A Qualitative Evaluation of the Stepping Home Service Supporting Ipswich and East Suffolk Clinical Commissioning Group

April 2020

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Executive Summary

About us...

Healthwatch Suffolk [HWS] is an independent organisation that works to determine what local people think about their health and social care services. It has statutory powers that enable it to use experiences to influence, shape and improve the services now and in the future.

HWS was commissioned by East Suffolk Council to provide an independent evaluation of patients and professionals' experiences of the Stepping Home service.

The rationale for this research

Stepping Home aims to facilitate improvements to the discharge process from hospital by reducing Delayed Transfers of Care (DTOC) and unnecessary hospital admissions for non-medical reasons. A number of methods are used by the service and this includes:

1. **An appointed hospital coordinator -** The Coordinator can work to resolve non-medical and housing related issues by linking with local authorities, health and community sector agencies. For example, the Stepping Home Coordinator could work with partners to deliver housing repairs, install key safes, remove furniture or provide decluttering services.

2. **Discharge to a Halfway Hub -** This aims to provide temporary accommodation to patients after they have been discharged from the hospital. This prevents delayed discharge and allows time for appropriate housing solutions to be arranged. Stepping Home started the evaluation with one unit at Emily Bray sheltered housing scheme in Suffolk. This has since been expanded to include units in two more schemes at Deben View and Pollard Court in East Suffolk.

3. **Data collection -** To provide a better understanding of the nature and frequency of housing issues affecting patients. This data is currently not being captured by any other source, and not always evident by DTOC codes. By better understanding the type and level of need, Stepping Home can increase resources and support where necessary.

HWS was commissioned by East Suffolk Council to provide an independent evaluation of patients and professionals' experiences of Stepping Home. This report is intended to assess the evidence for the impact of the service in addition to the data already collected by Stepping Home.

Quantitative impact

Stepping Home already collects data that provides an estimate of the costs and bed-days saved by the service. In 16 months of delivery up until April 2020, Stepping Home has recorded the following:

- Provided temporary housing for 19 patients. Although a total of 60 patients were suitable for the service only 19 could be accommodated because the housing scheme was already full.
- Saved East Suffolk and North Essex NHS Foundation Trust (Ipswich Hospital site) an estimated 546 bed days through the provision of temporary patient accommodation. At an assumed bed day cost of £250, this suggests the project has saved the Trust an estimated £136,500 by preventing delayed discharges and keeping beds available for patients who need them most.
- 220 other interventions have been made by the service. This includes home adaptations, for example, key safes, ramps, grabrails and home repairs. This figure also includes referrals made by Stepping Home to partner organisations. These interventions are estimated to have saved £94,350 for ESNEFT (Ipswich Hospital) in preventable admissions.
- Overall, the Stepping Home service estimates that it has saved the local health and care system a total of £230,850 over the 16 months that the service has been active. The total cost of the project for the period was approximately £104,000.
- A total of 252 referrals have been made to Stepping Home.

Methodology

HWS used three main methods to explore the impact of the Stepping Home service on patients and professionals:

1. **Professionals' survey -** Stepping Home promoted a short online survey to professionals who used the service. The survey asked about professionals' perceptions of the causes of DTOC and avoidable admissions, and their experience of using the Stepping Home service. There were a total of 25 replies to the professionals survey including:

    - Professionals based in the community who used Stepping Home to prevent avoidable admissions, for example physiotherapists or REACT staff.
    - Professionals in an acute or community hospital using Stepping Home to facilitate discharge. For example, this includes social workers, discharge coordinators and Independent Wellbeing Practitioners.
    - Professionals in services that Stepping Home work with, including Suffolk Family Carers and employees of the services Stepping Home coordinates.

2. **Professionals' focus groups -** In addition to the survey, the Stepping Home hospital coordinator arranged focus groups which were then carried out by HWS researchers. The three groups comprised of a broad range of professionals involved in both admissions avoidance and discharge facilitation.

