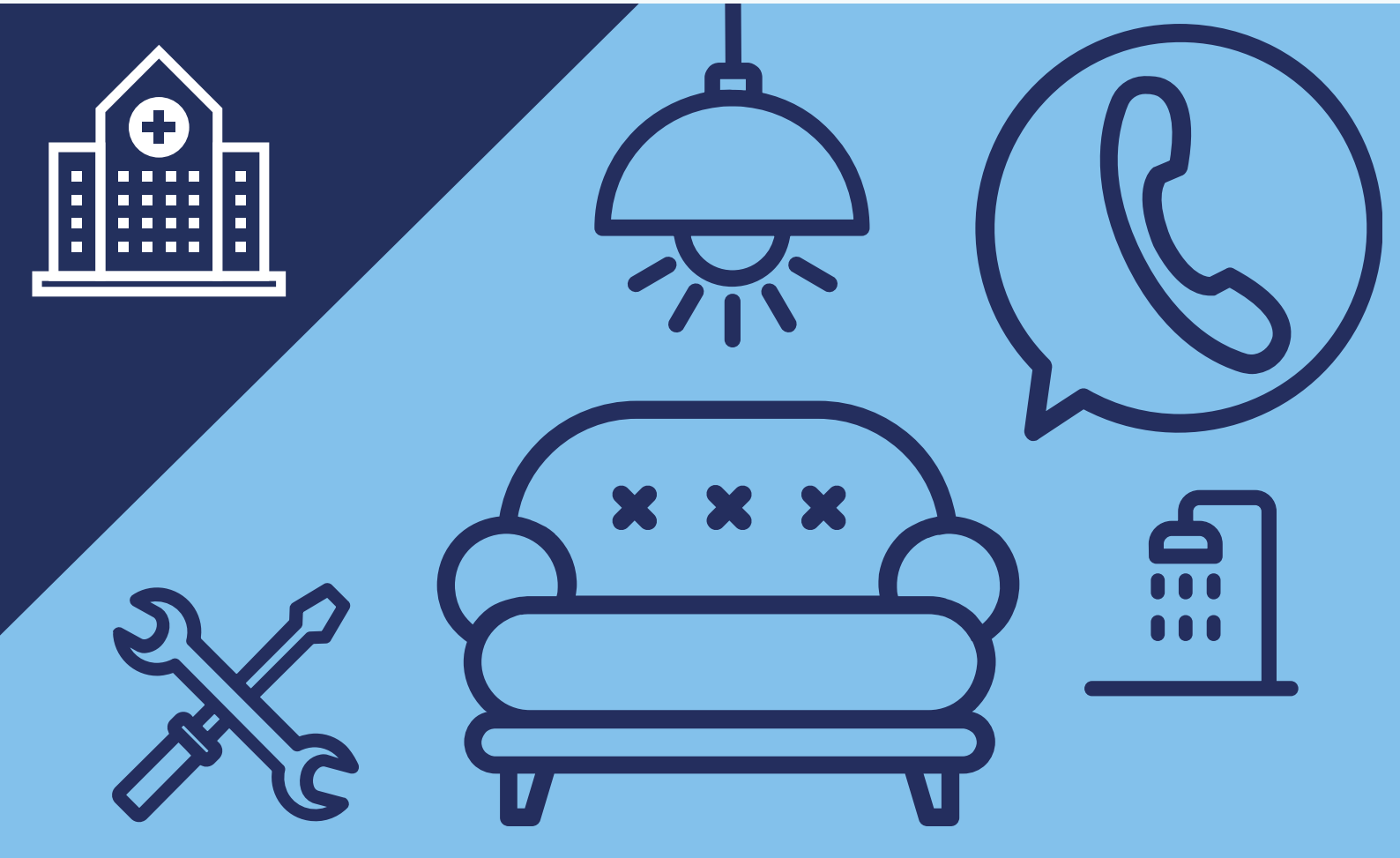
Improving homes, Changing lives

Care & Repair Cymru

Care & Repair

Hospital to a Healthier Home

Care & Repair Appraisal - 3 years on



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Care & Repair Cymru

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Executive Summary

Hospital to a Healthier Home is the solution to a problem.

The service works with hospital staff, patients and their families to identify and resolve housing and environmental issues that would otherwise prevent a hospital discharge.

It is a testimony to the dedication of Care & Repair staff, transitioning from work in the community to work within highly pressured health settings, that the Hospital to a Healthier Home service has grown rapidly from small seeds to a substantial blossoming service. This growth would not have been possible without the co-productive instinct of the NHS's frontline staff, who recognised the potential of this offer. This evaluation charts the development and expansion of the service over the last three years to show the positive difference that has been made to patient wellbeing, patient flow, quicker discharges of care and reduced readmissions.

Hospital to a Healthier Home is also a strong strategic choice for health planners. The service aligns well with the ambitions of A Healthier Wales, and more recently The Six Goals for Urgent and Emergency Care including pathways within Discharge to Recover then Assess which we hope helps Care & Repair maintain a long-term partnership with the NHS to deliver this service.

Chris Jones,
Chief Executive

Headline findings

- There are currently 17 caseworkers working out of 17 principal hospitals across five Local Health Boards in Wales
- The service has expanded into additional hospitals each year, and seen a year-on-year increase in numbers of referrals and service outputs
- Since 2019, over 10,000 across Wales patients have been referred to the service
- Since 2019, the service has saved the Welsh NHS over 62,000 bed days
- For every £1 spent, the service saves the Welsh NHS £8.60 in avoided delayed discharges of care alone
- The service has been proven to reduce readmissions, with a readmission rate of 5.7% compared to a health board average of around 12-15% locally
- The service has embedded good partnership working principles across Wales, and is a trusted go-to service for housing and environmental issues that would otherwise lead to delayed transfers of care
- The service has an excellent reputation for its speed, reliability and problem-solving skills amongst NHS staff, including solving housing issues for same-day discharge
- Crucially, the service saves clinical staff time. Many of the NHS staff we interviewed referred to our H2HH caseworkers as the 'linkage' between themselves and patients, their families, external companies, and community resources to save NHS staff time and resources
- The service fills a gap in service provision between health, housing and hospital discharge, and offers longer term support beyond works essential for discharge to make sure patients can return home to live safely and independently

What is Hospital to a Healthier Home?

Hospital to a Healthier Home currently operates out of 17 principal hospitals across Wales, employing 17 caseworkers.

The service began life as Hospital to Home in Bridgend County Care & Repair in 2014, and has operated nationally since 2019.

We submitted a national bid for Hospital to a Healthier Home following the Welsh Government consultation on developing a policy framework for unscheduled care in summer 2018.

Using H2H in Bridgend as our example of best practice, project work undertaken by Conwy & Denbighshire Care & Repair in Ysbyty Glan Clwyd, and our capital funding from Care & Repair's flagship Rapid Response Adaptations Programme (RRAP), we submitted a proposal for a wider service across Wales to Welsh Government's Head of Emergency Care Policy and Performance.

Following a successful Welsh Government pilot between Jan-March 2019, the service was funded by Welsh Government until April 2022. During this time we were strategically linked to the National Programme for Unscheduled Care (NPUC), participating in the NPUC Delivery Group for monitoring purposes, gaining endorsement from the NPUC Board, and gaining close support from Welsh Government officers with responsibility for this work.

The service is currently funded across Wales through a mix of Local Health Board and Regional Integration Funding and received NHS Welsh Delivery Unit support following a handover from Welsh Government. Throughout the final year of Welsh Government funding, Care & Repair Agencies engaged with Local Health Boards so show the services' great success in reducing the length of patient stays and reducing readmission across Wales.

Key principal hospitals

Glangwili Hospital
Care & Repair Carmarthenshire

Gorseinon Hospital
Western Bay Care & Repair

Morriston Hospital
Western Bay Care & Repair

Neath Port Talbot Hospital
Western Bay Care & Repair

Nevill Hall
Care & Repair Monmouthshire & Torfaen

Prince Charles Hospital
Cwm Taf Care & Repair

Prince Philip
Care & Repair Carmarthenshire

Princess of Wales Hospital
Bridgend County Care & Repair

Royal Glamorgan Hospital
Cwm Taf Care & Repair

Royal Gwent Hospital
Newport Care & Repair

Singleton Hospital
Western Bay Care & Repair

The Grange
Care & Repair Monmouthshire & Torfaen

Withybush Hospital
West Wales Care & Repair

Wrexham Maelor
North East Wales Care & Repair

Ysbyty Glan Clwyd
Conwy & Denbighshire Care & Repair

Ysbyty Gwynedd
Gofal a Thrwsio Gwynedd a Mon

Ysbyty Ystrad Fawr
Blaenau Gwent & Caerphilly Care & Repair

Across these health boards we also support discharge arrangements and step-down within a range of community and field hospitals.

