

A background image showing two women. On the left, an older woman with short white hair and glasses is smiling. On the right, a younger woman with dark hair and glasses is looking down, focused on a task. They appear to be in a workshop or classroom setting.

The role of housing in effective hospital discharge

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Introduction

Housing services have an important role to play in supporting the health and wellbeing of the population. In partnership with social care and health services, housing services are constantly adapting their offer to best meet the needs of local populations.

Housing is offering valuable solutions in both hospital discharge and the prevention of admission to hospital. Delays in discharging patients ([known as 'delayed transfers of care'](#)) is one of the factors that drives up hospital bed occupancy rates, preventing beds being freed up for those who need to be admitted, and adding to pressures on A&E departments.

The number of delayed transfers of care was relatively stable until the start of 2014/15 but since then the total number of delayed days has increased by 33%, reaching their highest point since 2008. There was a particularly steep increase in 2015, with delayed days rising 12% (equivalent to 16,030 extra delayed days) between April and December (see [Kings Fund](#)).

Housing providers have the potential to play a major role in helping people to get home with the support they need.

These case studies have been collected from a wide range of housing providers who have shared their experiences of developing hospital discharge services. The purpose is to demonstrate the partnerships that have been developed to meet hospital discharge needs, the incentives for partners, and the workforce skills and challenges required to ensure effective services. This resource is designed to:

- Stimulate conversations, both internally within organisations and with local partners
- Demonstrate and evidence effective partnership working and the process of developing it
- Show how working in this way can meet partners' targets.

The previous resource, [Hospital2Home](#) is a valuable multi agency toolkit to supporting effective services. This publication is intended to complement and support that toolkit, by providing examples of effective

joint working. This publication also supports the [Memorandum of Understanding](#) to support joint action on improving health through the home. Housing leaders agreed this memorandum of understanding with the Department of Health, the Department of Communities and Local Government, NHS England and Public Health England, along with other partners to establish the principles and purposes behind more integrated working.

This publication is useful for:

- Commissioners (social care and health commissioners)
- Providers of housing and support (local authorities arm's length management organisations, housing associations)
- Directors of care and support within the above organisations
- Workforce development leads within social care, health and housing provider organisations

Key Learning Points

Although the case studies included here are from a diverse range of housing providers and offer different approaches in terms of scale and offer, there are some common points across all case studies that are worthy of note. These can be seen as 'key learning points' for any service or partnership looking to develop or invest in hospital discharge services. These are:

1. Recognise and understand different working cultures

Many of the case studies highlight the time taken to understand each partner's differing sets of priorities and ways of working. Some examples, such as Heatherstones, embed close working relationships with health colleagues within their service model, which enables this better understanding to develop. It is therefore essential to take time to understand partners' language and culture and to develop relationships of openness and trust from the outset.

2. Build lasting relationships

All of the case studies were clear on the importance of strong relationships. In some cases, services had only been 'piloted' because of an existing relationship between partners (and individuals with some influence within those organisations). For commissioners, this means seeking out and developing relationships with potential partners or allowing this networking to become part of commissioning requirements for local services. Housing providers will need to seek out relationships and nurture these, aiming to be seen as an important potential supplier of housing and community support.

3. Enable effective and safe communication of information between agencies for the benefit of the individual

To allow safe and speedy responses to pressing needs such as hospital discharge, information must be shared in a secure and appropriate manner. In some of the case studies, time was needed to overcome barriers to sharing information, and protocols that can support this are necessary. Senior managers locally can best support such projects through the development of protocols and systems to enable information sharing. Managers and commissioners should work together to ensure that employees are sufficiently trained and have the skills to do this safely and in compliance with

legal requirements. Shared training on data protection, as part of developing a jointly agreed protocol, can underpin effective relationship building and effective operation of the scheme. It can also provide the ground work for further work to develop other shared services.

4. Sustainable and long term investment/provision

Housing organisations are facing new pressures on their supported housing schemes (often the place in which many of these schemes operate) due to the changes to the funding framework announced by government. It is currently under development and will be in place from 2019/20. The pressures on all partners will require them to be aware of the funding restrictions on all sides, and to look at how to move money within the system and amongst partners to build and sustain services such as the case studies here.

5. Building a person centred solution using complementary expertise and networks

The case studies demonstrate the value of a multi partner team focused on person centred solutions to achieve a successful outcome for the individual. Timely and successful transfer of care is dependent on the right clinical decision making but also on the connection with the right housing, support and community solutions. That might include professional re-ablement services, designed to help people to recover their capacity and skills of self-care and independence, but also helping people to identify and connect with more informal, social support networks which they may already have, or that they might need help to reconnect with. For example; in one case study, the transfer of care included helping the person to move area to be nearer to family. Many of the case studies emphasise the importance of re-ablement skills as key to the successful move-on from the service, where the focus is not on 'doing for' but helping people to regain independence and skills to care for themselves. The importance of training employees to have the skills, knowledge and behaviours to support that is a key element in many of these studies.