3. **Patient interviews -** The primary method used in the evaluation was interviews with patients who have used the Stepping Home service. Ten interviews were carried out with patients who had received a service from Stepping Home. Three of these interviews were also carried out with a family member or family carer present, meaning that a total of 13 people were asked about their experience of Stepping Home.

What does this report tell us?

The views of patients and professionals suggest that the Stepping Home project is meeting several of its key objectives:

- **Facilitating earlier discharge:** Consistent references by patients, families and professionals suggest there has been a reduction in bed days required within the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) by patients with complex non-medical or housing related needs.

  One group of professionals involved in hospital discharge referenced the service saving costs directly. Two professionals' focus groups also mentioned that the service could reduce time spent within community hospitals or the length of social care support. Professionals within all three focus groups referenced the ease of being able to call Stepping Home to seek resolution for non-medical or housing needs.

24 of 25

professionals said that non-medical issues delayed discharge

4.8 of 5 star

average rating by patients

"[Interviewer: So, if you hadn't come to the flat you'd still be in Waveney Ward?] I would. Which wasn't really a happy place." (Patient)

"Stepping Home has enabled patients to discharge to temporary accommodation. This has proven to be an invaluable resource." (Suffolk Family Carers Adviser)

- **Improving patient experience:** Patients, families and professionals felt that both the Stepping Home Coordinator and the Halfway Hubs had a positive impact on patient experience.

Within focus group sessions, professionals reported that facilitating earlier discharge led to improved outcomes for patients by preventing a potential deterioration in their health condition.

"It was perfect for him at the time because he had nowhere else to go." (Family member)

Reducing risk of preventable admission in the community: The REACT team focus group and respondents to the professionals' survey were able to give concrete examples of where services provided by Stepping Home had reduced a patient's exposure to risk of harm at home.

"Fitting key safes to allow safe access for vulnerable people on discharge." (REACT team member)

"Keep whatever you're doing, just keep doing it because it's working and it's really valuable." [Voice 2] But it's nice knowing that you've got that at the end of the phone. We need this, can you help? And they go, "Yeah. We'll get them out today or tomorrow. " And you go, "Woah." It's a fantastic service." (REACT team)

24 of 25

professionals were satisfied or very satisfied with the service overall

HWS also found suggestions for Stepping Home service improvement. These were:

- **Increase capacity:** Patients, families and professionals all suggested that the service could be improved by increasing the number of beds available within Stepping Home Halfway Hubs.

> "So, they need more rooms, like at Emily Bray, because two is just not enough for a massive town like Ipswich. Just think how many people are in this hospital when it's coming up to winter." (Hospital discharge group)
>
> "They are a really good service and need to continue but they probably need more funding and maybe extra staff and some more step-down beds to facilitate earlier discharges from hospital." (Physiotherapist)

- **Improve information for professionals:** Two focus groups of professionals suggested that, whilst they did not need to know full details of all services and functions offered by Stepping Home, information available about the service could be improved. There was recognition that the service offers solutions to problems that healthcare staff would not have the knowledge or information to resolve.

> "It's really so nice having that service where you can literally say, "Right, this is patient. Can I just leave you with it because we've got 27 other people to see?" And actually, the thing that that patient needs is not really an OT or a physio thing or a nursing thing… Because before this happened, we would be spending hours on these things because we don't really know what we're doing, we don't really have access to the right people. It's reduced a lot of time that we spend on these things. And Sue just takes it off your hands and she just sorts it, so it's lovely." (Hospital discharge group)

- **Improve facilities in the Halfway Hubs:** Four people felt that minor improvements could be made to facilities at the Emily Bray hub, for example, the installation of a disabled shower or additional provision of cooking equipment.

Overall, patients, families and professionals' experiences suggest that the Stepping Home project in the East of Suffolk has been successful. Participants in the research reported that the service saved bed days in ESNEFT (Ipswich Hospital) for patients with complex housing needs. Additionally, participants highlighted that this had associated positive impacts on patient experience and rates of deconditioning. The service appears to offer several other financial and subjective benefits to patients, families, professionals and the wider health and social care system.