Key purposes of Hospital to a Healthier Home

Support clinical staff and patients with quicker, safe discharges of care

Improve patient flow through the hospital

Reduce readmissions

Hospital to a Healthier Home Delivery Model

- Work closely with NHS staff in hospital to identify patients at the earliest opportunity who might be prevented from leaving hospital due to a housing or environmental issue
- Timely adaptations to support Occupational Therapists and rehabilitation at home and allow for safe patient discharges
- Support NHS staff and improve morale through being a known, trusted source to deliver quickly and flexibly
- Access to capital funding pots for minor/ medium repairs/adaptations that are held or accessed by each Care & Repair Agency, and the £2m WG funded Rapid Response Adaptations Programme (RRAP)
- Access to a range of nationally and locally generated income, to address emergency repairs impacting on cold homes, damp, leaks, electrical and gas safety, cluttered homes and general living circumstance
- Long term community and housing support to patients to prevent readmission into hospital including through a Healthy Homes Check undertaken from a standard assessment framework by our Trusted Assessor accredited specialist Hospital to a Healthier Home Caseworkers. This includes prudent healthcare advice, including falls risk assessment with patients at home
- Home safety advice and work, to allow patients to recover at home through links to our in-house Care & Repair practical (handyperson) service
- Links to Care & Repair professional technical/surveyor services for larger works when required
- Benevolent and charitable income sourced for works needed, where applicable
- Access to Care & Repair's Hardship Fund for clients whose works cannot be funded by any other source
- Welfare Benefit checks and applications that increase patient's income to positive impact heating, eating properly and ongoing care needs
- Support for patient access to Local Authority housing grants and community OT services
- Referral-on to local statutory and third sector providers for assistance with care needs, loneliness, disabled rights, financial advice etc
- Links to our Managing Better service- specialist casework support for clients with living with sight or hearing loss, dementia and for stroke survivors. This is delivered through WG Sustainable Social Services Grant, with our partner organisations Alzheimer's Wales, Stroke Association Cymru, RNIB Cymru and RNID Cymru
- Links to our 70+ Cymru service and Home Energy Officers for expert advice and support for those living in cold homes or in fuel poverty

Covid-19 and Recovery

Our H2HH service was fully operational, as was Care & Repair more generally, right through the pandemic.

Staff were initially relocated away from hospitals for patient and staff safety, however we continued to work on emergency home safety and hospital discharge, ensuring we could help mitigate any pressures on frontline and acute NHS services. Home adaptations, specific modifications, emergency repairs, and accessibility were critical issues for safe discharge and providing domiciliary care, and we were gearing up our staff capacity and resources to make homes safe and conducive for recovery and rehabilitation. In fact, the service expanded during this time both in numbers of hospitals present and number of referrals received. At the height of the pandemic, based on local NHS need, we also provided a range of non-Care & Repair Services e.g., temporary porter services, delivering and picking up equipment, accessing local laundry services, and delivering PPE.

Going forward, we have learned from this experience and have national industry-specific guidance on PPE, Risk Assessment and Safety-related SOP, to manage any re-emergence of pandemic conditions. We focussed on keeping patients safe, keeping staff safe, and keeping our external contractors safe. We have the expertise for working with older and vulnerable people, well-embedded supply chains for building work and home safety, some national funding for solutions, and logistical and operational relationships with the NHS in Wales, crucial to Covid recovery.

Why is Hospital to a Healthier Home vital to the NHS?

The NHS Planning Framework 2020-2023 requires Local Health Boards to factor in several background strategic and legislative drivers. Care & Repair's H2HH can assist LHBs to meet the following:

Six Goals for Urgent and Emergency Care
Goal 1: co-ordination, planning and support for people at greater risk of needing urgent or emergency care, helping people remain independent at home; Goal 5: optimal hospital discharge practice from the point of admission; and Goal 6: home first approach and reduce risk of admission.

H2HH facilitates quicker, safer hospital discharge into homes that have been adapted to allow for independent living and continued recovery and packages of care following a hospital stay. The service helps older people, a known risk group for hospital admissions. Our adaptations have proven to reduce readmission within a 28-day framework for an admission for similar reasons.

Discharge to Recover then Assess encourages staff to take a 'Home First' approach having liaised with the patient and ensured there are community infrastructure in place.

H2HH caseworkers offer a linkage between hospital and community care via long term support for housing and wellbeing issues, and onward referral to community support. Our caseworkers organise the practical modifications required to allow a patient to recover at home.

The Primary Care Model for Wales is underpinned by a more preventative, pro-active, and coordinated system which integrates health, local authority and voluntary sector care services and empowers people.

Preventing readmissions is at the core of the H2HH service. Care & Repair Cymru and Care & Repair Agencies are not-for-profit third sector organisations with strong public sector and voluntary sector referral networks. Trusted Assessor status has made our services a go-to point of contact for under-pressure Social Services and NHS teams, providing for quality, speed and providing feed-back loops for Occupational Therapy services that cannot visit properties to view the real-time scenarios.

Prosperity for All highlights the importance of investing in housing to promote independent living.

H2HH specifically tackles housing and environmental issues that affect older patient's ability to live independently and safely at home.

These principals are key to our holistic, person-centred approach.

A Healthier Wales takes a whole system approach to health and social care, with seamless services delivered as close to home as possible.

H2HH caseworkers are the linkage between the patient, their home and community support. By completing adaptations, emergency repairs and supporting social welfare issues, our services provide a holistic approach on which the principals of A Healthier Wales are founded.

We work within a **Prudent Healthcare** framework, utilising a coproduction model that places the patient, and 'what matters to them' at the heart of our service.

The H2HH service empowers NHS professionals to focus on reducing dependency and supporting independence at home.

All feeding into the legislative driver of the **Social Services and Wellbeing Act (Wales) 2014** that is built on core principals of voice and control; prevention and early intervention; well-being; co-production and multi-agency working.

Current pressures

Wales has the longest length of hospital stay of any UK nation.

Data from the Nuffield Trust, an independent health research charity, released in June 2022 showed that patients in Wales stay in hospital for an average of 60% longer than those in England, with seven- and four-day length of average stays respectively. This means that on average a bed in England will see around ninety-one patients a year, compared to fifty-two for Wales.

In early 2022, the Health and Social Care Committee launched an inquiry into hospital discharge and its impact on patient flow, receiving forty-five responses from a range of individuals and organisations working within the public sector and voluntary sector. The report highlighted that along with the impact of covid-19 resulting in a system wide change in approach to delivering health and social care, there were challenges around packages of care, step-down bed facilities, housing issues and partnership working.

The Royal College of Nursing states:

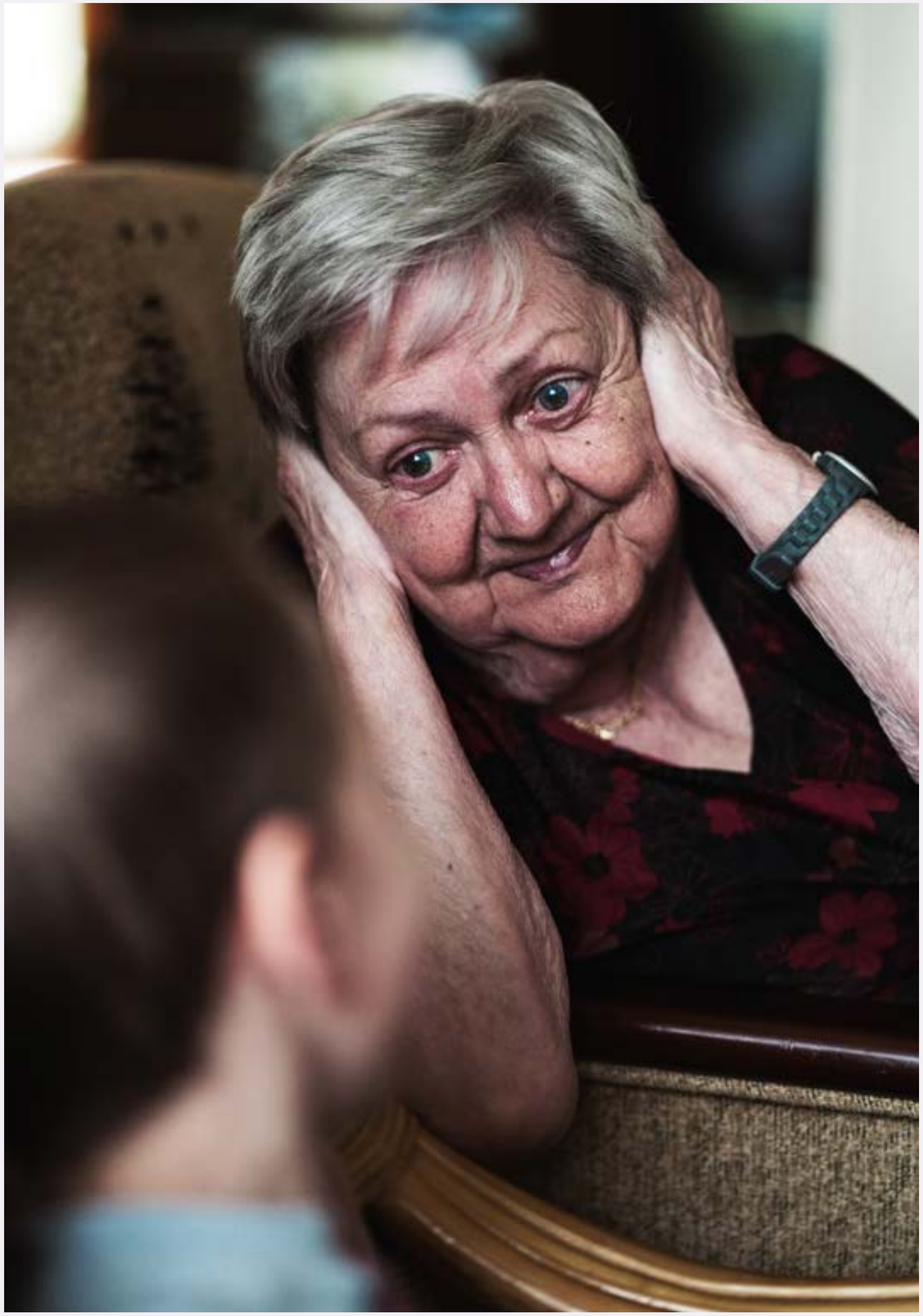
> *The 'Get Up, Get Dressed, Get Moving' campaign acknowledged that patients aged over 80 who remain in bed lose up to 10% of their muscle mass in just 10 days. The campaign noted that up to 50% of patients can become incontinent within 24 hours of admission and fewer than 50% of patients fully recover to preadmission levels within 1 year.*