Calderdale Council, Heatherstones Court

Background to the service

Heatherstones Court is a complex of 12 apartments for adults of any age, who are either being discharged from hospital or who need to vacate their property temporarily. It provides bespoke, short term accommodation, enabling support to clients (called 'guests') to help them to regain their independence and skills.

There are twelve apartments, three of which have shared kitchen and living areas with lockable bathrooms and bedrooms. Heatherstones is designed to facilitate hospital discharges, where people need a bit more time to regain skills and confidence. It was a site that was owned by the NHS (previously hospital staff accommodation) that had been empty for quite a long time. Connect Housing bought the land and housing, and Calderdale Council and the local NHS Trust worked with them to refurbish the apartments. It is a stand-alone project but it links to the re-ablement services within the council. There is a social worker attached to the project, as well as a physiotherapist and occupational therapist who work most days of the week. There is a 'healthy living facilitator' who also helps with specialised exercise programmes. Clients get physiotherapy on site and an occupational assessment for equipment etc. Multi-disciplinary team meetings take place every week, so there is on-going involvement from social care too.

The aim of the service

The scheme aims to achieve a homely environment where people have the right support to enable them to regain the skills they need to live in their own homes. Staff have the time to spend with people, encouraging and supporting them, whereas traditional home care services may not. The support is on site but not 24 hours; it tries to replicate what someone might have in their own home. Currently it is available 8am-1pm and 4.45pm-9.45pm but this is flexible, depending on client needs. The service is designed for people to stay a maximum of 6 weeks, although people generally remain for 2 or 3 months.

What was the approach?

All referrals to Heatherstones come through the council's Gateway to Care system. Whether someone is in hospital or the community, the social worker will assess and then refer the person to Gateway to Care who will then make a triage assessment and send it through to the team at Heatherstones. Some come direct through the social worker if they are living in the community. The physiotherapist alerts staff on hospital wards to the service.

The ethos is not about 'going in and doing for' but about encouraging and supporting people to do more for themselves, which is now embedded within the staff team. There are multi-disciplinary team meetings to review progress of clients which helps staff to focus on making progress to independence. The involvement of the physiotherapist and occupational therapist helps with that focus. There are seven re-ablement support assistants, two come from a traditional home care background and the others have experience in housing, end of life care and dementia care.

Calderdale Council has a comprehensive induction and training which gives a very good grounding of what is expected before they do the job. Having re-ablement staff out in the community already meant that it didn't require a new job profile or training plan. Further person-centred training is planned, to ensure staff record and evidence the approach (this is being taken forward through Skills for Care's registered managers' network).

The importance of a consistent system of communication and information sharing has been highlighted because of the difficulties experienced by the team, coming from two different services (both health and social care).



What has been achieved?

It stops people deteriorating further from a long wait in hospital while waiting for a package of home care, losing the skills they had. It has reduced re-admissions from others being discharged too soon. The person coming to Heatherstones must want to engage, want to improve and get better.

What has been learnt?

There is a thorough and robust training plan and interview and recruitment programme. Further work to develop more about the re-ablement side of the work is required to reinforce the enabling focus of the role. The multi-disciplinary team really works - all are clear that, regardless of the different employers, there is a common goal of re-abling the guests.

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First Choice Homes Oldham (FCHO), Hospital2home home support and outreach service

Background to the service

The project works within the devolution agenda and agreement in Greater Manchester and builds on existing partnerships in place. At the Greater Manchester level, three specific areas were identified where it could be demonstrated that housing interventions brought improved results for health, the aim is to now roll these out across all boroughs. The projects are:

- Warm Homes (building on the existing and successful Warm Homes Oldham partnership between housing providers, the council and Oldham clinical commissioning group to take private sector owners and tenants out of fuel poverty using a payment by results model)
- Hospital discharge schemes
- Housing options for older people services.

As a member of the Oldham Health and Wellbeing Board, FCHO was keen to identify more projects which could provide a clear offer for health partners at the borough level. It worked with CIH consultancy to develop this offer around areas where they could reduce demand for and costs of health interventions. Help to speed up the discharge of people from hospital when they were ready to leave but unable to because of housing issues was an obvious opportunity.

The aim of the service

Discussions with the local clinical commissioning group, Royal Oldham Hospital, the council and Care Trust highlighted that delayed hospital discharge and the rate of hospital re-admissions was a significant problem. This was leading to many high cost unnecessary delayed and preventable hospitalisations. Housing related causes were significant in triggering this, for example the need for rehousing, minor repairs and adaptations and clearing properties where people hoarded.

However, FCHO and other housing partners already have services that could provide solutions for these problems, e.g. repairs and handypersons services, trusted assessors and independent living officers, minor adaptations services, caretaking etc.

The pilot project was therefore aimed at ensuring early identification and coordination of these services as appropriate to the individual patient, to support an early and effective discharge from hospital.

What was the approach?

