Hospital discharge and admission avoidance: Essex County Council

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Context

Essex County Council established a Better Care Fund pilot in 2019 to create priority pathways for housing-related interventions that support hospital discharge or avoid hospital admission. The one year pilot covered nearly all districts within Essex by having one senior housing OT in each quadrant. After evaluation, half of the districts chose to continue the service (Colchester, Braintree, Chelmsford, Maldon, and Harlow) with support from three senior housing OTs. These roles have now operated for seven years, with rolling three-year contracts funded through Better Care Fund arrangements and partnership agreement between social care and each district.

The challenge

Hospitals faced significant discharge delays when patients required major adaptations to return home safely. Traditional social care OT pathways meant:

- 12+ week waiting times for standard social care OT assessment for home adaptations
- Further delays at district level for DFG application and approval processes
- Patients waiting in hospital beds costing approximately £400-800 per day
- Unsuitable interim placements in care homes while awaiting adaptations
- Lost opportunities for rehabilitation due to extended hospital stays
- Hospital readmissions when people returned to unsuitable housing
- ‘Bed blocking’ preventing admission of other patients requiring acute care.

Additionally, people in the community experiencing sudden health changes (unplanned amputations, rapid deterioration, falls) faced hospital admission because their home environment couldn't support their changing needs, even temporarily.

The role

The Better Care Fund housing OTs provide a rapid response pathway specifically for cases where housing adaptations are essential to enable hospital discharge or prevent hospital admission. The role includes:

- Direct referrals from health teams – Bypassing standard social care referral route for patients who meet the following criteria: local residents who are homeowners or tenants privately renting or in housing association properties; with a life limiting or life altering health condition or rapid deterioration, and the major home adaptation relates to essential access in/around their home.
- Rapid response timescales – Assessment within 1 to 3 weeks (compared to 12+ week standard pathway) and often within days for most urgent cases. This includes patients returning home from out of county hospitals who meet the criteria.
- Hospital-based discharge planning – Liaising with hospital discharge teams from point of admission, to plan discharge from acute settings or rehabilitation facilities.
- Urgent adaptation assessment – Identifying essential adaptations needed for safe discharge (ramps, stairlifts, bathroom adaptations, door widening).
- Discretionary funding access – Using non-means-tested discretionary DFG funding to expedite hospital discharge cases by removing the need for financial assessment.

- Admission avoidance work – Responding to community referrals where urgent home adaptations could prevent hospital admission.
- Interim solution planning – Identifying temporary measures to enable discharge while permanent solutions are being arranged with no additional handover to other teams. If person has care needs, can also access 'Stepping Stone Home' programme for interim stay in sheltered accommodation for up to 12 weeks to allow adaptations to be completed.
- End-of-life care support - Fast-tracking adaptations to enable people to remain more safely at home if it is their preferred place of care, rather than in a hospital or hospice.
- Post-surgical planning - Assessing before elective procedures to ensure home is ready for discharge.

Benefits to the system

Housing benefits

- Strategic use of discretionary DFG funding for cases with highest health/social care impact
- Reduced pressure on temporary accommodation services
- Prevention of unsuitable emergency housing placements.

Health and social care benefits

- Significant reduction in delayed transfers of care
- Cost savings from reduced hospital bed days (£400-800 per day avoided)
- Prevention of hospital admissions through timely community interventions
- Reduced interim care home placements (approximately £1,036-1,382 per week avoided)
- Prevention of health deterioration during prolonged hospital stays
- Improved rehabilitation outcomes when people can return home quickly
- Reduced hospital readmissions due to unsuitable housing.

Financial impact (Colchester example)

- 25% of annual DFG spend consistently accounts for hospital discharge/admission avoidance cases
- 100% of priority pathway cases receive funding without financial assessment
- Cases processed within 2-3 weeks vs. 12+ weeks standard pathway
- Every case completed represents avoided hospital bed days (minimum 84 days avoided = £33,600-67,200 saved per case).

Benefits to individuals and families

- People return home quickly rather than waiting in hospital or interim care settings
- Patients can participate in rehabilitation in their own homes
- End-of-life patients achieve their wish to die at home with dignity
- Families avoid the distress of loved ones stuck in hospital due to housing barriers
- Reduced risk of hospital-acquired infections from shorter stays
- Maintained independence, reduced pressure on care-giver, and connection to community
- Prevention of deconditioning and loss of function during hospital stays.