Longer patient stays in hospital mean that there are limited beds available to complete scheduled care. In June 2022 there were 732,241 patients in Wales on waiting lists to start treatment. frequently described as one in five people in Wales on a waiting list, although some people may be on more than one waiting list. This is a 60.2% increase on the numbers of patients waiting for treatment in Wales in March 2020. Of this figure, 36% (263,781) had been waiting more than thirty-six weeks. In March 2020, this figure was only 6.2%

Lack of bed space has also affected the performance of the Welsh Ambulance Service and Emergency Department performance as reduced bed availability means longer waits before admission into hospital. Some examples of ambulances waiting outside Emergency Departments have gained national Welsh media attention as the public becomes increasingly aware of the pressures on the NHS. In June 2022 just over 1/3 of patients spent more than four hours in Emergency Departments across Wales, totalling 58,876 patients.

From our own experience, the service is seeing increasingly complex cases Increase in complex cases. Housing, health and social issues have been left, meaning that by the time patients are admitted to hospital issues have built up requiring additional work and support to get patients home.

One caseworker noted that they have seen many patients throughout the course of the pandemic that had clearly suffered strokes but were too scared to contact the GP or emergency care in case they contracted Covid. The caseworker's concern is that if this is the case for acute conditions like strokes, then it is likely that many other chronic and longer-term conditions have also gone unreported, which in turn has led to more patients remaining in hospital for longer periods, creating pressure on the healthcare system.



The bigger picture: housing and health

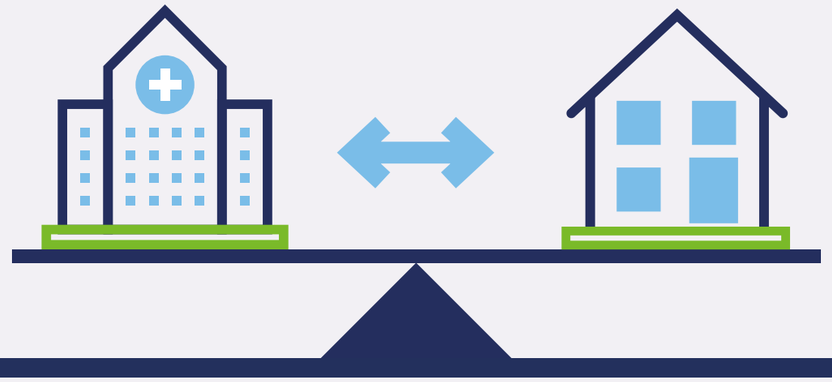
Hospital clinical pressures and patient demand from poor housing:

- 18% of homes in Wales pose an unacceptable risk to health
- 83% of older people live in their own home
- Older people are amongst those at greatest risk from poor housing
- Cold damp homes increase circulatory, respiratory and cardiovascular illnesses
- £96 million treatment cost per year following accident or illness related to poor housing

Pressures through the system from poor housing:

- Around 278,000 older people will fall in their own home
- Around 139,000 older people will fall more than once in their home
- Of these falls, around 8,100 will result in serious injury
- Around 3,000 older people receiving a hip fracture each year
- Around 1,500 older people not recovering to independence in 12 months following a fall

Care & Repair Evaluation: 3 years on



Methods for this evaluation

- Desktop research to establish whether the initial problem Hospital to a Healthier Home set out to alleviate remains the same, better, or worse
- A quantitative analysis of the services' numerical outputs over the three years
- A cost-benefit analysis and return on investment
- A qualitative study, based on interviews conducted with a range of NHS staff across all five health boards the service operates in to understand their experience of using the service over time
- Interviews conducted with our Hospital to a Healthier Home caseworkers focusing on their experiences and challenges over the last three years
- Telephone interviews conducted with our patients using a before and after scale to measure the impact of the H2HH intervention

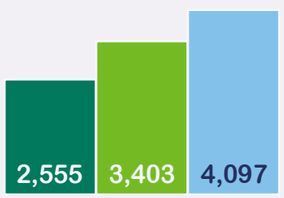
Headline findings – "it's never a no"

- The service has become better embedded over time working in true partnership with NHS staff. Relationships built on trust and good communication between our H2HH caseworkers and NHS, with some caseworkers taking part regular staff meetings on delayed discharge
- Staff cite the speed of the service and our Caseworkers' knowledge and problem-solving skills as their key incentives for relying on the service
- Our value for money and cost savings have increased year on year, with a low unit cost yielding a high impact value per NHS patient. Over the three years we have conservatively saved the Welsh NHS over £13.6m by reducing delayed transfers of care
- Our work reduced readmissions, with a pilot study in one health board showing a H2HH intervention led to a 5.7% readmission rate, compared to a conservative average of 12.5%

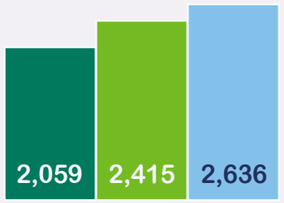
Quantitative

Full Financial Year

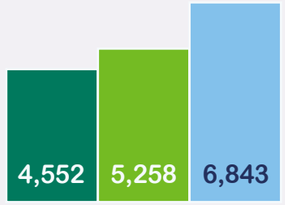
2019 - 20 | 2020 - 21 | 2021 - 22



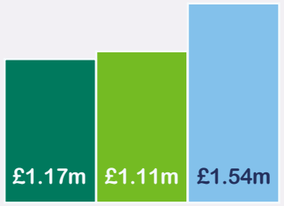
Number of patients helped to leave hospital more quickly



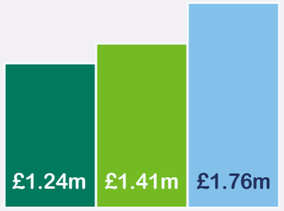
Number of Healthy Homes Checks completed



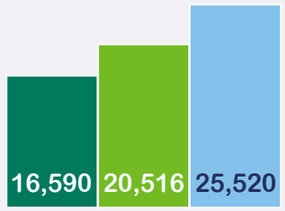
Number of adaptations and home improvement works to ensure hospital discharge



Value of works in £ millions



Means tested benefits claimed in £ millions



Number of NHS bed days saved

- Over 10,000 patients helped leave hospital more quickly over the last three years, with the number of patients helped increasing each year
- 7,110 Healthy Homes Checks completed to ensure longer-term safety at home and reduce readmissions
- 16,653 adaptations and home improvement works completed to help speed up safe hospital discharge
- Over £4.14m sourced in means tested benefits, increasing an average patient's annual income by £4367
- We reduce a patients' stay on average by six days
- Between April 2019 – March 2022, the average unit cost per patient helped was £156.58

- We sourced an average of £231 in capital for each work over the last three years
- Over the last three years the service has conservatively saved the Welsh NHS £13.6million in delayed discharges alone
- Save £8.60 for every £1 spent on delayed discharges alone
- An average readmission rate of 5.7% compared to a health board average of between 12-15%

We understand that beds are rarely empty, rather freed up for the next patient. Notional cost savings from a hospital discharge therefore yield a redirected investment potential. Our cost savings figure does not include the readmissions we helped prevent, the clinical staff time we saved, and the packages of care we enabled, the families we reassured, or the long-term support we provide patients at home.

Qualitative

Care & Repair interviewed staff from all health boards the H2HH service operated in, as well as all caseworkers the service employs.

We wanted to target our interviews at the front-line staff who interact with the service daily, to find out how and why they use the service alongside their work and tease out any frustrations or ways the service could be improved. We thank them for their valuable time, assistance and support.

Much like hospital discharge itself is a multi-faceted operation requiring many moving parts coming together at the same time, it was challenging to compartmentalise the breadth of interlinking factors that make up the H2HH service. The key findings below are co-dependent. Over time, relationships built on good communication, trust and understanding of the service have developed – which allows for more creative partnership working, problem solving and better outcomes for staff and patients.

Key findings

1. Helping to ease hospital pressures by speeding up safe discharge home – "their can-do attitude, it should be bottled to pass around people"

Housing is an essential piece of the puzzle in enabling people to return home at the right time, with the right care and support in place, with the right housing environment to support recovery. Hospital to a Healthier Home resolves housing issues essential for discharge within **two working days, or same day if possible.** The speed and reliability of the service is one of its key successes and was reflected favourably on throughout the evaluation.

