as rails supported reablement, care services and family carers. Health and care staff said that in most cases where people were either successfully discharged or helped to remain at home, the work completed allowed reablement or care to take place.
3. **Reduces preventable hospital admissions/re-admissions** - This is very difficult to assess as there are so many factors involved. It would be very hard for WE Care to determine this from the data they hold as they do not follow up on patient's later progress. It is only possible to obtain this information from case studies. Two stroke patients were enabled to remain safely at home. In another case where someone was re-admitted the work completed enabled them to be discharged quickly because the home had already been made safe. However, several of the case study patients in this evaluation returned to hospital due to a deterioration in their condition or a fall. Whether the work done by Dolphin prevented any others returning is very hard to know.
4. **Requires further resources to meet demand -** the findings showed that prior to the Covid-19 crisis the service was beginning to reach capacity. The service exceeded the original target with 461 jobs completed compared to a target of 440. By the last quarter of 2020/21 the Dolphin service was completing almost 80 cases per month. There is scope to use the existing hospital discharge handypersons to provide support. They were already starting to offer faster services and during the Covid-19 crisis learning from Dolphin has permeated the whole service. However, the Dolphin service needs secure funding for the next two years.

Under normal circumstances it takes more than a year for a new service to become established. However, this has not been a normal year. The Covid-19 crisis is still not over and social distancing and restrictions on movement may remain in place for many months to come. It is a period of immense change in the way Health and Care services are delivered. There is also a huge backlog of elective surgery and a need to ensure that more people are on a fast track discharge pathway to minimise cross-infection.

The new Integrated Control Centre in Bristol, better communication networks and close working with Sirona and the Red Cross means that We Care is on course to become a key partner in the hospital discharge process in Bristol. The Dolphin service has demonstrated that an effective fast track service can be delivered. It now needs on-going support so that it can reach its full potential.

Recommendations to increase impact

Any new service takes time to become established, but it is particularly difficult in complex systems such as hospital discharge where there are numerous staff, wards, and discharge hubs involved in the process. The Covid-19 pandemic has introduced changes to the discharge system in which the voluntary sector is more firmly involved, but this is still evolving:

1. For the Dolphin service to receive funding over a longer period, ideally three years, to allow it to become fully established as a key part of the Bristol hospital discharge system.
2. That the capacity of the Dolphin service is looked at once a more settled pattern of hospital discharge has been re-established – this may involve using the existing hospital discharge handypersons in a more flexible way to provide support.
3. Continue to develop the relationship with the Integrated Control Centre and Sirona, the community care provider, to ensure that the referral process works effectively.
4. Broaden and deepen the relationship with the Red Cross, the other main provider of hospital discharge services from the VCSE sector.
5. When the WE Care IT management system is upgraded ensure that the NHS number and dates of hospital admission and discharge are included to be able to better evaluate the impact of all WE Care hospital discharge services, including Dolphin. It is also important that staff can easily input data remotely.
6. Continue to review and streamline the WE Care internal referral communication pathway to ensure that referrals are dealt with effectively by the most appropriate person
7. Work with the Health and Social Care discharge teams to collect information on customer satisfaction with all parts of the discharge process, including the Dolphin service.

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APPENDIX A

Evaluation methods

Data from the WE Care case management system

The main source of information was the WE Care case management system. Spreadsheets were provided for the consultants that covered all hospital discharge work, but to ensure anonymity no names or addresses were included. The Dolphin cases and other work done by the Dolphin technicians were extracted from the files. However, the case management system has limitations for evaluation as it was set up for management purposes prior to the development of the home from hospital services. It does not record information about hospital discharge and because the system does not include the client's NHS number it is hard to link WE Care data to health data.

Case study interviews - Phase 1

These were designed to obtain more detailed information about the type of patients helped and whether the rapid service improved discharge times and allowed care in the home. In the early autumn of 2019, a random selection of cases was obtained, and interviews set up with the referrers in the hospital discharge teams. At that point, the service had been running for six months and most staff had only dealt with the occasional Dolphin case. Staff refer on to a range of WE Care services and they found it hard to differentiate between them. They also found it hard to recall individual cases, particularly if they were not recent. Looking cases up on hospital IT systems was hampered by the fact that details are archived a certain time after patients have returned home. We obtained general feedback about the Dolphin service from specific referrers but few details about individual patients and the work done to their homes.

Case study interviews with frequent referrers - Phase 2

By early 2020 it was apparent that a few staff were making a significant proportion of all referrals. A list of recent cases was selected, and interviews carried out with these individuals in hospitals and clinics to go through a standard set of questions (see below). This allowed the collection of more detailed information for 18 anonymised cases on the reasons for their hospital stay, referral to the Dolphin service, the impact of the work carried out on discharge and subsequent care, the timing of discharge, whether the person was subsequently re-admitted and what the referrer thought of the service. We intended to complete further interviews to get data on more cases, but this was curtailed by the pandemic.

Interviews with WE Care staff

This allowed further information to be collected about the progress of the service at intervals throughout the period Apr 2019 – June 2020. The evaluators also went out in the van with the technician. Further visits were planned at the end of the project, but these were also hampered by the pandemic. Instead telephone interviews were conducted with the lead Dolphin technician, his line manager and senior WE care staff to get their views on how the service had developed over the first year.

