

Hospital discharge schemes operated by HIAs

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Swan Care & Repair

Swan C&R has designed a Gateway service which integrates Falls Prevention, Home from Hospital and Rapid Response services. Many older patients in A&E fall between two support pathways: they need more than the one-off intervention provided by home-to-hospital projects, but they don't need an intensive 4-6 week care package offered by reablement schemes. As a result patients often have to be unnecessarily admitted and some have their discharge delayed because the right type of support isn't immediately available.

To plug this gap, Swan Care & Repair, in partnership with their own care provider Vivo Support, created a new service. Handypersons are available seven days a week, 7am-11pm. Within four hours of a doctor, nurse or emergency department phoning the agency, the patient is visited by a handyperson and senior care worker and provided with up to six days of support at home.

The scheme is able to see 87% of people referred to it within four hours to put together the care and housing package and 96% of people referred elect to use it rather than be hospitalised. Between October 2014 and March 2015, the scheme has dealt over 500 referrals in North East Essex.

Manchester Care & Repair

The home from hospital service offers a telephone follow up service to all over 60s who have visited A&E or been discharged after a stay in hospital. In the year to September 2014, the project phoned some 13,150 patients being discharged from the 3 acute hospitals in Manchester. Of these 60% (8000) were successfully contacted and of those over 20% accepted some sort of service aimed at building resilience in the days after discharge.

The service ensures that vulnerable or isolated patients aged over 60 are provided with personalised discharge support which is tailored to their needs. The service runs between 13.30 - 22.00 7 days a week, 365 days a year and includes transporting patients home, settling them in, doing emergency shopping etc.

Manchester CCG noted a significant reduction in the number of people aged over 60 being re-admitted to hospital within 30 days in North and Central Manchester along with other interventions. The service has helped people to cope at home feeling supported and able to manage and with less risk of deteriorating emotional and psychological health and reduced risk to their physical health through interventions to make their home safer, warm and habitable.

Aster Living Somerset

The Hospital Discharge workers are targeted to enable 200 discharges per year and last year the agency achieved over 340 discharges, showing increasing need. The Hospital Discharge workers liaise closely with hospitals and Adult Social Care staff ensuring the client's return to home is not delayed.

The Somerset HD service visits the person in hospital and their home with permission to ensure they can have a safe and speedy discharge. They do a home safety check backed up by the handyperson service to undertake minor works needed to facilitate discharge, such as installing grab rails, key safes, telecare services, moving beds and other furniture, assembling flat-pack furniture, repairing trip hazards, minor home improvements and small adaptions. They also check benefits and finances, make sure the client has food in the fridge and essential services haven't been cut off. Additionally, the agency liaises with other support services in the area and refers the client on for any additional long-term help they might need.

All the front line staff across Somerset, including the handyperson technicians have received warm homes training. Using checklists on an initiative home assessment tool especially for HD workers they can ensure they offer all help/support available on thermal comfort and energy efficiency.

Small measures such as draught proofing and hot water jackets can be carried our directly by the handyperson technicians, more complicated heating problems are referred seamlessly back to the agency caseworkers.



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