> "We had a new member of staff recently who moved from England, and she couldn't believe that we had a service that would go out the same day to do a key safe… that's why we add it into the introduction to the team because it's a pathway we use for a lot of our cases."
>
> **Bethan Williams,**
> Social Worker in the Joint Discharge Team
> **Withybush Hospital**

> "That pressure of flow in the hospital. Any kind of delay in length of stay, it just backs up and clogs up the whole system… by having these adaptations, it's reducing the need on the service, it's keeping people independent in their primary environment."
>
> **Bethan Hughes,**
> Occupational Therapist Clinical Specialist
> **Bangor Hospital**

From an NHS perspective, busy wards offer a time-sensitive opportunity to transfer a medically fit for discharge patient home before risking deconditioning. With experience our caseworkers now make decisions on prioritising patients, with some agencies triaging works into essential and non-essential for hospital discharge, and into urgent or non-urgent depending on the expected length of stay. This helps manage workloads and expectations, and is possible thanks open dialogue and partnership between NHS staff and caseworkers.

> "The caseworker knows she can help to prioritise, she knows we've got one patient that could be going home next week, but there's somebody on the list that doesn't need to go home for six weeks... I think it's just having a face to face rather than sending emails or phone calls going around in circles with different people."
>
> **Lynne Driscoll,**
> Site Matron
> **Neath Port Talbot Hospital**

Like all Care & Repair's work, the service is targeted at older people more at risk of unscheduled care admissions. Patients within this demographic may require a package of social care to support living at home. The service plays a role in supporting discharges that require packages of care by ensuring homes are accessible for care workers, ensuring packages of care do not fall through at the last minute because of a housing issue leading to delays in discharge:

> "A good example is to do with cleanliness in properties and deep cleans. We have an awful lot of patients that we can't get out because carers won't work in those properties in those conditions, and that's made a huge difference to discharge planning and getting people out of hospital quicker"
>
> **Charlotte Warner,**
> Band 7 Occupational Therapist,
> Acute Medical Team
> **Prince Charles Hospital**

> "Installing key safes is huge. It's something we really struggled with before. And then those cases those it can be essential for discharge because a package of care starting can be dependent on access to property."
>
> **Bethan Hughes,**
> Occupational Therapist Clinical Specialist
> **Bangor Hospital**

> "There's been some instances where carers refused to go into somebody's property to provide the care because of hoarding problems, risks to the carers, infection control. So having that cleaning quote and removal quotes made the process much smoother because [the H2HH caseworker] coordinated that side of things"
>
> **Bethan Williams,**
> Social Worker in the Joint Discharge Team
> **Withybush Hospital**

Our learning from the evaluation proved how the service continues to support the discharge planning process. The flexibility of caseworkers and resource available through Rapid Response Adaptations capital and handypersons mean that the service is agile and responsive in both larger works essential for discharge, and small emergency adaptations.

The seemingly smallest parts of hospital discharge such as moving furniture, sourcing aids, supply of white goods, and housing access, often presented some of the most challenging problems that our caseworkers could assist with.

> "They will assist on moving furniture when very often other organizations, including social services, would find that very difficult. A simple example is moving beds, we wouldn't do that these days. We are not geared up to do the practical things that Care & Repair does"
>
> **Wayne Turner,**
> Social Worker
> **Royal Gwent**

There was a sense from the operational staff we interviewed working at the penultimate point of the discharge process that the service is a go to tie up essential loose ends, where otherwise patient need could not be met easily resulting in delayed discharge.

> "We've had some issues with some patients and we just, we can't think of how we're going to solve this. But with Cath being in it's been an extra person to problem solve some things with … she always says or leave it with me"
>
> **Rachel King,**
> Occupational Therapist
> **Ysbyty Ystrad Fawr**

Staff referred to relying on our caseworkers' knowledge and expertise of support available from ourselves and in the community, to help solve snagging problems that would otherwise take a time to research, resource, and resolve.

2. Embedded service and accessibility

To protect staff and patients, most of our caseworkers began working remotely during the pandemic. This offered new challenges and opportunities. Some staff began to take part in virtual ward and team meetings, and referrals were received via phone and email.

Presence back in hospital now varies across Wales, with some staff present in hubs with allocated discharge team hubs several days a week, some in hospitals every day, and some on an ad hoc basis to check in with NHS staff and pick up referrals. We found this there was no set pattern to this across Wales and was site specific rather than health board based.

Most caseworkers were involved in some sort of virtual or in-person ward round or planning meetings, with the caseworkers being viewed as a resource and a valuable source of information in those areas where they were needed most. The specifics of these meetings naturally varied between hospitals with different ways of working, pressures, and policies.

Integration via virtual team meetings to offset reduced hospital presence:

> "[The H2HH caseworker] sits on our clinically optimized meetings weekly, and then we discuss any hurdles that there are for patients to go home, which quite often is a lot of the housing issues, whether it's cleaning or rails and so on"
>
> **Lynne Driscoll,**
> Site Matron
> **Neath Port Talbot Hospital**

Integration through built-in referral pathways to offset reduced hospital presence:

> "[The service is] built into our initial assessment as a pathway onwards, that's how much kind of we use it. And it's actually a part of our team. As I started the role, it was introduced to me as a service that we use for patients to support discharge"
>
> **Olivia Newton-Hale,**
> Occupational Therapist, Medical Surgical Team
> **Ysbyty Gwynedd**

In person presence at a Joint Discharge Hub:

> "If you came along and met the team you wouldn't really know she's a third party, which is beneficial for [the H2HH caseworker] and us. To have that access because she has so much more knowledge, but she is also independent from the health and social care aspect, you have that aspect of being based in the hospital but going into the community a lot more"
>
> **Bethan Williams,**
> Social Worker in the Joint Discharge Team
> **Withybush Hospital**

In our previous evaluation, we concluded that best practice amongst our caseworkers came from those who are fully involved in ward rounds, discharge planning meetings and provided a desk within the hospital amongst other inclusions which made for better partnership working that could really target earlier intervention. We stated that 'where integration of H2HH is best, it is a clearly identifiable go-to service'. Knowing that our staff now work in a mix of ways around hospital restrictions, we wanted to test whether H2HH was still the go-to service, and whether in some areas a reduced presence in hospitals had impacted how included our caseworkers felt, and how accessible staff found them.

We have still found that the service is a go-to service. This is driven by tenacity of caseworkers, who proactively sought referrals during periods away from hospitals and continued to 'show face' online and in person to remind NHS staff of the service and its capabilities. In newly onboarded hospitals, caseworkers have provided leaflets, posters, and presentations to staff to explain the service to gain trust and help communicate the service.

3. Accessibility of caseworkers - “it’s never a no”

In a busy hospital, communication is key. Over time the service has become a trusted go-to for staff. Increasing referral numbers show this to be true, but when asked why they refer to the service, staff repeatedly referred to the availability and responsiveness of caseworkers meaning the service could be a relied go-to to ensure that discharge processes were smoother.

> “I think we’ve got really good communication now. So that’s helpful for us, it means that our sort of momentum and our discharge planning is really streamlined as much as possible. And I think communication is key. It’s lovely to have those two-way conversations so that we know exactly what’s happening. And we can feed back to the board, we’ve been asked all the questions all the time, you know, when things been done, equipment going in, etc. So I think having [the H2HH caseworker there] there as a point of contact and advice and keeping the momentum is really key”
>
> **Catherine Williams,**
> Occupational Therapist
> **Ysbyty Ystrad Fawr**

We found that since moving to hybrid working, accessibility of caseworkers either remained the same or improved, with new phone or email referral pathways saving time. Presence in the hospital is still essential to inform staff about the service, build rapport with staff and patients, discuss specific cases and team wellbeing, but it is not essential to receiving referrals.

> “I’ve got her phone, she’s really good on emails and on the phone, and she’ll phone us imminently just to triage a referral as well. So I think she’s that person who can identify the need, rather than the general office to triage it themselves, she’s probably got a better outlook on the acute need, or the necessary for it to be essential for discharge as well”
>
> **Zoe Hall,**
> Occupational Therapist
> **Ysbyty Eryri**

> “So before [NHS staff] used have to fill those three-page referrals and send them through to the office to get the work done. But they love it now they can just catch me in the corridor, they can just ring us, or they see us on the ward, and they say ‘Oh, actually, Mrs. Jones in that bed over there needs…” so the referral process has been really streamlined down to just the one sheet of paper or just a phone call. They just need to give us minor details and we can go on the ward and get the rest of ourselves. So in terms of that it’s really helped the hospital staff the same saving their time”
>
> **Meinir Woodgates,**
> H2H Caseworker at Bridgend County Care & Repair, working out of the Princess of Wales Hospital

Although hybrid working has improved the flexibility and simplified the referral process for NHS staff, we must acknowledge the potential knock-on effect this has on patients who now may not see the caseworker before their hospital discharge. Again, this varied by individual case, but a general trend shows that overall the contact time with patients in some hospitals prior to discharge has reduced. Staff have developed skills to prioritise patient contact time to those who may be in need of additional longer-term support at home.