Case study interviews – Phase 2 Feb/Mar 2020

Interviewee:

Team/location:

Date of interview:

Case number: **Gender:** **Age:**

Stage	Key dates	Notes
Pre-admission - what was the patients state of health and wellbeing prior to admission (if known)?		
Admission - tell us about the reason for admission and the patient's state at that time?	Date of admission:	
Hospital stay - what happened during the patient's stay in hospital? Did their mobility/ability to manage their own personal care change?		
Pre-discharge - were there any factors which prevented a timely discharge from hospital e.g. medical fitness, availability of care or need for minor adaptations?		
Use of WECHI handyperson - how did the service help – what work was needed?		
Completion - did WECHI let you know the work was completed?		
Discharge – how soon after you heard the work was done was the patient discharged?	Date of discharge:	
Outcomes - would the patient have returned home without the handyperson work being completed?		
Care at home – did the work done allow care to be provided at home?		
Bed days saved - please estimate the number of additional days the patient might have spent in hospital?		
Home - what feedback did you have about the patient following their return home?		
Re-admission Has the patient subsequently been re-admitted? Why did this happen?	Date of re-admission:	
Any other comments		

APPENDIX B

Home from hospital services operating elsewhere

ENGLAND
45% of home improvement agencies (HIAs) provide services to support timely discharge from hospital.[33]

Manchester Care & Repair, in addition to providing one of the largest handyperson services in England (which is provided free apart from the cost of materials), it provides services to support disabled and vulnerable residents with health-related housing needs:[34]

- **Home from Hospital service** funded by NHS Manchester CCG and the city council offers help to all people over 60 discharged from the three main hospitals in Manchester. Dedicated staff telephone to offer a free handyperson service or a home visit from a caseworker - advice, help with benefits, home safety, falls prevention or home repairs.
- **Enhanced Home from Hospital service** at North Manchester General and Manchester Royal Infirmary operates seven days a week to escort vulnerable patients home and settle them in. They can access emergency grants to reduce falls risks and for cleaning, boiler/heating/hot water repairs, or for essential items such as new appliances. Aim is to keep people safe at home, prevent a decline in health and reduce risk of readmission.
- **Home Health Checks** - to deal with repairs, damp, heating, safety and security. Fast, simple application process for a grant or interest-free loan.

County Durham Handyperson Service has supported over 77,710 customers and delivered over 136,000 tasks over ten years of operation. They estimate that every £1 invested in their service provides £2.64 in costed benefits - equates to over £1m of savings for health and care.[35]

Middlesbrough Staying Put hospital service - an officer is based in the hospital who can be contacted by any of the teams or direct by a patient, their carer or advocate. They offer help with telecare, assistive technology, minor and major adaptations, falls prevention and winter warmth. Any housing interventions are recorded on the patient's hospital electronic notes and through a case note on the social care screen. Discharge to home is faster because a patient's needs are identified sooner. They offer a follow-on service to see how well people are coping once back home and whether there are outstanding housing needs.[36]

Norfolk - large rural county, offers a rapid discharge service. Pilot 2017/18 five district council officers co-located in the integrated hospital hub, had access to hospital information systems and worked directly with patients. Supported 106 patients, 75% 60+, 170 jobs, bed days reduced by 386 - saving £77,000 over the pilot period. Over 12 months on a seven-day week basis would lead to savings of £330,000 for the NHS. It halved average length of stay in geriatric medicine beds and overall average length of stay for all assisted patients by 42%.[37]

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[33] Foundations (2019) Handyperson Services: Defining the added value, Glossop: Foundations. https://www.foundations.uk.com/media/6258/20191223-handypersonservicesreport.pdf.
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Peabody, Kent - **Health and Housing Co-ordinator** based in the Integrated Discharge Team in Tunbridge Wells Hospital. The introduction of the service was monitored for a year. The co-ordinator promoted the service across the hospital, spoke to patients, assessed the home pre- or post-discharge and liaised with handypersons to deliver the work. The pilot showed a decline in delayed discharge in that part of Kent compared to a control area without a similar type of scheme. Service funding was provided by the Better Care Fund DFG budget.[38]

WALES

Care & Repair Cymru Rapid Response Adaptation Programme – first developed in 2002/3 and now delivered across Wales. It helps over 16,000 people a year. Quicker hospital discharge is achieved in 30% of cases and it is estimated that £1 spent on Rapid Response saves £7.50 for health and social care budgets.[39]

Bridgend County Care & Repair Hospital to Home service – this has operated out of the Princess of Wales Hospital since 2014 and now offers a comprehensive 5-day week service. The return on investment for bed days saved is £5.50 per £1 invested and it is estimated to deliver a total social return on investment per patient discharged of £9 per £1 invested.[40]

Hospital to a Healthier Home pilot - ran from Jan-Mar 2019 in 11 hospitals and delivered by staff from nine Care & Repair services who were based with hospital discharge teams. A total of 626 patients were referred and 508 were helped to make their homes safer and more accessible. The service generated a return of £2.80 for every £1 invested (both revenue and capital). NHS discharge teams interviewed felt the service was of significant benefit.[41]

[38] Adams, S. and Hodges, M. (2019) West Kent Hospital Discharge Scheme – a council, independent agency and NHS Trust partnership. https://www.ageing-better.org.uk/sites/default/files/2018-10/West-Kent-Hospital-Discharge-Scheme-profile.pdf.

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