Wiltshire Council

Health Select Committee

3 September 2019

Home from Hospital Services

Executive summary

This paper provides an update on the Home from Hospital services delivered by Age UK Wiltshire. The Home from Hospital Services provide short term support to Wiltshire residents, predominantly aged 60 plus for up to 6 weeks following a stay in hospital. It is at the discretion of the service provider whether to make exceptions for referrals for customers with support needs aged 50-59. The services include a mixture of both practical and emotional support that together enable older people to transition back home and regain their confidence and independence, reducing the likelihood of people becoming socially isolated or lonely and being readmitted to hospital. Services are aimed almost exclusively at individuals who are not otherwise eligible for a social care service or for NHS rehabilitation or HomeFirst.

Proposal

That the committee notes the report.

Reason for proposal

Health Select Committee requested an update on the Home To Hospital service.

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Home from Hospital Services

Purpose of report

1. This paper provides an update on the Home from Hospital services delivered by Age UK Wiltshire.

Background

2. Age UK Wiltshire is contracted to deliver a Home from Hospital Service from Salisbury Hospital (SFT). This service is jointly funded by Wiltshire Council and Wiltshire CCG at a cost of £84,000 per annum. The contract is for a period of 2 years and due to end in June 2020.

3. Last winter, Wiltshire Council and Wiltshire CCG commissioners recognised that there was potential to increase patient flow through the remaining acute hospitals via the Home from Hospital services. In December 2018 two pilot Home from Hospital services based out of Royal United Hospital (RUH), Bath and Greater Western Hospital (GWH), Swindon were established.

4. The Home from Hospital Services provide short term support to Wiltshire residents, predominantly aged 60 plus for up to 6 weeks following a stay in hospital. It is at the discretion of the service provider whether to make exceptions for referrals for customers with support needs aged 50-59. The services include a mixture of both practical and emotional support that together enable older people to transition back home and regain their confidence and independence, reducing the likelihood of people becoming socially isolated or lonely and being readmitted to hospital. Services are aimed almost exclusively at individuals who are not otherwise eligible for a social care service or for NHS rehabilitation or HomeFirst.

5. The priority was to maximise the impact of the service over the winter period, and, on that basis, the agreement with Age UK was to start in RUH (where a B&NES Home from Hospital service already existed and the infrastructure was available) and to delay implementation in GWH until the service at RUH was in place. This delayed roll-out has meant that the funding of £77,000 Winter Pressures monies can be spent over an extended period.

Evaluation

6. There are marked differences in how the services have developed and are delivered based on historical factors and on the preferences of the hospital, for example:

7. **SFT** (Salisbury Foundation Trust)

   a. Age UK do not have a staff presence within the hospital – patients are referred to Age UK via the hospital's 'Home from Hospital Co-ordinator'
   b. The service is advertised by the hospital's Home from Hospital Co-ordinator and leaflet's produced by Age UK circulated within the hospital

c. The service can be accessed by people living up to Ludgershall (North) and Tisbury (West)
d. Transport home from hospital is not provided
e. The service is available for a maximum of 4 weeks

8. **RUH** (Royal United Hospital)

a. Age UK has a staff presence within the hospital
b. The service is advertised via Age UK staff who also attend white board meetings
c. Transport home from hospital is provided
d. The service is available up to a maximum of 6 weeks
e. The service works in conjunction with Age UK Bath who have been delivering a Home from Hospital service out of RUH for a number of years

9. **GWH** (Great Western Hospital)

a. Is the process of being set up following the model at RUH

10. The activity data detailed below details the impact and volume of service to date

11. **SFT**

a. 120 patients have accessed the Salisbury Home from Hospital service from June 2018 to the present date

b. The table below shows that take up of the service has fluctuated during the course of the first year of service.

Quarter	**No. of customers accessing SFT service**
Quarter 1	8
Quarter 2	36
Quarter 3	19
Quarter 4	57

c. Commissioners have worked to improve take up in Salisbury over the course of the last year by:

- Extending the geographical area that the service covers
- Extending the service to those in receipt of small packages of care
- Lowering the age limit at which patients may access the service
- Working with the Head of System Flow
- Working with the SFT Head of Integrated Discharge

d. Although take up of the service has increased over the course of the last year it is felt by commissioners that referral figures are still relatively low when comparing take up to the RUH service. However, it should be noted that B&NES Council already had an established service model in place for a number of years which Age UK Wiltshire have been able to utilise to provide a service to residents of Wiltshire.