FCHO has funded and employed one full time equivalent post specifically to provide a Hospital2Home (H2H) service for an 18 month period. The timing for the pilot project was helpful – a new integrated discharge team was being established at Royal Oldham Hospital and the FCHO H2H worker is now part of this team, working to a new post of integrated hospital discharge coordinator (who is employed by the Care Trust, based at the hospital and managed by the council). The team also works across care homes looking at how to support people in 'step down' beds so that they are also able to return home successfully.

The H2H support worker is the single point of contact and advice for all housing related discharge referrals and works in partnership with hospital staff to:

- Undertake a face-to-face assessment to determine if the patient's home is fit for return (across all tenures)
- Act as the housing key worker for those referrals to deliver the discharge plans and provide continuity of contact for, and progress updates to, the referral agency, customer and their families, as well as the integrated discharge coordinator
- Obtain consent for a H2H survey to assess housing conditions where necessary
- Agree a schedule of actions with agreement of patient and identify appropriate funding sources (where in private sector)
- Commission and oversee repairs / adaptations etc. with patient's consent
- Commission FCHO and other social housing providers to deliver the agreed interventions within agreed deadlines for their tenants – emergency within 24 hours, urgent within three working days

- Coordinate and liaise with Oldham Council where care services are required to initiate these in a timely manner.

After the discharge from hospital they will also:

- Visit the customer in their home to reassess their housing and support needs
- Liaise with GP/community services to monitor progress
- Raise any safeguarding or other concerns.

Services available to commission include:

- Housing options and advice services including welfare, debt and legal advice
- StayWell at Home including support with medical appointments, falls prevention etc.
- Community development and support services, including addressing loneliness and social isolation, healthy eating, exercise
- Warm and Well, including Warm Homes Oldham, energy efficiency, etc.
- Accessible homes, home security, assistive technology, hazard assessment
- Home repairs including referrals to handy person service.



What has been achieved?

The project has taken a managed approach to building up the case load. For the first three months, it focused on FCHO tenants and homeless people and then expanded to other social landlords over the following three months. There after it included people living in the private sector although to date that has largely been focused around people who need to access alternative suitable homes (i.e. housing options support)

The first three months also included work to raise awareness of the officer's role and to market the service with hospital, care home and social care colleagues. Service standards were developed and agreed with partners and other housing providers, and processes piloted. Work to develop an outcome framework and targets began, which is being completed as more is learnt. In the first six months thirty patients have been supported to return successfully to their home from hospital or from a "step down" care home and back to independent living. Five of these have been rehoused to more suitable homes (including adapted homes) thus helping to prevent early re-admission. There were also two further homeless preventions completed in this first six month period. Currently, a further ten customers are being helped to secure more appropriate longer term accommodation (e.g. sheltered and /or adapted) to help prevent falls and hospital readmission.

A further six patients are currently being supported to be discharged and return home to independent living.

Of the cases so far supported:

- 52% are older people requiring assistance to return home
- 7% have required help as a result of poor property conditions
- 19% have had mental health issues
- 3% have drug and /or alcohol dependency issues for which they have required support
- 13% have required rehousing
- 56% have been social housing tenants

- 9% owner-occupiers
- 19% private rented
- 16% homeless / no fixed abode
- 73% have been in hospital and 27% in care homes

An independent evaluation of the project and its outcomes will be undertaken to report back on the first year of the service and start to consider longer term proposals for the future of the service with partners.

What has been learnt?

The level of understanding of housing providers and what they could do to help was low, so a lot of the initial process was to raise this level of understanding amongst health staff. Flyers were produced and the post holder spent a lot of time 'walking the wards' and linking with the four care homes, to build up understanding and relationships. Learning the language and using the right terms is important to build those bridges.

The person appointed to the post was from the independent living team, so was used to finding solutions to support people. They also had lots of experience working with occupational therapists so that helped the transition. But it was also important that the person should be confident and an effective communicator, as they were the only housing staff member within the wider multi-disciplinary team.

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Home Group bed management and discharge facilitations scheme

Background to the service

Many of the difficulties of successful discharge from hospital for people with mental health problems are not due to medical/clinical issues but problems of homelessness or an unsuitable home environment for people to return to, and financial insecurity impacting on the security of the home.

Failure to address these issues can affect the success of the discharge, often being a trigger for further episodes of ill health. Failure to discharge people in a timely way can also impact on the overall, long term success of their treatment.

The aim of the service

The Norfolk and Suffolk NHS Trust commissioned Home Group to develop a team to work within the Bed Management and Discharge Facilitation Team, alongside clinical staff in three hospitals, to resolve the social care and community focused issues around the discharge of patients from mental health wards, to enable the trust to reduce the length of bed stays and operate more efficiently to save money, as well as ensuring more successful outcomes for the individuals concerned.

What was the approach?

The Discharge Facilitation Team has consisted of three Discharge Coordinators, one in each of the three hospitals across the Norfolk and Suffolk NHS Trust since 2012. It has recently increased this number to four discharge coordinators. The staff work in a care, support and recovery model, not a clinical model, which is important to build trust with patients as the discharge coordinators are not involved in decisions about medication, refusal of discharge / restraint etc.