Developing the role: a practical guide

Setting up the role

- Secure Better Care Fund or equivalent integrated care funding. Position this as reducing delayed transfers of care and hospital costs.
- Establish direct referral pathways from hospital discharge teams, intermediate care, hospice, community health teams, and mental health settings.
- Define clear eligibility criteria focused on hospital discharge/admission avoidance.

- Create service level agreements with social care or acute trusts, specifying response times and referral processes.
- Establish access to discretionary DFG funding that is non-means-tested for this pathway.
- Set up communication systems between OT, hospital discharge coordinators, grants officers and contractors.
- Define geographic coverage and caseload capacity based on hospital catchment areas.

Building the priority pathway

- Create simple referral forms that hospital staff can complete quickly with essential information.
- Develop triage protocols to differentiate true hospital discharge/admission avoidance cases from standard adaptations.
- Establish response time commitments (for example, initial contact within 48 hours, assessment within 5-7 working days).
- Build relationships with hospital discharge teams through regular meetings and presence on wards.
- Create fast-track agreements with grants team for priority pathway cases.
- Develop a list of contractors who can respond quickly to urgent adaptation requirements.
- Set up tracking systems to monitor hospital bed days saved and discharge facilitation.

Protecting the priority focus

- Resist scope creep. Be clear that this pathway is for hospital discharge/admission avoidance, not general adaptations.
- Use access-focused criteria, such as getting in/out of the house, accessing rooms, accessing toilets, getting up to bed.
- Redirect standard adaptation requests to appropriate social care pathways.
- Educate referrers about what constitutes a priority pathway case versus standard pathway.

Overcoming challenges

- **Challenge:** Inconsistent access to discretionary funding across different district councils.
- **Solution:** Advocate for policy harmonisation. Build business case showing cost savings from hospital discharge versus cost of discretionary funding. Use upcoming local government reorganisation to push for consistent discretionary policies. Document cases where funding inconsistencies prevented optimal outcomes.

- **Challenge:** Hospital teams over-referring non-urgent cases or referring too late in admission.
- **Solution:** Provide education to discharge coordinators about when to refer – ideally from point of admission. Create visual decision tools showing priority versus standard pathway criteria. Encourage contact to check patient suitability to meet criteria. Give regular feedback on referral appropriateness. Attend discharge planning meetings to advise in real-time.

- **Challenge:** Balancing rapid response for hospital cases with growing caseload demands.
- **Solution:** Maintain strict eligibility criteria. Use phone/video assessment where appropriate for initial triage. Work with grants team to streamline approval processes. Build capacity through additional posts if demand consistently exceeds capacity.

- **Challenge:** Limited ability to track outcome data on hospital bed days saved or admissions prevented.
- **Solution:** Create a simple tracking spreadsheet, capturing: referral date, assessment date, admission/discharge date, adaptation completion date, estimated bed days saved. Even estimates provide powerful data. Work with health colleagues to access hospital system data where possible.

- **Challenge:** Contractors unable to respond quickly enough for urgent discharge deadlines.
- **Solution:** Develop preferred contractor lists of those who can respond to urgent cases. Consider framework agreements with guaranteed response times. Explore interim solutions (temporary ramps, commodes) while permanent adaptations are arranged. Build relationships with contractors who understand the priority pathway purpose.

Demonstrating impact

- Track the number of hospital discharges facilitated, and average bed days saved.
- Calculate cost savings: bed days saved × cost per bed day.
- Monitor reduced care home interim placements and associated savings.
- Document admission avoidance cases and estimated hospital stays prevented.
- Measure time from referral to discharge.
- Record percentage of cases receiving discretionary funding approval.
- Track hospital readmission rates for priority pathway cases versus standard pathway.
- Collect patient/family feedback about experience and outcomes.
- Present impact reports to Better Care Fund commissioners and acute trust executives.

Top tips for managers

- Recruit OTs who can work autonomously and have thorough knowledge and experience in major home adaptations, as well as understanding of cross-system pressures.
- Protect the priority focus – don't let standard adaptations work crowd out hospital discharge capacity.
- Build strong relationships with hospital discharge teams, intermediate care, social care, and grants teams. This role depends on collaboration particularly to engage hospital staff/wards.
- Advocate for discretionary funding policies that enable rapid response without means testing.
- Create clear success metrics focused on hospital bed days saved and cost avoidance.
- Use compelling case studies to maintain Better Care Fund/ICB commitment and funding.
- Plan for sustainability beyond pilot funding. Demonstrate value to embed permanently.
- Support the OT to present regularly to health and care system leaders to maintain visibility.
- Recognise that response times and flexibility are critical, which may affect traditional 9-5 working hours.