4. Partnership working to save time – “they coordinate the uncoordinated, the oil in the machine”

The partnership ethos of the service shone through in the evaluation. Many of the NHS staff we interviewed referred to our H2HH caseworkers as the ‘linkage’ between themselves and patients, their families, external companies, and community resources. The staff referred to the amount of time the caseworkers saved them by taking on this important role.

> “One of the best things that we’ve had really is that [the H2HH caseworker’s] visit the home sometimes, and she’ll take photos, which has really been helpful for us in the hospital… then we can add that to our assessments here.”
>
> **Rachel King,**
> Occupational Therapist
> **Ysbyty Ystrad Fawr**

> “We do rely on their skills a lot as well, knowing the type of walls that rails can be fitted to, because we’re just going through what the patient says a lot of the time. And if they don’t know how solid their wall is - there’s quite a few factors. They [Care & Repair technical staff] are very skilled, we rely on them a lot. They go out most of the time, and we never even see the property.”
>
> **Olivia Newton-Hale,**
> Occupational Therapist, Medical Surgical Team
> **Ysbyty Gwynedd**

> “[The H2HH caseworker] will say I can have a look at that when I go out and link in with you. So that’s made a huge difference, just not having to go out leaving the wards or actually takes a huge amount of time, not just the actual visit the travel time, and then your documentation. So it saves us an awful lot of time. And actually, he can look at things that we might not necessarily think of as well, I think he can see it from a different perspective. And think of different ways that we can get things resolved that we wouldn’t be able to do. And a good example of that is things to do with cleanliness in properties deep cleans”.
>
> **Charlotte Warner,**
> Band 7 Occupational Therapist,
> Acute Medical Team
> **Prince Charles Hospital**

> “I think the amount of work that [the H2HH caseworker] would have put in for the amount of phone calls and time doing visits and documentation, you’d need another two OTs on site to basically cover though the job.”
>
> **Tracy Daniel,**
> Band 7 Team Lead Orthopaedics
> **Princess Charles Hospital**

Where H2HH works best, our staff have proven just how useful they are in allowing busy, under pressure hospital staff to get on with their job and fill in the gaps that they or social services cannot provide. The service plays a vital role in organising, problem solving, funding and completing housing repair and adaptation work essential for hospital discharge, and over time has gained the trust of hospital staff that we are able to do this with speed, quality and reliability.

> “As an OT, we would spend a lot of time trying to facilitate the minor adaptations key safes and trying to find grants and things for cleaning homes, which would remove our presence from the ward for doing rehab assessments ourselves. So if anything, you’re allowing us to do our role to a better standard while we’re able to just link them with you, just for a small window of our working day, and know that that’s going to be sorted in the background and that we are getting those updates as we go along. My role would be consumed with the adaptation side of things and tracing things and patients would be delayed in hospital because of it. There’d be delayed discharges, and there would be readmissions because of it.”
>
> **Zoe Hall,**
> Occupational Therapist
> **Ysbyty Eryri**

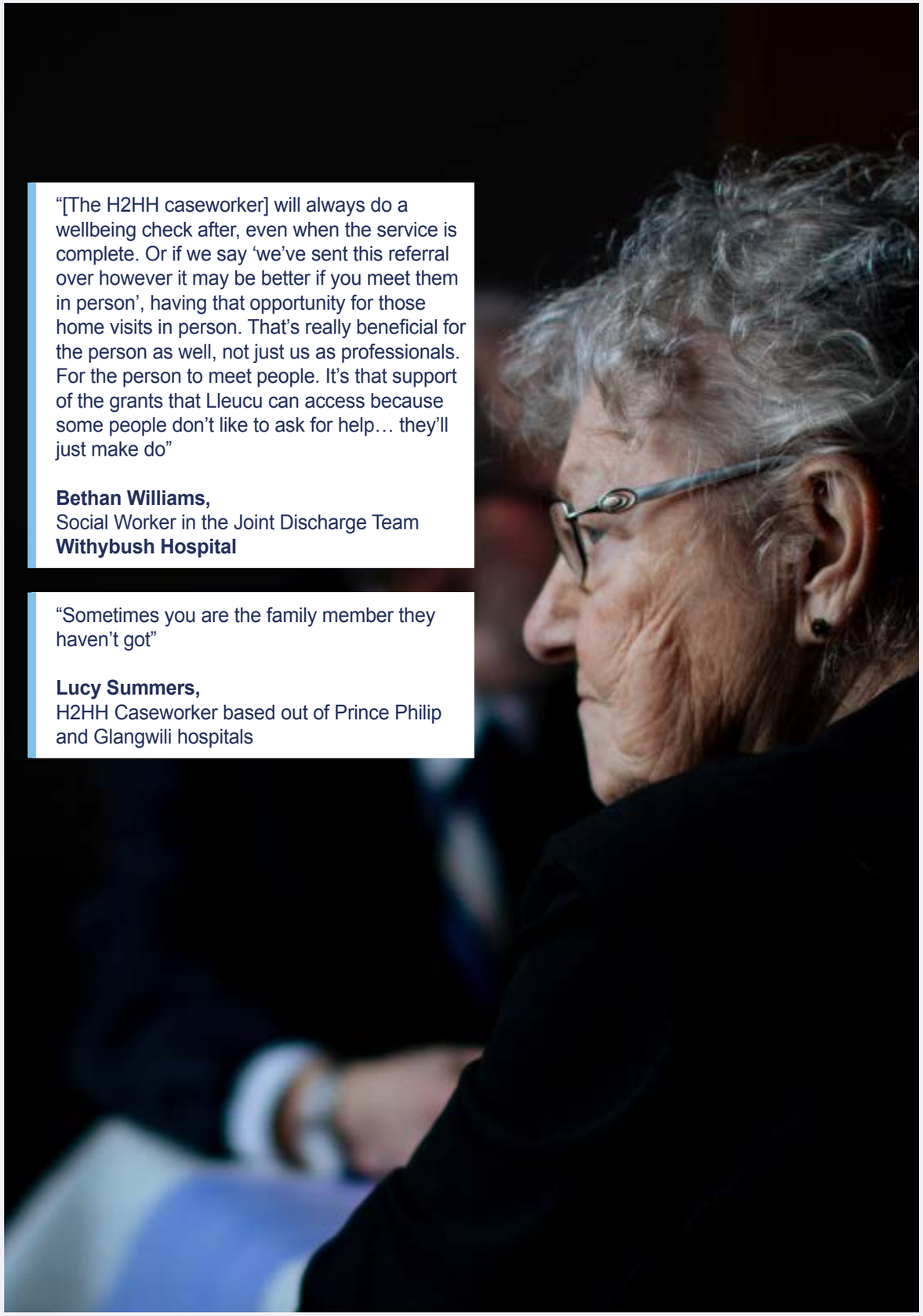
5. Maximising independence and reducing readmissions through additional long-term support for patients – “It’s almost like a safety net, having some contact with some service”

Independent living at home in unfit housing for older people across Wales often means worry and anxiety, risks of accidents such as flips and trips, and illnesses brought on my cold and damp environments. From an NHS perspective, works referred to the H2HH scheme to ensure safe hospital discharge are often small, targeted works aimed at assisting with a particular mobility problem identified in hospital at the bedside. Our Healthy Homes Check is undertaken by our caseworkers as part of the H2HH service offer. It provides a thorough home audit of all risk factors in the home to support people to live independently for longer and has been proven to reduce readmissions and delay admission into residential care settings.

> “We’ll ask for, say, a toilet rail here and this there… but [the caseworker] will go out and do a full assessment on top of that…it does give you a bit of reassurance. Not only is [the patient] going to get what you’ve asked for, but you know that there’s going to be an all-round check”
>
> **Rachel King,**
> Occupational Therapist
> **Ysbyty Ystrad Fawr**

> “The quality [of discharges] is a lot better since we’ve got Care & Repair because there are a lot more checks going on than we would have done and been able to action previously. If you’ve got people with, say chest problems with damp and things in property, because they are those properties that actually been changed now, that stops them being readmitted again in the future because of the housing condition. So, it’s a knock-on preventative effect”
>
> **Tracy Daniel,**
> Band 7 Team Lead Orthopaedics
> **Princess of Wales Hospital**

> “I know that all patients we’ve referred when discharged home have follow up by Care & Repair, and needs may have been identified that were not essential for discharge, or they may that the caseworker come back to said actually, the patient’s gone home, but they’re really struggling with this…and that’s something that would have been missed if we hadn’t got the H2HH caseworker. It’s more important for the patient as well. It’s a big jump – you can become institutionalised in the hospital”
>
> **Vinny Tilley,**
> Occupational therapist
> **Denbigh Infirmary Community Hospital, Ruthin Community Hospital**



> “[The H2HH caseworker] will always do a wellbeing check after, even when the service is complete. Or if we say ‘we’ve sent this referral over however it may be better if you meet them in person’, having that opportunity for those home visits in person. That’s really beneficial for the person as well, not just us as professionals. For the person to meet people. It’s that support of the grants that Lleucu can access because some people don’t like to ask for help… they’ll just make do”
>
> **Bethan Williams,**
> Social Worker in the Joint Discharge Team
> **Withybush Hospital**

> “Sometimes you are the family member they haven’t got”
>
> **Lucy Summers,**
> H2HH Caseworker based out of Prince Philip and Glangwili hospitals

6. Expansion into Emergency Departments to assist with Discharge to Recover then Assess

In some areas, the service has expanded beyond its original wards to cover the Emergency Department, so that patients can be turned around at the front door with additional support to avoid a hospital admission. In these areas, the service is supporting Discharge to Recover then Assess

> "For example, an elderly frail lady who may have fallen and, and fractured her wrist. So under normal circumstances, she manages pretty well at home. But because she's got this fracture, it's resulting in her not being able to get about as independently. So she doesn't want to be admitted, we don't need her admitted, because it's just going to decondition her even more. So what we want is for that, just that little bit of additional resource to support at home, and that might be something as simple as a handrail. It's as simple as that. Historically, we would have to do with social work referral, we would have to do wait for that social worker to be allocated. And they are inevitably they end up being admitted. So from our perspective, particularly ED, [H2HH] it's invaluable."
>
> **Eleri Evans,**
> Head of Nursing
> **Ysbyty Gwynedd**

For this model to be expanded into other hospitals, additional resource would be required. We should note that in some areas, Care & Repair services are working at a Primary Care level, with GP Clusters, and through social prescribing mechanisms, to prioritise prevention of dependency on more acute services, or to provide on-going focus on safe and comfortable conditions for recuperation at home.