The Discharge Facilitator works with the teams of clinical staff to identify the people that need additional housing and other community-focused help to ensure a timely and successful discharge. Staff attend weekly team meetings on the wards to identify who needs help and at what time, and they also conduct face to face interviews to assess the issues that may block the patient's discharge from hospital.

The point at which the discharge coordinator becomes

involved will vary according to the circumstances of the admission. In the case of a crisis triggering admission, they may work with them from the point of admission to tackle the trigger issue, or they might get involved at a later stage after a significant period of treatment when the individual's health is stable and they can look at planning to leave.

The staff provide a bridge for the individual between the hospital and community environments. Interventions include:

- Accompanying clients to view a potential new home
- Arranging measures to tackle problems in the client's existing home
- Supporting people to establish their financial matters, such as applying for benefits, setting up bank accounts; etc.
- Supporting families to be prepared as well as the individual themselves for their discharge.

The team also support many clients who are without access to public funds. This involves a very complex process, liaising with the Home Office either to support individuals to remain in the country or have a safe return journey to their native home with continued clinical care. These individuals are often very costly for the trust because of the complexity of their needs.

What has been achieved?

Within the first six months of operation, the team had saved the hospitals the annual cost of the contract (£96,000) through reduced length of stay. On one 24-bed ward, the team achieved an average 16.25 reduction in bed stay nights. Within six months of 2016, the team supported 28 people to have a timely and successful discharge from hospital.

Discharge can be back to the person's original home, with measures taken to make it suitable when needed e.g. handyperson minor repairs, security measures, or it can be delivered into a new home if they have previously been homeless, including into supported housing where appropriate.

The contract has recently adopted the [Warwick-Edinburgh wellbeing](#) scale to track quality of life and outcomes for the people they support and early results demonstrate significant impacts e.g. 107 per cent increase in patients feeling optimistic about the future and 138 per cent increase in feeling they have been dealing with problems well.

The team has enabled further services to develop that also provide support to people in mental health crisis, for example a treatment team which can step in to help people when issues arise that might otherwise trigger a crisis in their health, and therefore a potential emergency admission to hospital. Such triggers are often not medical but related to anxiety over debt, finances, etc.

What has been learnt?

As the contract was initially (and technically remains) a pilot, all staff were seconded from existing Home Group services and continue to have a substantive post to which they can return. However, many have continued in the discharge team in spite of the ongoing rolling contract (being renewed every six months).

All of the team members have come from other contracts that involved working with people with mental health issues or other complex situations e.g. a family intervention project. The staff therefore already had experience of multi-agency working, and many had experience of engagement with health professionals.

Given the environment in which they operate, it was important that staff could demonstrate their awareness of and compliance with health service requirements for information security and data governance, safeguarding, etc. The staff also needed to be assertive, to ensure that their own expertise and professionalism could be understood within a clinically/medically focused environment.

Resilience, lateral thinking and problem solving are key attributes for all of the staff delivering the contract.





Kettering Borough Council hospital discharge pilot project

Background to the service

A six month pilot between Kettering Borough Council, Kettering General Hospital NHS Foundation Trust and Northamptonshire Healthcare NHS Foundation Trust has been developed to:

- Provide better outcomes for individuals by providing housing solutions where possible
- Measure the level of housing issues in delayed hospital discharge
- Demonstrate the benefits of investing in housing solutions as part of the discharge process

The development of the pilot project was generated from a meeting of strategic leads in health and housing staff to look at how they can work together and what shared outcomes they wanted to achieve. Three key objectives were identified:

- To support residents to improve health and wellbeing through homes and communities
- To identify and support residents at risk of poor health and wellbeing within communities
- To facilitate discharge from mental health, community and acute hospital services into safe and suitable home environments

The aim of the service

There was an understanding amongst the housing and health leads at the meeting that the home environment was a key factor in delaying some individuals' timely and successful discharge from hospital, but evidence was not available to substantiate and measure the impacts of that.

So the pilot has also been developed to help the three partners measure and evidence the impact of housing issues in supporting effective discharge, in order to support a long term investment into a permanent service.

What was the approach?

The pilot project is in the early stages of development. It is building on an earlier agreed process of linking housing into hospital teams, where housing options staff have been available to link with hospital tracking teams (looking at getting people ready for discharge).

The project team plans to increase awareness about the contribution of the home and social interventions in enabling a successful discharge. The pilot project, with a member of the housing team located within and working as part of the hospitals, will make building relationships and understanding of how the right home can help discharge, an easier process.

A member of the housing options team will be seconded to work across the hospital and community services to identify people where their housing issues are part of the problem to be addressed to support a safe discharge.

All partners have recognised the value of this pilot and will be providing resources for the pilot project to enable the secondment to take place for six months.

What has been learnt?