Introduction

About us...

Health and social care services work best when users of these services are involved in decisions about their treatment and care. Local Healthwatch were established by the Health and Social Care Act 2012 to be the "consumer champions" for health and social care services. Healthwatch aim to ensure that service user's and carer's voices are heard where it matters and where decisions are made.

Healthwatch Suffolk [HWS] is an independent organisation that works to determine what local people think about their health and social care services. It has statutory powers that enable it to use experiences to influence, shape and improve the services now and in the future.

HWS also provides an information and signposting service to help people navigate the health and social care system.

The rationale for this research

Ipswich and East Suffolk covers around 500 square miles, with several medium-sized towns and the large town of Ipswich making up a population of around 367,000[1]. Delayed transfers of care [DTOCs] are a national issue and the National Audit Office[2] reported that unnecessary delay in discharging people from hospital is systemic and in 2015 accounted for 1.15 million bed days nationally.

The Stepping Home project evolved from the Warm Homes Healthy People service. Warm Homes Healthy People [WHHP] is a Suffolk wide, partnership service which provides practical support and funding to households in fuel poverty. The service is hosted by East Suffolk Council, on behalf of all Suffolk's local authorities. The aims of the service are to reduce cold home related ill health, reduce hospital admissions and delayed discharge associated with heating and energy in low income homes.

Closer work between WHHP with the discharge planning teams found it was relatively common for patients to have their discharge complicated by sometimes very simple housing problems or be admitted due to housing reasons other than lack of heating. The delays related to housing and non-medical needs were also often recorded at a high level, and led to delays sometimes over a month This included, for example, patients awaiting adaptations, ramps, key safes, front door keys, stairlifts, downstairs living adjustments, de-clutters, or awaiting more suitable accommodation.

Stepping Home aims to facilitate improvements to the discharge process from hospital by reducing Delayed Transfers of Care (DTOC) and unnecessary hospital admissions for non-medical reasons. A number of methods are used by the service and this includes:

1. **An appointed Hospital Coordinator -** The Coordinator can work to resolve non-medical and housing related issues by linking with local authorities, health and community sector agencies. For example, the Stepping Home Hospital Coordinator could work with partners to:

[1] Local Government Association (2018). Tackling delayed transfers of care in Ipswich East Suffolk.
[2] Department of Health (2016). Discharging Older Patients from Hospital.

- Deliver heating repairs or other housing repairs that could impact on health
- Organise same day key safe fitting and modular ramp fitting
- Arrange furniture removals or decluttering via Lofty Heights
- Coordinate with social services on care and hoarding issues
- Fast track disabled adaptations
- Arrange telecare services
- Provide signposting

2. **Discharge to a Halfway Hub** – this aims to provide temporary accommodation after they have been discharged from hospital. This prevents delayed discharge and allows time for appropriate housing solutions to be arranged. Stepping Home started the evaluation with one unit at Emily Bray sheltered housing scheme in Suffolk. This has since been expanded to include units in two more schemes at Deben View and Pollard Court in East Suffolk. The Halfway Hubs are intended to:

    - Deliver a better patient experience by putting the individual at the centre of solution planning.
    - Provide a cost-saving to the Suffolk health and care system by allowing patients with non-medical or housing needs to be discharged from hospital.

3. **Data collection -** To provide a better understanding of the nature and frequency of housing issues affecting patients. This data is currently not being captured by any other source, and not always evident by DTOC codes. By better understanding the type and level of need, Stepping Home can increase resources and support where necessary.