Progress on previous recommendations made in 2019

1. Maximising opportunities for independent living and speeding up safe discharge

Recommendation 1: routine 'offer' of a Healthy Home Assessment to all frail patients being discharged from hospital as a preventative intervention

All established Caseworkers have completed trusted assessor, with those onboarded in financial year 2022-2023 either obtaining or close to obtaining this qualification meaning they can complete HHCs safely and professionally

The overall number of HHCs being completed each year has increased, however the percentage of patients receiving a HHC has decreased. Our caseworkers receive more referrals than can reasonably be expected to complete a HHC for every single patient. Instead, our caseworkers have developed skills in identifying, triaging and prioritising longer-term HHC support and works by working with NHS staff and social care to identify patients most in need of on-going housing and wellbeing support post discharge.

Recommendation 2: Care & Repair Cymru to develop a H2HH good practice guide to drive effectiveness, efficiency and consistency across hospital sites

Good practice guide developed and shared with all caseworkers

In need of review and will be timetabled using this report and as the experience of working to the Six Goals for Urgent and Emergency Care identify greater opportunity and provide greater focus

2. Providing added-value and reducing risks of readmission

Recommendation 1: a more formal link between H2HH and NHS Planning Policy

Patchy implementation of principals of national policy across health, linked to Covid recovery and systematic approach to developing joint-working relationships. Some good links established with the NHS Delivery Unit and continued relationship with Welsh Government's Urgent and Emergency Care Policy Team

There could be a greater role for CRC and CRA in shaping visibility of the service within hospital and building relationships

Recommendation 2: greater understanding of the 'housing offer' from a H2HH, potentially linked to NHS workforce development (awareness training)

A more embedded approach to NHS induction for new starters, staff rotation and agency staff, to include awareness of housing and independent living services such as H2HH

3. Co-location and NHS Systems Enhancement

Recommendation 1: longer-term funding to sustain and expand the co-located model of service delivery of H2HH

Covid restrictions have resulted in the co-location model being adapted, demonstrating the agility and responsiveness of the service. The service continues to identify the most effective site presence and communication systems to optimise the service's accessibility for busy NHS staff

The service continues to experience issues with long term funding

4. Patients/Clients and Transitions of Care

Recommendation 1: Feedback loops should be embedded, to ensure H2HH post-discharge reports are provided to key professionals in the MDT for discharge coordination

Feedback and communication between caseworkers and NHS staff identified as a positive during this evaluation period, with NHS staff praising the proactive updates they receive on patient works

Next for H2HH: new recommendations based on new learning:

Recommendation 1: retain or re-establish a regular physical presence in all hospitals

This report makes it clear that the variation across the service in hospital presence is a strength of the service. There is no 'one size fits all'. However, it is clear from our qualitative research that ensuring a regular physical presence across all hospitals would bring multiple benefits to caseworkers, NHS staff and patients.

> "It would be nice to have [the H2HH caseworker] doing a bit more back on sites. We miss it. The same with our discharge coordinators. maybe we could do something about twice a week they came in. They could be joined at the end of a band meeting, maybe just to say, right, we're here"
>
> **Eleri Evans,**
> Head of Nursing
> **Ysbyty Gwynedd**

> "It would be a very powerful addition. But [the lack of hospital presence] doesn't necessarily get in the way because the avenue to contact the service is so open. But it could complement it. Face-to-face contact certainly wouldn't hamper things"
>
> **Wayne Turner,**
> Social Worker
> **Royal Gwent**

Recommendation 2: all H2HH caseworkers integrated into regular discharge planning meetings

This has been identified as an example of good practice during this report and should be expanded to across all caseworkers across all principal sites to ensure the service continues to be visible and well-embedded.

Recommendation 3: include H2HH in induction information for all new relevant NHS staff, rotation

Including information about the service as part of inductions for new starters, staff rotation and agency staff has been identified as an example of good practice happening across several hospitals the service operates in, and should be expanded to all.

Recommendation 4: regular information sessions with H2HH caseworkers to inform NHS staff of new support the service can provide

The nature of third-sector funding means that the scope of our service can change over time as new grants for works become available, meaning regular refresher sessions about the service and its scope would benefit staff and patients.

Recommendation 5: service information to provide to patients for self-referral

> "This whole ethos of empowering the patient to do as much for themselves as possible, if there was an up-to-date leaflet, with the extra services available, or ways that patients could refer themselves, that would be great"
>
> **Rachel King,**
> Occupational Therapist
> **Ysbyty Ystrad Fawr**

Recommendation 6: develop a hardship fund for cleaning and decluttering works accessible to H2HH caseworkers to support hospital discharge

Whereas decluttering and deep cleaning was not featured in our pilot evaluation in 2019, the topic came up in every health board we engaged with during the process of this report. Our caseworkers are consistently experiencing increased demand for decluttering services:

> "We're desperate for some money for decluttering. Some of the caseworkers are going out and doing the decluttering themselves. We had five decluttering cases this week"
>
> **Meinir Woodgates,**
> H2H Caseworker at Bridgend County Care & Repair speaking in August 2022, working out of the Princess of Wales Hospital

In financial year 2021-2022 Care & Repair Cymru were able to offer a Decluttering Fund to meet this need.

> "it always falls to an OT to sort. Whereas functionally, this person might be completely independent and have no functional, needs. So I think that's been a really good service [the H2HH decluttering fund], just to link in with because that was a big gap"
>
> **Bethan Hughes,**
> Occupational Therapist Clinical Specialist
> **Bangor Hospital**

However, the need has not gone away. Speaking across the board, NHS staff also recognised an increasingly prevalence and attributed it, among other things, to isolation and lack of access to community services during lockdown restrictions that may have prevented underlying hoarding tendencies to build-up into hazards at home.

Recommendation 7: strategic level partnership building to help manage and monitor the service

The report has demonstrated the strong operational level relationships caseworkers have with clinical staff across the service. The service would benefit from strengthened strategic relationships to communicate the successes of the service, including patient-outcomes, cost benefit, reducing hospital pressures and meeting longer-term policy goals.

Recommendation 8: data sharing agreements to allow for better patient outcome measurement

Although we collect our own patient outcome data, this would be strengthened for both parties by working more closely with health boards. Thanks to our long-term support for patients, we can offer health boards longitudinal data about patient independence and confidence at home, as well as access to patient stories and case-studies long after the patient goes home, to better understand gaps in service provision. From Care & Repair's perspective, we have worked with one health board to establish a readmission rate for the service, and wish to develop this nascent work to further prove and quantify the additional benefits to the service from a health perspective.

Recommendation 9: long-term, sustainable funding for the service

The service has proven its worth in terms of cost savings, patient outcomes and staff wellbeing. The service fills a gap in the discharge process that health boards do not have scope or capacity to do. To develop and innovate, the service must have the security of long-term funding.