It was really important to use an existing member of the housing team as they were aware of the local landscape and can link into the right services as quickly as possible. There is an awareness that there will be a learning curve in terms of supporting that staff member to develop the relationships and to help health partners to understand the role housing can play.

Gathering the evidence and being able to demonstrate the cost benefits from the pilot is critical to winning longer term funding from health partners for a permanent role, but their willingness to fund the pilot is an indicator of the base from which the project can build.

They hope that it will also enable more focused 'upstream' approach, identifying housing issues in the admission process as soon as possible.

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Kirklees Council, Home from Home

Background to the service

The Home from Home (HfH) service provides seven accessible flats as temporary accommodation for people awaiting hospital discharge whilst adaptations or other changes are made to their permanent accommodation. The comparison of the costs of residential care compared with a flat that is adapted is stark - the flat is a lot cheaper and the individual will also pay a contribution (often via housing benefit). In addition the person will contribute to their care package as they would in their own home.

The clinical commissioning group (CCG) and both health trusts were supportive of the HfH service development. They supported it financially in the first year and now the local authority funds it. The goal was to avoid people going into residential care and this linked into some of council's performance indicators (e.g. 90 days remaining at home after discharge, reducing delayed transfer of care). In addition, those taking up a residential placement were deteriorating in that setting and to ensure their independence was maintained was a priority, otherwise there was a risk that some could lose their independence altogether. This could mean that they never got back home or ended up having to rely on larger care packages than would have been needed at the point of discharge from hospital.

The aim of the service

The HfH flats are in extra care, retirement living and the independent sector. It has been designed like this so that people under the age of 60 who didn't want or warrant going into a residential care home had more options. Prior to the HfH scheme, a residential care home was all that was available to them. The service has a range of accommodation including two bedroomed properties as relocation of the patient could also mean family members as well.

The flats are owned by housing associations and Kirklees Neighbourhood Housing. The extra care homes are owned and run by a housing association, with the local authority having allocation rights. The care and support is offered on site which means that

the discharge can happen quite rapidly. The other properties in the scheme have care and support as needed from the authority's usual home care providers. The service is more focused on the properties than support as in some cases the people need accommodation but not necessarily a traditional care package.

What was the approach?

The service is about supporting people and moving them on, not about them staying in temporary accommodation. In this service, clients have an allocated worker who helps them look at housing options if they can't go back to their own home, for example; helping them bid for properties.

There are community support and assessment officers in the authority, performing similar work to social workers (assessments, care packages). Two of these officers work in the HfH service, overseeing all of the HfH and extra care properties (about 200 properties). They assess people for HfH and extra care and work across housing and social care. Over the last three years, the people in these roles have developed their knowledge around housing issues by working closely with housing partners. They have received training around housing issues, for example; how to bid for properties and how to help people to apply for housing benefit. Training has been provided by our housing partners on understanding the housing register and the 'choose and move' process. There was an impact on the workforce as they needed to work differently. This wasn't initially well received but when they saw it in practice and what it was offering their clients, they were happy. It is now a role that staff enjoy, so there is no difficulty in recruiting or retaining people in these roles.

What has been achieved?

The most effective part is that people aren't trapped in hospital or residential care. They can also be offered the re-ablement service to boost their independence. It has benefited the retirement housing service. Once they experience these schemes through the HfH offer, many like the environment and opportunities for social activities and look to be rehoused.

What has been learnt?

Initially the scheme was not well resourced in terms of coordination, which created a cost that was not envisaged, as the turnaround of the empty properties was quite poor. Once this was addressed, by incorporating it into the role of the extra care housing assessor's role, the void turnaround improved and is now better than predicted.

The implementation was intense for all partners, as this was a new way of working and a new service. There was no model or example operating elsewhere to follow. One of the positive aspects of this scheme, apart from the benefits to customers, was the true integrated working that went on in the implementation.

One of the other learning points related to housing benefit which was not initially being applied for promptly, leading to some arrears. Again this was identified early and resolved.

The staff at first found this daunting as this was a very steep learning curve for them but partners worked closely together to train staff where needed and provided extensive support and advice.

The learning from this service is the pivotal importance of the coordinators' role within the scheme from the outset adding it to roles such as neighbourhood housing managers and service managers does not work.

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Nottingham city homes (NCH) hospital to home project

Background to the service

Nottingham City Care Partnership coordinates a local approach to bring together services and provide joined up care to patients. The integrated care programme brings together the clinical commissioning groups and the local authority to integrate adult health and social care services.

The partners recognised that in many cases the housing situation of patients was a contributory factor to their lack of wellbeing and, in some instances, a barrier to them being able to return to live safely at home after a period in hospital. However, it was difficult for stretched teams to know where to go and how to navigate housing partners to find solutions.

NCH, the ALMO managing the local authority's council housing, has a supply of approximately 1,900 specialist independent living homes for older people. These provide safer accommodation for many whose current accommodation contributed to their ill health, risk of accident or injury, or where it was unsuitable for them to return from hospital.