Stepping Home also can support other organisations who work in the community to prevent hospital admissions. These services can approach Stepping Home for assistance with non-medical need that requires intervention. Services include:

- Reactive Emergency Assessment Community Team (REACT)
- Neighbourhood teams
- Voluntary agencies

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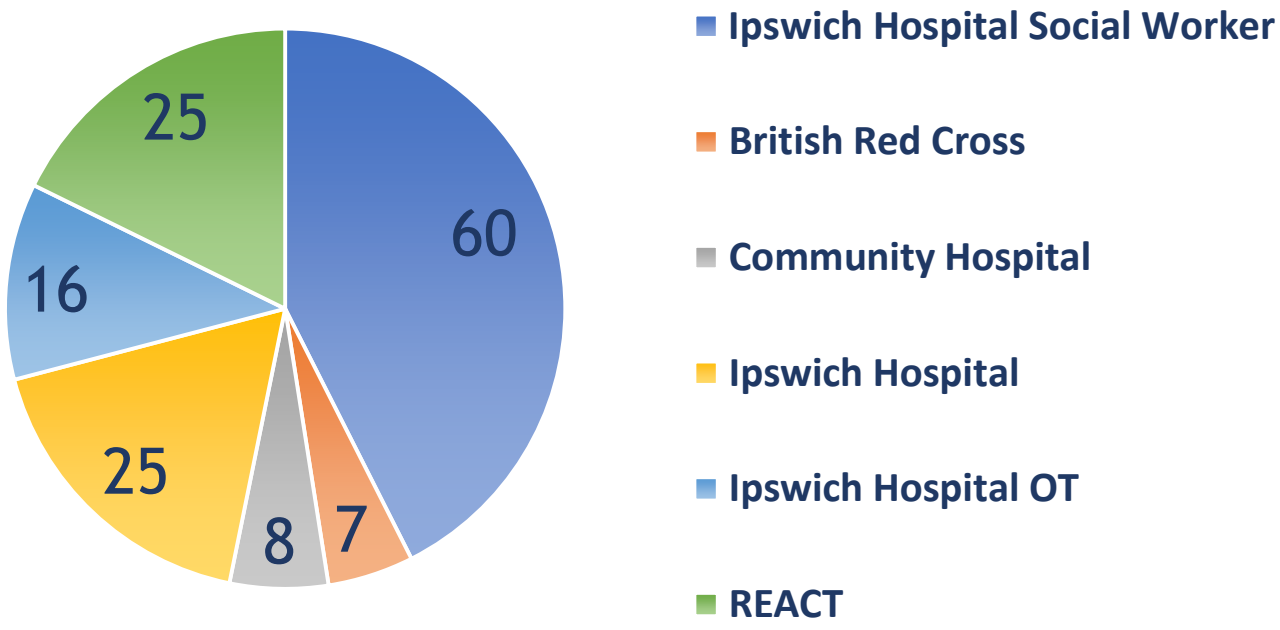
- 220 other interventions have been made by the service. This includes home adaptations, for example, key safes, ramps, grabrails and home repairs. This figure also includes referrals made by Stepping Home to partner organisations. These interventions are estimated to have saved £94,350 for ESNEFT (Ipswich hospital) in preventable admissions.
- Overall, the Stepping Home service estimates that it has saved the local health and care system a total of £230,850 over the 16 months that the service has been active. The total cost of the project for the period was approximately £104,000.
- A total of 252 referrals have been made to Stepping Home.

Chart 1: Sources of referrals to Stepping Home



Methodology

Three methods were used to explore the impact of Stepping Home for patients and professionals.

1. **Patient interviews**

The primary method of data collection was interviews with patients who have used the Stepping Home service. Patients were interviewed in person by the Stepping Home Hospital Coordinator, either after they had returned home or whilst they were staying in the Stepping Home Halfway Hub. The interview questions were designed to be:

- Mostly qualitative, to capture the details of each patient's story
- Semi-structured, to allow the interviewer to be flexible and ask follow-up questions

The interviews were audio-recorded and transferred to HWS for independent analysis of key themes.