e. Further discussion has taken place with the new Head of System Flow in Salisbury and it is hoped that further changes will take place over the course of the next few months which will further increase take up, such as:
   - Direct referral access from any ward or service to Age UK
   - Age UK to have onsite presence twice a week in the first instance
   - Age UK representative to link in with ESD and ATL teams, focusing on patients on the following wards, Redlynch, Whiteparish and Durrington

12. **RUH**

a. 120 patients have accessed the RUH Home from Hospital service from January 2019 to the present date

b. Of the 120 patients that have accessed the service, 87% of which were over the age of 75 years old

c. 89% of customers accessing the RUH service were not readmitted to hospital within 30 days of discharge. Further detail as to why as to why 11% of customers were readmitted is not known at this time.

d. 100% of customers said that the service both met their support needs and improved their wellbeing.

13. **SFT and RUH**

a. To date it is estimated that Age UK Wiltshire have had 2,219 contacts with a total of 153 patients – an average of 15 contacts per person with Age UK

b. Both services have provided an average of 6 types of support per person. Examples of the types of support given are:

   - Falls Prevention – practical support and information regarding falls prevention: and in particular to access exercise classes and personal alarm systems
   - Income maximisation – Information on benefits entitlements
   - Socialisation – information and/or support to attend a variety of social activities of the patient’s choice

- Maximising independence – help to find: domestic help, a meal provider, access to community transport, handyperson services, housing options and shopping
- Wellbeing – giving information/support to access services that could resolve an anxiety or practical problem such as gardening, safety and security, personal care
- Referrals to statutory services

14. **GWH**

    a. 7 patients have accessed the GWH Home from Hospital service from 1 August 2019 to the present date. The priority was to maximise the impact of the service over the winter period, and, on that basis, the agreement with Age UK was to start in RUH (where a B&NES Home from Hospital Service already existed, and the infrastructure was available) and to delay the implementation in GWH until the service at RUH was in place

15. The following case study provides an example of the types of support, information and advice provided by the Home from Hospital Service and the benefits it can provide to a customer.

16. *Mr B is a 76-year-old man who lives alone in a third floor flat in Trowbridge. There is no lift at the property and 28 steps to his front door. He is usually independent.*

17. *Mr B was admitted to RUH following a fall outside his flat resulting in a hip fracture. He had a previous hip replacement 2 years ago. He was discharged with no formal care. Mr B was concerned how he was going to manage on his own as his mobility was still reduced and he wouldn't manage to get to the shops himself. The physiotherapist on the ward referred him to the Home from Hospital service.*

18. *Age UK's Discharge Supervisor visited him on the ward and reassured him a support worker would visit and assist with the shopping and housework.*

19. *Mr B said he had stocked up on supplies so didn't think he needed a visit the day he went home so a support worker visited a few days later. She arranged to visit twice a week for the first two weeks then would review the situation. On her first visit she discovered the fridge wasn't working properly and a lot of food needed throwing away, fridge needed cleaning and checking.*

20. *Mr B felt anxious about falling again so the support worker discussed the option of having a pendant alarm.*

21. *The support worker visited Mr B for six weeks assisting with shopping and general housework. She shopped for him for the first few weeks, then as his mobility improved they visited the shops together to help build his confidence.*

Advice was given about getting a dossett box for his medication and he is going to order one from his pharmancy.
Thanks to the support from the Home from Hospital team, Mr B has been able to continue living independently in his home. From food shopping and cleaning, the support he received has enabled him to have a successful return home. He felt reassurance from the visits and by assisting him to get a pendant alarm helped him regain confidence. Mr B was able to recover at his own pace feeling supported along the way.
Mr B said we helped him improve his quality of life and his wellbeing was improved. He said, " I was more than happy with the service, it was brilliant thank you."

Conclusion

22. The Joint Commissioning Board considered the progress of the Home from Hospital Service earlier this year and has agreed to continue services at RUH and GWH, to give them more time to embed, and continue over the 2019-20 winter period, and to continue to work with colleagues at SFT to improve take-up of the service. Commissioners will then work to recommission a county-wide home from hospital service that will ensure consistency, allow for an all-age service and allow for a more consistent contract management process which takes account of both the Home from Hospital provider and the different hospital referral processes.

23. On the basis that services are embedded and deliver the expected outcomes, a business case and specification for a county-wide home from hospital service will be presented to JCB later this year for approval.

24. In the event that services do not demonstrate the outcomes expected, Wiltshire Council and the CCG's Joint Commissioning Board will be asked to approve the decommissioning of all three current services from June 2020.

Recommendation

25. That the committee note the report.