There was an advantage in joining forces to look at how alternative housing solutions might be found in these cases.

The aim of the service

The aim was primarily to provide appropriate and timely support to individuals to help them to move from hospital to a safe home environment and to enable them to return to independent living. Working with community teams means that they can also identify people at risk of hospital admission due to their ill health and look at housing support and interventions and also reduce reliance on intensive care packages. Enabling people where appropriate to move into more suitable accommodation can also contribute to better physical and mental health outcomes and wellbeing for the people involved and their carers.

At the same time, it provides an opportunity to ensure the full and best use of the specialist housing for older people managed by NCH.

The project addresses a number of outcomes set in the national NHS framework and also key needs identified in Nottingham's Joint Strategic Needs Assessment. Its approach is one that fits into the Sustainability and Transformation Plan for the city and county, focused on increasing the years of healthy life expectancy of the area's population and reducing the number of years of poor health.

What was the approach?

A twelve month pilot project was set up and jointly funded by NCH and Nottingham CityCare Partnerships from November 2015, to provide two housing and health coordinators (HHCs) to work within the integrated care system, to find housing options and support for people inadequately housed.

The HHCs work across two teams in the system; one which looks at helping people remain independent (the Independence Pathway) and one which focuses on supporting people with long term conditions (the Coordinated Care Pathway). They take referrals from health professionals when the person is unable to return home, or if the home is negatively impacting their health, in order to prevent (re)admissions to hospital. The HHCs support people in any tenure and where it is appropriate and agreed, support then to move into alternative accommodation which is generally an independent living home or bungalow offered by NCH.

Support is given to the individual and their family / carers throughout that process and also signposting to additional help and support that might be available to them.



What has been achieved?

An evaluation of the project was undertaken nine months into the pilot. At that point 153 referrals had been taken. Fifteen per cent were referred as they were unable to be discharged from hospital but the majority were referred from the community as their homes were adversely affecting their health or were unsuitable for them. Of those referrals, sixty-four people were successfully rehoused into NCH properties.

Seventeen of those sixty-four were discharged from hospital or rehabilitation schemes where they were unable to return home due to its unsuitability. The average time from referral to rehousing took 33 days (in comparison if they had been given medical priority on the waiting list the average length of time to rehouse would be 129 days. The estimated savings for health and social care partners in these cases was £169,288, 1,585 bed days, making an average saving per case of £9,958).

The savings from early intervention cases is more problematic to gauge (measuring events that would be likely to occur that the intervention has prevented) but looking conservatively at those cases most likely to require hospital admission or intensive social care intervention (27 cases) the project saved an estimated £182,083, 81 per cent of which would have fallen on NHS partners.

But the significant impacts are for the people helped. Follow up surveys with customers are being undertaken - of those returned to date (14) satisfaction with the service and with their new home is high. Many now feel safer, and more able to manage their health and wellbeing. They are also reporting greater social connections addressing issues of social isolation and loneliness. Support needs assessments are reviewed six months after the move, and again, of the 22 undertaken, all but one have either the same level or less need for help.

The pilot has been evaluated to assess the financial cost-benefit of the HHC programme, comparing the costs of delivering the scheme with the expected savings as a result of the intervention.

The savings fall to three stakeholders - the NHS (locally funded by the Nottingham City CCG), NCH and the local authority, Nottingham City Council (NCC). Overall, 55 per cent of the savings fall to the NHS, 28 per cent to NCC and 17 per cent to NCH. The total net savings achieved

by the scheme is £434,927. The estimated net financial return on investment is therefore £6.55 for every £1 spent on the scheme.

(More detail about the evaluation and savings can be requested from [NCH](#))

What has been learnt?

The early months of the project were spent in raising awareness of the project and what NCH could offer as a partner, and making links with the relevant teams. It involved meetings with all the care coordinators across the city's eight care delivery groups, plus staff in the rehabilitation units and the two main hospitals, as well as community teams. They also included local community agencies and local authority teams such as environmental health.

The early stages also involved navigating some of the differences in organisational structures and cultures, in order to identify the right people in teams for effective referrals. They also had some work to raise understanding of the parameters within which housing operated, for example, the age related eligibility criteria for the housing options available.

The HCC project was initially funded for a 12 month pilot period, and so the continuation of the scheme depends on securing further funding for the project in the longer term. The financial and social benefits demonstrated through this evaluation suggest that further investment in this project would be highly cost-effective.

The project has clearly revealed a high level of demand for this type of service. Efforts at the start of the project to raise awareness of the scheme have resulted in a high level of referrals at nine months. The two HHC officers are now working at maximum capacity to handle the number of active cases in their case load. Additional staff resource would potentially enable more cases to be taken on, and could reduce the re-housing process time. Best use of staff resources/skills could be achieved by separating out some of the administrative functions from the face-to-face client support role.

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One Housing Roseberry Mansions

Background to the service

Roseberry Mansions is an extra care scheme providing independent living for people over 55, that includes 10 flats available for use on a short term basis to support people ready to be discharged from hospital but requiring some additional help to be able to return safely to live independently at home.

