# West Kent Hospital Discharge Scheme – a council, independent agency and NHS Trust partnership

## Good practice theme

### 1. A proactive and responsive partnership to support people returning safely to home from hospital and to reduce risk of readmission

## Context

This initiative operates in the three local authority areas of Sevenoaks, Tunbridge Wells and Tonbridge and Malling, market town/semi-rural/rural areas in the west of the county of Kent with a combined population of c.347,000.

In West Kent there is an established culture of collaboration between local authorities in ways of working and recent increases in Better Care Fund DFG allocations have been a catalyst for considering options that may contribute significantly to addressing delayed transfers of care issue. The main drivers for change to adaptations provision in this sub-region came from environmental health practitioners who, with support from portfolio holders and an 'appetite to be brave' helped create an effective partnership between the three district councils, an independent home improvement agency (operated by Peabody housing association) and Maidstone and Tunbridge Wells NHS Trust.

### 1. The West Kent hospital discharge scheme

The local handyperson service has been historically delivered by Peabody. However, as a result of the austerity programme funding from the statutory sectors had been significantly

reduced. The consequent need to operate a charging policy had resulted in fewer vulnerable people presenting for support. It was considered that this valued service was not being used in an optimal manner. It was also known from national experience that the pressure to discharge older people from hospital to home can result in discharges being made in the absence of housing circumstances of the patient being fully known.

The increased Better Care Fund DFG allocations in the three local authorities was considered to be a route through which they could run a pilot scheme to equally share the costs of employing a full time Health and Housing co-ordinator employed by Peabody. The pilot scheme was operated for twelve months commencing in November 2016. It is a free service and operates across all housing tenures.

The post holder, based in Tunbridge Wells Hospital, is part of the Integrated Discharge Team and is also responsible for promoting the hospital discharge scheme to other relevant teams based in the hospital including Adult Social Care and Care Navigators. The Health and Housing co-ordinator's role involves speaking to patients whilst they are in hospital and, where appropriate, undertaking a home visit to assess the home environment for its suitability for a prompt discharge.

Currently most of the home visits are undertaken post discharge but if a home visit is essential to facilitate discharge a pre-discharge visit is made. They liaise with the handyperson scheme especially if minor adaptations, equipment or modest interventions such as moving beds, cleaning and/or decluttering, key safes are required. **The cost for the majority of this support is met from the Better Care Fund DFG budget managed by the respective local authority where the patient resides.** They make referrals to other local agencies and also contact the occupational therapist in each of the councils as appropriate for an assessment for other forms of assistance including a Disabled Facilities Grant. The occupational therapist can also determine if there are more suitable temporary or permanent housing options for the resident. Making referrals from the scheme direct to the occupational therapist seconded into each local authority rather than to the occupational therapists operating at county level results in the assessment process being undertaken more quickly.

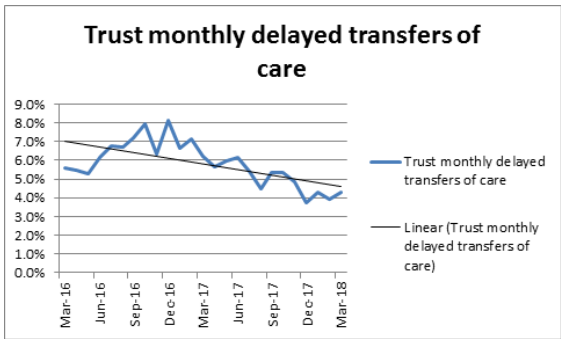
The coordinator also responds to any housing issues that can prevent or significantly slow down discharge including property condition, safety and homelessness. It is recognised that not all necessary interventions can be delivered at, or very near, the date of discharge but instead some modest interventions can be provided promptly as an interim measure with other more services/changes to the home such as more major adaptations identified and implemented. This two stage approach facilitates discharge and reduces the risk of readmission.

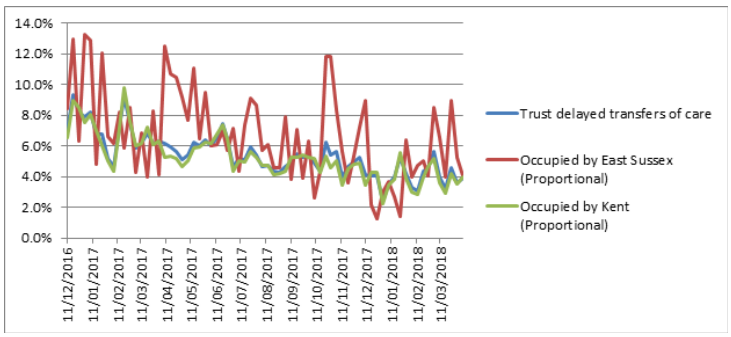
### Impacts of the scheme

- The evaluation of the hospital discharge scheme undertaken by Maidstone and Tunbridge Wells NHS Trust and Peabody within the pilot scheme period concluded that there was a strong correlation between the introduction of the new arrangements and delayed transfers of care. Performance in Tunbridge Wells Hospital was compared to patients who lived in an area not served by the scheme which confirmed the positive impact in delivery. A decision to continue operating the arrangements was made and

indeed it has been extended to Darent Valley Hospital, Maidstone hospital and William Harvey Hospital Ashford. With each additional hospital using this scheme, increasing numbers of Kent District/Boroughs are working together with the appropriate NHS trust.

- A detailed analysis at the end of pilot period revealed where patients lived and re-apportioning of the scheme costs between the districts has occurred.
- It was fully anticipated that each person eligible for the scheme would have unique circumstances. Consequently in order to increase the effectiveness of the housing intervention each of the original three local authorities has revised its discretionary forms of assistance under the Regulatory Reform Order to help address identified gaps.
- It was agreed at the outset by all Councils funding would be required to ensure the success of the scheme and its wider preventative role. How each of the Council achieved this is slightly different although the common principle is the assistance must be flexible and focuses financial help towards hospital discharge, prevention of falls, improving safety and security, keeping people warm and providing independence within the home.
- Feedback from service users is undertaken by Peabody with the views captured indicating that older people in particular appreciate a single point of contact for housing led issues and that their health and wellbeing has significantly improved leading to greater independence, confidence in the home and happier lives.
- A more recent graphical representation of delayed transfers of care has been undertaken. The graphs below are NHS trust data and the whole trust is operating a home first approach which our service is part of. Maidstone and Tunbridge Wells NHS Trust and Kent Community Health Foundation NHS Trust track their performance against the national linear target and since our service started in December 2016 the performance of the trusts overall output has improved which our service has directly contributed to.
- Interestingly the trust is located in Kent bordering East Sussex. The data has also shown a significant positive difference for people living in Kent with access to this service and other home first initiatives as part of their stay in this acute hospital compared to the negative impact for in-patient stays for people from East Sussex.



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