In total, thirteen people were asked about their experience of the Stepping Home service in interviews. Ten interviews were conducted with individuals who had received a service from Stepping Home. In three of these interviews, there was also a family member or family carer present.

2. **Professionals' focus groups**

In addition to the patient interviews, the project also explored the experience of professionals who use or work with the Stepping Home service. The Hospital Coordinator arranged focus groups that were facilitated by HWS researchers. The three focus groups were attended by a broad range of professionals involved in both admissions avoidance and discharge facilitation. These were:

1. A group of four REACT staff (Reactive Emergency Assessment Community Team)
2. A group with seven professionals involved in hospital discharge
3. A mixed group of four, including British Red Cross and social work teams

The focus group questionnaire was entirely qualitative and semi-structured, allowing for open-ended feedback and flexibility in the group discussion. These groups were audio recorded and analysed for key themes by HWS.

3. **Professionals' survey**

Stepping Home also promoted a short online survey to professionals who used the service. The survey asked about their perceptions of the causes of Delayed Transfer of Care (DTOC) and avoidable admissions, and also their experience of using the Stepping Home service. The survey aimed to complement the professionals focus groups by providing additional quantitative feedback.

The following results section presents feedback from patients and professionals in the following order:

- Professionals' survey
- Professionals' focus groups
- Patient interviews

Information about the sample for each method is given at the beginning of each section.

Professionals' survey

There were a total of 25 replies to the professionals' survey. A breakdown of their job roles is shown in table 1. Of these:

- Four were health professionals based in the community who used Stepping Home to prevent avoidable admissions.
- Fifteen were professionals in an acute or community hospital using Stepping Home to facilitate discharge.
- Three were professionals in services that Stepping Home work with, including Suffolk Family Carers, one professional who prepares homes for discharge, and one unnamed service coordinator.
- Two were professionals from one of the Stepping Home Halfway Hubs.
- One "other" was from an out of area hospital who spoke to Stepping Home for advice.

Table 1: Job roles of the professionals who responded to the survey

ESNEFT (Ipswich Hospital)	**15**
Social Worker	5
Discharge Coordinator	4
Independent Wellbeing Practitioner	2
Occupational Therapist	2
Nurse	1
Administration	1
Community health	**4**
Physiotherapist	2
REACT	1
Therapy Assistant Practitioner	1
VCSE/ Community services	**3**
Halfway Hub	**2**
Other	**1**
Total	25

The impact of non-medical and housing needs

24 of the 25 professionals who responded to the survey agreed that it was common for non-medical, housing or environmental factors to cause delayed transfers of care [DTOCs] or preventable admissions. One said that they did not know.

24 of 25

professionals said that non-medical issues delayed discharge

> "The Stepping Home project has **enabled some customers to be discharged** to an alternative environment… [and] **assisted in the prevention of further deconditioning of some customers**… [where] the only alternative would be to seek temporary accommodation in a residential home setting or to remain in an acute hospital" (Social Worker)

63% said that non-medical issues are not identified early enough in the discharge process