The service is a partnership between Camden Adult Social Care, Central and North West London NHS Foundation Trust and One Housing and is funded by social care.

The hospital in Camden, where Roseberry Mansions is situated, already had a designated re-ablement coordinator, to support more timely and successful discharge from hospital. This enabled One Housing, with its experience of working well with health and social care, to make effective links to provide a number of flats at Roseberry Mansions available for a re-ablement service.

The service combines the housing and support expertise from One Housing staff with input as required from community health and social care staff to provide a wrap around, personalised service that reskills and restores confidence for people to return home or into more appropriate accommodation such as extra care housing.

What we wanted to achieve

The service aims to:

- Improve the quality of people's lives, enabling them to return home safely, or move into other appropriate accommodation
- Enable people to be discharged in a timely way from hospital and avoid unnecessary re-admission
- Prevent or delay the need for people to move into residential or nursing care
- Contribute to significant savings for NHS and address severe demands of services

- Encourage greater awareness and understanding of extra care housing in the public and with potential residents.

What was the approach?

Referrals to Roseberry Mansions are made via social workers when people are ready to be discharged from hospital but need time to rebuild skills and confidence, or move to more suitable alternative accommodation. 57 per cent of referrals come through this route but others come from community health teams, for example, mental health teams.

The rooms are fitted out with the aids and adaptations and technology that the individuals are likely to need when back at home so they can begin to get used to using them.

Each person has a keyworker who is their main contact throughout their stay but they also receive the support they need from a multi-disciplinary team, including One Housing's dedicated care and support team, led by the deputy manager, and community health staff such as occupational therapists, physiotherapists, district nurses.

The length of stay is up to six weeks, with the average length of stay being 41 days. There are weekly multi-disciplinary team meetings to assess each person's progress towards the outcomes set out in the care and support plan which is put in place within 48 hours of admission to the re-ablement scheme.

What has been achieved?

72 per cent of people receiving the service either returned home successfully or moved into more appropriate accommodation (sheltered housing, extra care). 28 per cent of people were able to have a reduced care package when moving back to independent living from the re-ablement service.

The re-ablement service ensured a timely discharge for its customers and provided savings to the NHS of £288,695. This is a conservative figure based on actual cost of reduced bed stays; it does not factor in reduction of likely repeat admissions that might have otherwise occurred or other benefits for the individual from restored confidence and independence.

In reducing the likelihood of moving on into residential or nursing care from hospital, it also saved between £3,848 to £42,900 per person per annum for social care.

(More information available in the [Roseberry Mansions re-ablement service evaluation report](#))

What has been learnt?

One Housing had already established a successful extra care service in the borough and highly successful models of integrated working with health and social care partners.

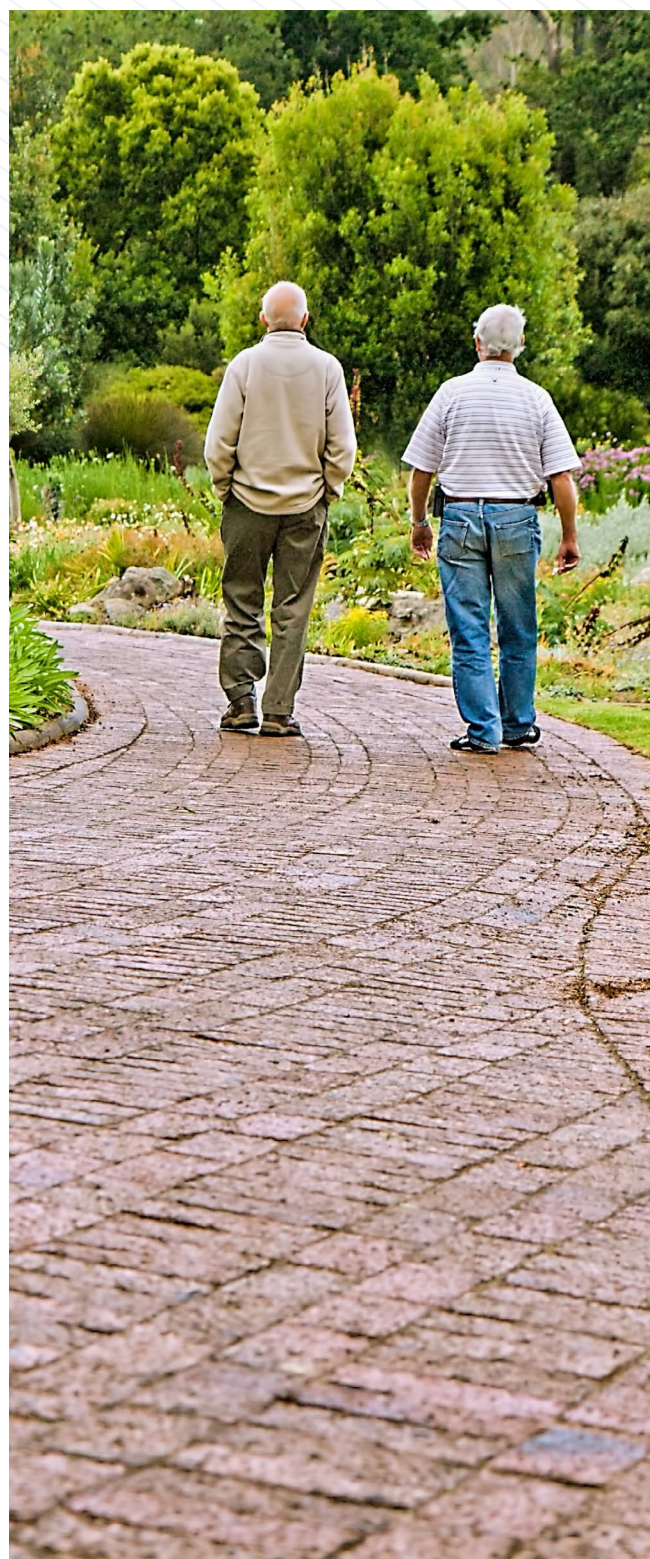
This helped with the development of the re-ablement service at Roseberry Mansions, as did the existence of a re-ablement coordinator in the trust, as the lead person to liaise with the service manager and deputy manager who leads the specialist team of One Housing's staff

