Reducing Housing Related Hospital Discharges

Achievements

The housing contribution to reducing delayed discharge in Aberdeen clearly identified

A sub-group of the demonstration project collected data to analyse the impact of housing, adaptations and equipment issues on hospital discharge delays at the two city hospitals and to recommend areas for improvement.

Specialist housing advice routinely included in discharge hub meetings at the city hospitals

A specialist Housing Liaison Officer from Aberdeen City Council routinely attends meetings to provide specialist input, liaise with housing colleagues to source appropriate accommodation, and to keep an oversight of all complex cases.

Reductions in the number of people delayed in hospital where housing is a factor

Sustained improvements have been made, with cases falling from around 20 at any one time to 5 or less, and an overall improvement in discharge delay of 19% over the last reporting year.

A short **video** produced by Kinbank Productions that tells the story of the delayed discharge work in Aberdeen is available on the iHub website.

Aberdeen's person-centred **service redesign** has linked housing, hospital care and community occupational therapist services, leading to improved **hospital discharge**, a more accessible **housing options advice & housing allocations** policy, increased use of **technology enabled care**, and **better design** outcomes.

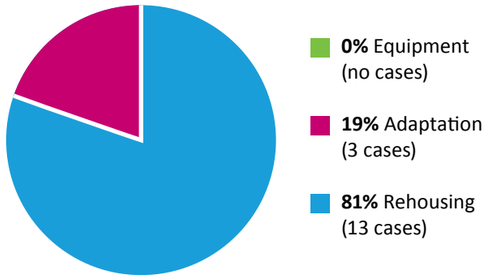
How they did it

Analysing the housing aspects of hospital discharge

The number of bed days occupied by people delayed in hospital has been persistently high and a priority focus of attention for the Health and Social Care Partnership in Aberdeen City. Whilst not initially connected to the Adapting for Change demonstration project, the broad membership of the Project Group provided a timely opportunity to explore delayed discharges where housing, adaptations or equipment were a factor.

A sub-group was set up. Data was extracted from the national EDISON[1] database for both hospital sites in Aberdeen city over a three-month period. Analysis of this showed that the incidences of delays being attributed directly to housing issues were relatively low as a proportion of all delays, at only 6.4% of all recorded delays. However they accounted disproportionately for almost one third (32%) of all the bed days lost.

Looking in detail at the 16 cases where housing was a factor, a need for re-housing was by far the most important factor.



1 EDISON is the Electronic Discharge Information System Online Nationally. It is a national system used to routinely record hospital discharge based on the clinical team leader's assessment of readiness, and to code the main reason for delay.

An **Evaluation Report** identified 16 recommendations for improvements including a new system for identifying 'housing' cases, changes to the City's allocations policy, a need for step down accommodation and the value of a housing coordinator role. The report helped to focus the service redesign (see Practice Note on Person Centred Service Redesign). The analysis is to be repeated in 2017 to track progress.

Appointing a dedicated housing link with hospital teams

A Housing Liaison Officer (HLO) post has been created by Aberdeen City Council. The post-holder oversees all complex discharge cases where the solution is most likely to be secured from local authority housing or newly built social housing.

The HLO provides a direct link between the local authority housing need assessment team, the hospital clinical care teams, and the community based Occupational Therapists, to progress individual cases though a joint approach at the regular Discharge Hub meetings.

The Disabled People's Housing Service (DPHS) also attends the Discharge Hub meetings. Referrals can be made direct to the DPHS, which provides a crucial advocacy role for people who may not have the strength or ability to present their own case, or who simply don't know where to start. A simple housing options fact-sheet produced jointly by DPHS and a hospital-based Occupational Therapist is available to help patients to be more aware of the options and assistance available.

Patients and their families can have strong views about where to live, although available housing supply is rarely available exactly where and when it is needed. As a voluntary sector organisation, DPHS is able to provide cross-tenure advice for people unable to return to their existing accommodation that is informed by, but neutral of, either clinical care or housing providers. This frees clinical teams to concentrate on patient recovery. Individual choice is never curtailed, but the risk of

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remaining stuck in hospital because of unrealistic expectations can be explained in an impartial and person centred conversation.

The links between services currently work on an informal basis, but will be mainstreamed through more formal protocol arrangements as part of the service redesign being developed jointly by all partners.

Collaborative working across a range of agencies

Multi-disciplinary Discharge Hubs at the two hospital sites now include specialist housing advice as a routine part of discharge reviews, facilitating earlier risk assessment and problem solving for patients leaving the vascular wards. Housing Options advice, independent advocacy and more flexibility in the local authority's housing allocations policy have all become integral to discussions during a person's hospital stay and in the discharge process. **(See Practice Note on Housing Options and Allocations)**
Direct links have been established between professionals working in health, in housing, and in social care. This has created a better understanding and awareness of the potential input of each sector, and potential housing issues and solutions are starting to be identified at a much earlier stage.

The earlier identification of housing factors that may affect a person's ability to be discharged is taking time to become embedded across all the multi-disciplinary clinical teams. However the clear benefits, alongside promotion by Project Group members, is gradually leading to the approach being taken up across all wards.

Using technology to speed up adaptations and equipment before a person is discharged back home

The use of wi-fi enabled tablets is being used to link hospital based occupational therapists and people still in hospital with community occupational therapists at the person's home. This enables partners to review a person's home environment and discuss adaptation and TEC solutions before the person is discharged.

Requests for equipment by hospital based occupational therapists were previously all routed through Bon Accord Care. To streamline this part of the process, an 'OTA in a Van' service has been introduced. Hospital based occupational therapists can now order equipment directly, with a specified delivery slot. A mobile occupational therapy OT Assistant (OTA) can deliver and install the equipment and has the authority to review the situation and whether additional equipment or follow up assistance may be required.

Key contacts

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Useful Documents and Links

- Adaptations Service User Report (November 2015)
- Delayed Discharge Project Evaluation Report (2015)
- Telecare in Aberdeen Poster & Storyboard (November 2015)
- Telecare Screening Tool
- Aberdeen City Council: Communities, Housing and Infrastructure Committee; Extreme Need for Medical Housing (May 2016)
- Kinbank Productions Video: Hospital Delayed Discharges; The Aberdeen Experience (August 2016)
- Housing Options Fact Sheet (2016)
- Ideal Pathway for Major Adaptations

The following Advice Notes are available:

- Person Centred Service Redesign
- Housing-Related Hospital Discharges
- Housing Options and Housing Allocations
- Promoting Technology Enabled Care
- Individual Case Examples

All Adapting for Change Practice Notes are available from **The Improvement Hub** and **Scotland's Housing Network**

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