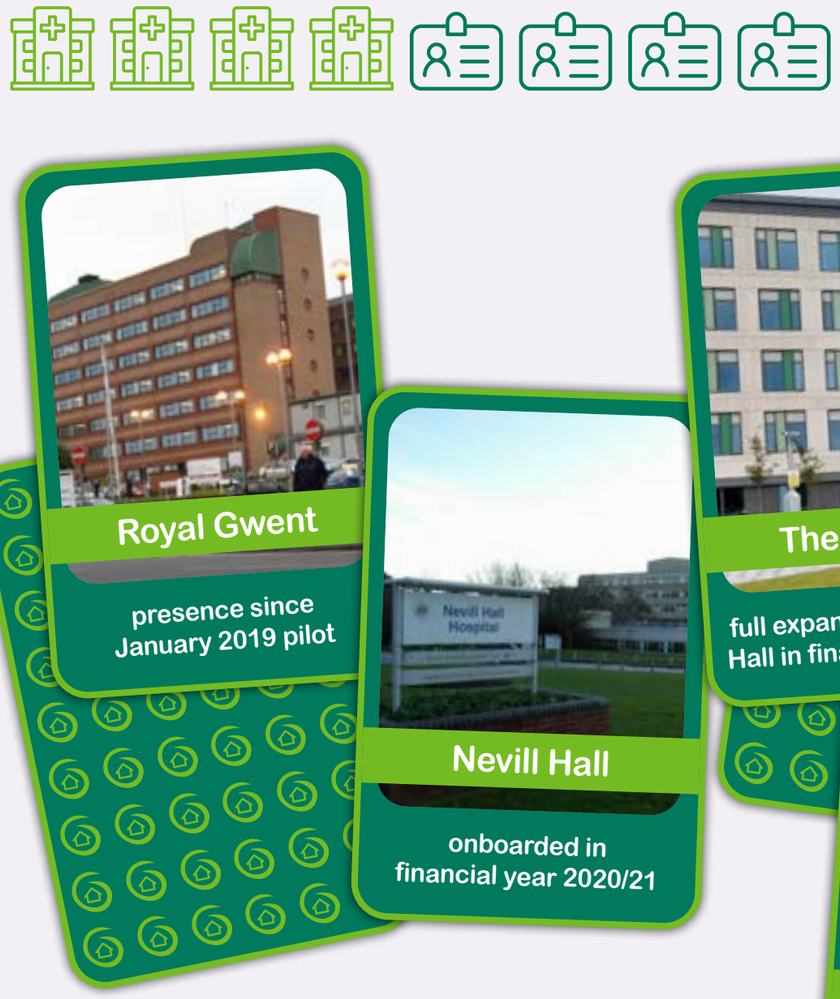
H2HH Local Health Boards Profiles

Aneurin Bevan University Health Board

A service going from strength to strength with local support

Blaenau Gwent & Caerphilly Care & Repair,
Care & Repair Monmouthshire and Torfaen, Newport Care & Repair

4 principal hospitals and 4 caseworkers



Community hospitals

St Woolas, Mardy Park, Chepstow Community Hospital, Monnow Vale Health and Social Care Centre, St David's Hospice, Royal Papworth, County Hospital Pontypool

Patient story

Mrs H is 77 years of age and was referred to the H2HH Caseworker whilst a patient at Nevill Hall Hospital, following a full right arterial stroke.

A referral was made by an Occupational Therapist, to provide an additional electrical socket in the front lounge for a hospital bed ready for discharge. Without the socket the bed installation could not take place, meaning the package of care would be lost. The electrician Care & Repair organised to install the additional sockets in the lounge reported concerns to the Caseworker regarding the safety of the electrics at the property and he recommended an urgent rewire of the sockets in the kitchen.

The patient's daughter had moved to help organise the house however was feeling overwhelmed and isolated.

The H2HH Caseworker arranged to carry out the Healthy Homes Check (HHC) assessment with the daughter. The Agency arranged for a Contractor to remove the door to the living room for the hospital bed and to fit a curtain pole instead for a heavy curtain to make the layout of the living room more usable. We also made funded the fireplace to be boarded over to prevent draught and dust, funded via the Care & Safety at Home Grant Funding. We funded a rewire and additional socket in the kitchen for a washing machine through RRAP as the patient was double incontinent.

The caseworker also completed a welfare benefits check with Mrs H and her daughter. This led to Mrs H's receiving a higher-level Disability Living Allowance, increasing her annual income to £3,426.80. We helped Mrs H's daughter apply for Carers Allowance, increasing her income by £3,515.20 per annum, and talked through the advice and support available locally to her as a new carer. This included Torfaen Carers Centre for legal advice, and The Support Programme for New Carers. After discussion, Mrs H agreed for the Caseworker to register her for the Western Power Distribution's Priority Service Register with permission to share their details with Wales & West Utilities and Welsh Water. Free smoke and heat detectors were also fitted.

The work carried out at the property enabled the safe discharge of Mrs H. From an initial referral for an electrical socket, our caseworker has made sure that the property is warn, safe and free from draught to ensure Mrs H can live comfortably. Mrs H's daughter was able to access valuable advice and support and the family increased their annual income by a total of £6942.

> "You are an angel. Thank you so much for your help, caring and support. It's much appreciated"
>
> **Mrs H's daughter**

Betsi Cadwaladr University Health Board

Home first delivery model in challenging geographical area

Gofal a Thrwsio Gwynedd a Môn, Conwy & Denbighshire Care & Repair, Care & Repair North East Wales

3 principal hospitals and 3 caseworkers

Community hospitals

Deeside Hospital, Mold Community Hospital, Chirk Community Hospital, Ruthin Community Hospital, Colwyn Bay Community Hospital, Denbigh Community Hospital, Ysbyty Penrhos Stanley, Ysbyty Cefni, Ysbyty Eryri, Ysbyty Bryn Beryl, Ysbyty Alltwen, Ysbyty Tywyn, Ysbyty Dolgellau

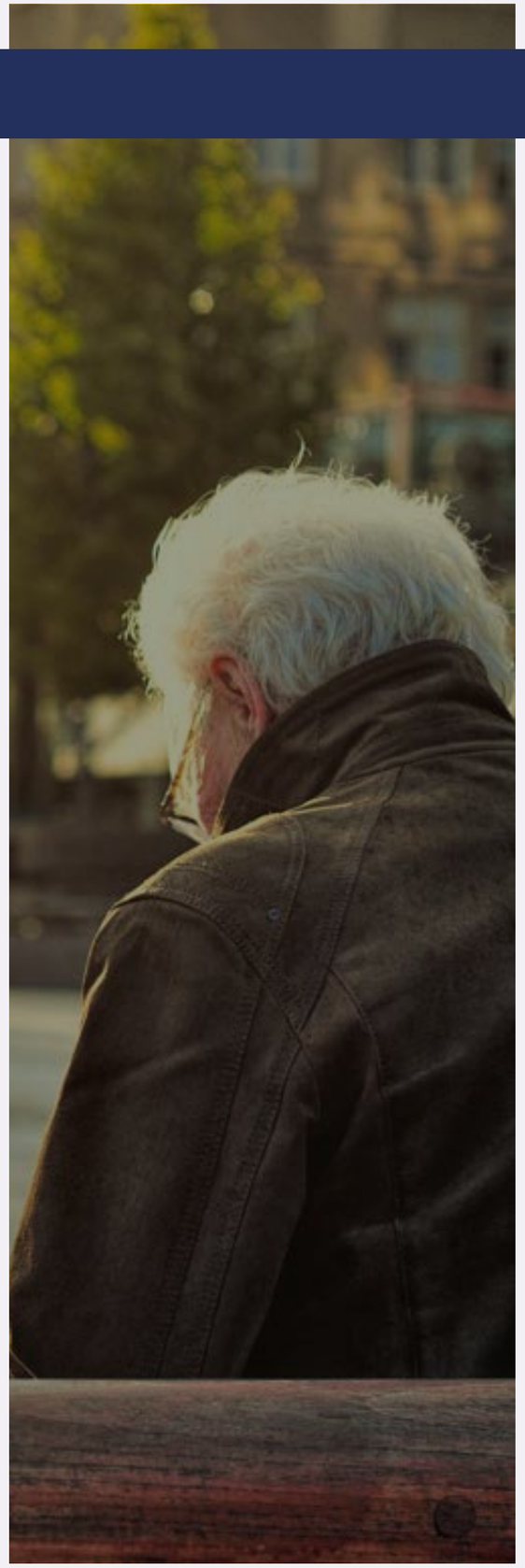
Patient story

Mr J is 84 years old, lives alone and was admitted to the A&E Department at Ysbyty Gwynedd, Bangor after suffering a fall in his home, due to mobility issues as he has very bad arthritis.

Before discharge the H2HH caseworker received a referral from the on-duty OT at the A&E department for an additional banister rail, and a handrail to be fitted on the wall next to the toilet in the downstairs bathroom. This work was carried out 2 days later by the handyman, funded through RRAP at a cost of £116.

After the initial work had been completed, the Caseworker carried out a HHC and a benefit check. It transpired that Mr Jones did already have a number of small adaptations around the house which had been previously installed by Care & Repair for his wife's needs, but she had passed away the previous year. Mr Jones said that he was coping "fairly well" but had been struggling for a while with only one banister rail on the stairs, but the additional rail had been "really useful and gave him extra support and confidence" using the stairs which made him feel better.

At first Mr Jones was rather reluctant to claim any benefits, so the Caseworker left him with information on Attendance Allowance and how he could now claim the single occupancy Council Tax (as he had not thought to inform the Council that he was now living alone) to think about, and with a promise to ring him back. On following up with Mr Jones he decided to go ahead with the benefit advice. This resulted in him receiving a rebate payment from the Council of £461 and then a 25% reduction in his future Council tax. His claim for Attendance Allowance was successful and he received a one-off sum of £537.60 and then a £89.15 weekly payment.



Cwm Taf Morgannwg University Health Board

Strength of embedding in the hospital

Bridgend County Care & Repair and Cwm Taf Care & Repair

3 principal hospitals and 6 caseworkers

Community hospitals

Glanryhd hospital, Angelton Clinic, Ysbyty Seren, Llynfi Hospital, Ward 21 (relocated Maesteg Hospital), Bryn y Cae

Patient story

Mr C is 70 years old and was admitted to the Princess of Wales Hospital following a fall at home. It was identified that a deep clean and declutter was required of the property prior to his discharge. Our Hospital Caseworker met with the specialist cleaning company at the property, with Mr C's permission.