There is a multi-disciplinary approach and input of community health staff. The experience has shown the importance of working in partnership to establish a re-ablement culture in short term services. There is a need for commitment to shared learning and training, and joint staff meetings for both the onsite care team and wider multi-disciplinary team. This now forms a key element of service set up and is being considered in advance of the establishment of other re-ablement services, for example, in Haringey and Essex.

It is important that there is a dedicated team of care and support workers (or 'enablers' as the team are called at Roseberry Mansions), who receive additional training to ensure that they understand the principles of re-ablement (so that they will not intervene too early as people re-learn skills.) Crucial to this is the principle of 'not doing for, but doing with'. Recruitment is values led rather than for specific existing skills, with patience and a person-focused approach being fundamental.

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About the partners

These case studies have been produced jointly by the Chartered Institute of Housing (CIH) and Skills for Care.

CIH is the professional body for the housing sector with one simple purpose; to ensure that everyone has a decent, affordable home in a thriving, safe community.

We are a registered charity and not for profit organisation, with education at the core of our charitable status. Our work is rooted in three main objectives; to support the housing sector to learn, improve and influence (<http://www.cih.org>)

Skills for Care provides practical tools and support to help adult social care organisations in England recruit, develop and lead their workforce. Working in partnership, we focus on the support, guidance and standards needed to provide excellent quality of care. (www.skillsforcare.org.uk)

Resources

There are a wide range of resources to help support housing services planning or operating hospital discharge services, both to develop their service and to support the learning of their staff. Here are a selection, but for many more please go to www.skillsforcare.org, www.cih.org and www.cih.org

CIH

Health and housing webpages: <http://www.cih.org/healthandhousing>

Developing your local housing offer to health and care: targeting outcomes (with Housing LIN): http://www.cih.org/publication-free/display/vpathDCR/templatedata/cih/publication-free/data/Developing_your_local_housing_offer_for_health_and_care

New approaches to housing for older people (with housing LIN) <http://www.cih.org/resources/PDF/Policy%20free%20download%20pdfs/New%20approaches%20to%20delivering%20better%20housing%20options%20for%20older%20people.pdf>

How to promote good adult safeguarding practices: http://www.cih.org/publication-free/display/vpathDCR/templatedata/cih/publication-free/data/How_to_promote_good_adult_safeguarding_practice

Qualifications: <http://www.cih.org/qualifications>

CIH consultancy, support to develop your housing offer: <http://www.cih.org/consultancyservices/healthandhousing>

Skills for Care

Culture change: <http://www.skillsforcare.org.uk/Leadership-management/Positive-workplace-culture/Positive-workplace-culture.aspx>

Workforce integration: <http://www.skillsforcare.org.uk/Documents/Leadership-and-management/Workforce-integration/The-principles-of-workforce-integration.pdf>

Leadership: <http://www.skillsforcare.org.uk/Leadership-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.aspx>

Information sharing guidance: <http://www.skillsforcare.org.uk/Documents/Topics/Digital-working/Information-sharing-for-social-care-employers.pdf>

Workforce redesign and role change: <http://www.skillsforcare.org.uk/Leadership-management/Workforce-redesign/Workforce-redesign.aspx>

Designing learning and development around changing needs: <http://skillselector.skillsforcare.org.uk/>

Other resources

Hospital2Hometoolkit: http://www.housinglin.org.uk/hospital2home_pack/

SCIE Delayed transfers of care signposting resource: <http://www.scie.org.uk/files/integrated-health-social-care/better-care/delayed-transfers-of-care.pdf?res=true>



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