A quote of £995 was provided for a deep clean and de clutter of the property, including removal of waste, contaminated waste and a hot shampoo of carpets and furnishing. The cost was met by Care and Repair Cymru's H2H decluttering fund and Veteran Hardship fund.

However, it was also identified that there was no hot water or heating at the property and the WC needed replacing. A Healthy Homes Grant of £350 was secured by the Caseworker to repair Mr C's boiler and provide a new toilet.

The Occupational Therapist at the hospital approached the Caseworker to request assistance with sourcing a recliner chair for Mr C for discharge. The Caseworker was able to raise grant funding of £795 to purchase a recliner chair that was delivered by the time of discharge. However, it was found on delivery that there was no electric socket in situ, a RRAP grant was therefore accessed to provide a new electric socket at the property.

Mr C was very anxious of returning home and possibly falling again, the Caseworker therefore completed a Telecare assessment with him on the ward and arranged for our Home Safety Officer to install the system the day before his discharge.

Mr C was discharged following completion of the above works and the Caseworker visited him within a week at his home to complete a full assessment. She completed an application form for Attendance Allowance, which resulted in an award of the higher rate at £89.60 per week.

She also arranged for the Agency Occupational Therapist to visit Mr C, she has since submitted recommendations to the Local Authority for a Disabled Facilities Grant for a wet room, the Caseworker is currently assisting with this application.

Mr C's was still concerned about his boiler as it was very old and inefficient and unlikely that parts would be available if it broke down again. The Caseworker raised £3,000 benevolent funding from the RAF charitable fund and a new boiler system has been installed at the property.

Mr C also has ongoing issues with his flat roof, our Technical Officer has visited and is arranging quotations for the repairs. As Mr C is now in receipt of Attendance Allowance, he will qualify for a Comfort, Safety and Security Grant, which the Caseworker will process on his behalf.

Hywel Dda University Health Board

Partnership working – PIVOT

Care & Repair Carmarthenshire and West Wales Care & Repair

3 principal hospitals and 2 caseworkers

Community hospitals

South Pembrokeshire Hospital, Tenby Cottage Hospital, Amman Valley Hospital

Patient story

Ms F was a 63-year-old female in Withybush hospital. Ms F was referred to our H2HH Caseworker by one of the social workers in the Joint Discharge Team. The patient had been admitted to hospital suffering from kidney and liver failure. Initial request was to support the patient with some minor adaptations to get her property safe and suitable for her to return home.

Staff were concerned at how far along the failure was and questioned why she had not been admitted into hospital sooner. For this reason, Social Services became involved due to the concerns that the patient, as a vulnerable adult, had been abused and or neglected and action had not been taken to keep her safe from harm and risk. A POVA order was issued, with her household member placed on the POVA list. This meant that the patient needed to find somewhere else to live.

The patient had inherited her mother's old property and after many discussions with the patient it was decided they would move there after it was cleared, cleaned, and made safe for her. The patient did not have savings and no financial information or cards with her at the hospital. Care & Repair organised for the new property to be emptied, and our H2HH caseworker liaised with the patient's previous household member to collect their belongings from their previous property. Care & Repair funded storage of these items to speed up the process of preparing the house and speed up discharge from hospital. Our H2HH caseworker then arranged for the house to be deep cleaned and secured funding for this.

The property did not have a functioning kitchen so our H2HH caseworker sourced some free cupboards and cabinets from Care & Repair West Wales links with the housing association and purchased a large worktop under RRAP. A Care & Repair handyperson fitted the worktop and cupboards the same day to ensure the patient could prepare food upon discharge. A washing machine and cooker were purchased for the property from Care & Repair's central Hardship fund. Crockery was sourced from a local Care & Repair partner, the charity Frame.

Post-discharge, the H2HH caseworker visited to complete a HHC. Care & Repair fitted various grab rails around the property via RRAP to improve home safety and reduce risk of falling. The H2HH caseworker referred the patient on to Nest for a new heating system; the Fire Service for fire alarms; and a referral for an accessible wet room was made. The H2HH caseworker also ordered aids including a commode, perching stool and a toilet raise to be delivered.

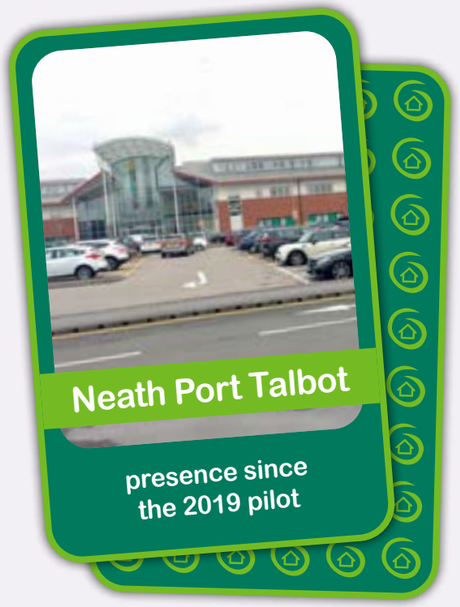
Finally, a benefits check was completed and the H2HH caseworker successfully applied for a council tax reduction on the patient's behalf of 25%.

Swansea Bay University Health Board

Working throughout the health board

Western Bay Care & Repair

3 principal hospitals and 2 caseworkers



Community hospitals

Singleton

Patient story

Mrs S had a stroke, to support her return from hospital various works were carried out by Care & Repair under a RRAP referral from the hospital, including rails to external steps and galvanized rail to a rear path, mopstick rail on the stairs. These works were essential to ensure Mrs S could return home from hospital to safely continue her recovery.

After these essential works had been completed, the Hospital to a Healthier Home caseworker made contact and arranged to visit to complete a HHC and discuss any concerns Mrs S might have.

Mrs S still had her bed downstairs and was not using the mopstick rail which had been installed to support her as yet, but she had been going up and down the stairs when her family were with her to get used to doing so again. The Caseworker sat and listened to her concerns; she was a very determined lady who intends to be as positive about her recovery although she was aware that she will need time to adjust to the effects of her stroke. The caseworker carried out a Benefits Check and discussed an application for Attendance Allowance. Mrs S was not aware of Attendance Allowance and was happy to apply. An application was duly made resulting in the high level of Attendance Allowance being awarded meaning an additional £4,635 a year in income.

The Caseworker while carrying out the HHC noted that there was no smoke detector upstairs, a referral was discussed and made to the Fire Service for free smoke alarms.

With thanks to

There would be no H2HH service without our fantastic caseworkers, whose hard work is the success of the service.

We would like the thank the following Care & Repair Hospital to a Healthier Home Caseworkers:

Allyn Litchfield and Julie Lomas, based in Prince Charles Hospital and Royal Glamorgan Hospitals

Amy Black, based in Wrexham Maelor

Carol Williams, based in Gorseinon, Morriston and Neath Port Talbot Hospitals

Cath Tetley, based in Ysbyty Ystrad Fawr

Danielle Hankey, based in Ysbyty Glan Clwyd

Donna Coughlin and Vicky McGrath, based in The Grange and Nevill Hall Hospitals

Elin Evans, based in Ysbyty Gwynedd

Gethyn Peploe, based in Royal Gwent

Jemma Lewis and Claire Miles, previously based in Prince Charles Hospital and Royal Glamorgan Hospitals

Lleucu Powel, based in Withybush Hospital

Lucy Summers, based in Prince Philip and Glangwili Hospitals

Meinir Woodgate, Cath Dixon, Lisa Sullivan and Christine Beadsworth, based in Princess of Wales Hospital

We would like to take this opportunity to thank the NHS staff who took time to be interviewed for this report:

Aneurin Bevan University Health Board

Catherine Williams, Occupational Therapist, Ysbyty Ystrad Fawr

Joshua Curtis, Discharge Coordinator Ward D4 East, Royal Gwent Hospital

Rachel King, Occupational Therapist, Ysbyty Ystrad Fawr

Wayne Turner, Social Worker, Home First Team, Royal Gwent and Nevill Hall Hospital

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Bethan Williams, Social Worker, Joint Discharge Team, Withybush Hospital

Sarah Davies, TOCALS Physiotherapist, Glangwili

Swansea Bay University Health Board

Lynne Driscoll, Site Matron, Neath Port Talbot Hospital

Glossary of Terms

CRC – Care & Repair Cymru

CRAs – Care & Repair Agencies

H2HH – Hospital to a Healthier Home

H2H – Hospital to Home, the name of the service in Bridgend County Care & Repair where the service was initially proto-typed and developed

[i] Senedd Cymru, Health and Social Care Committee, Inquiry into hospital discharge and its impact on patient flow (2022), page 21

[ii] Stats Wales, Health and Social Care, NHS Hospital Waiting Times Referral to Treatment, Accessed August 2022. Available at: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment/patientpathwayswaitingtostarttreatment-by-month-groupedweeks-treatmentfunction ; Senedd Research, Access Delayed: The Waiting Times Backlog in NHS Wales (June 2022) Available at: https://research.senedd.wales/research-articles/access-delayed-the-waiting-times-backlog-in-nhs-wales/

[iii] Stats Wales, Health and Social Care, NHS Waiting Times, Accessed August 2022. Available at: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/emergency-department/performanceagainst4hourwaitingtimestarget-by-hospital

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