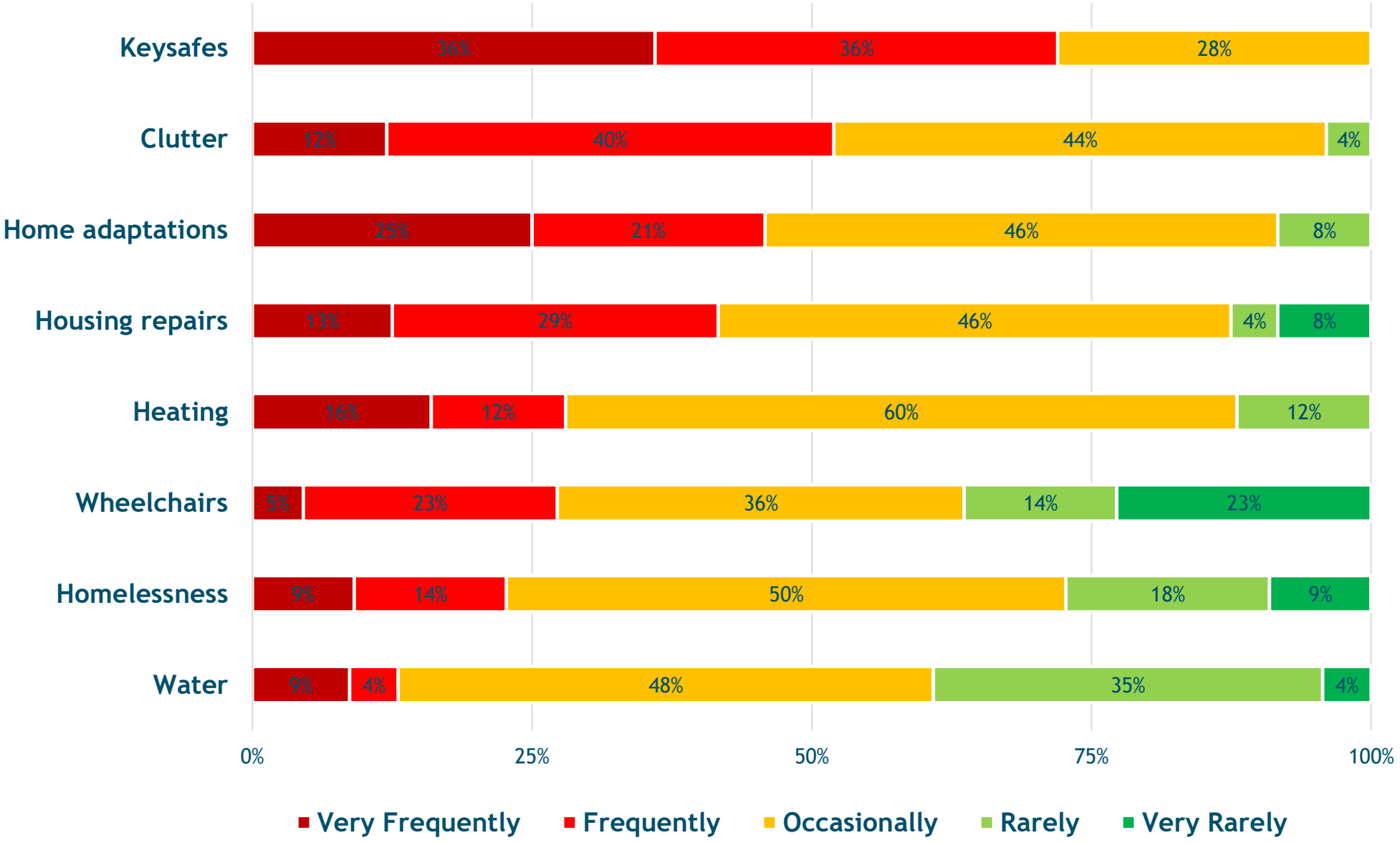
Professionals were also asked how frequently certain non-medical needs delay patients discharge from hospital or cause hospital admissions. The three factors that professionals reported could most often cause DTOC or preventable admission were:

- Needing a key safe fitted
- Needing decluttering
- Needing home adaptations

The overall results are shown in chart 2. Professionals were also given the option to suggest other factors. These included:

- Pendant alarms
- Family issues
- Awaiting packages
- Cleanliness

Chart 2: Professionals views of the most frequent non-medical causes of DTOC or preventable admission.



Making a referral to Stepping Home

100+

referrals were made by respondents to the survey

In total, the professionals who responded to the survey had made over 100 referrals to Stepping Home.

24 of 25

were satisfied or very satisfied with the service overall

24 of 25 professionals were satisfied or very satisfied with the service overall. One did not respond.

24 of 25 professionals reported that the referral process to Stepping Home was easy or very easy to use. One said that the ease of referral was acceptable.

24 of 25 had a good or very good knowledge of Stepping Home

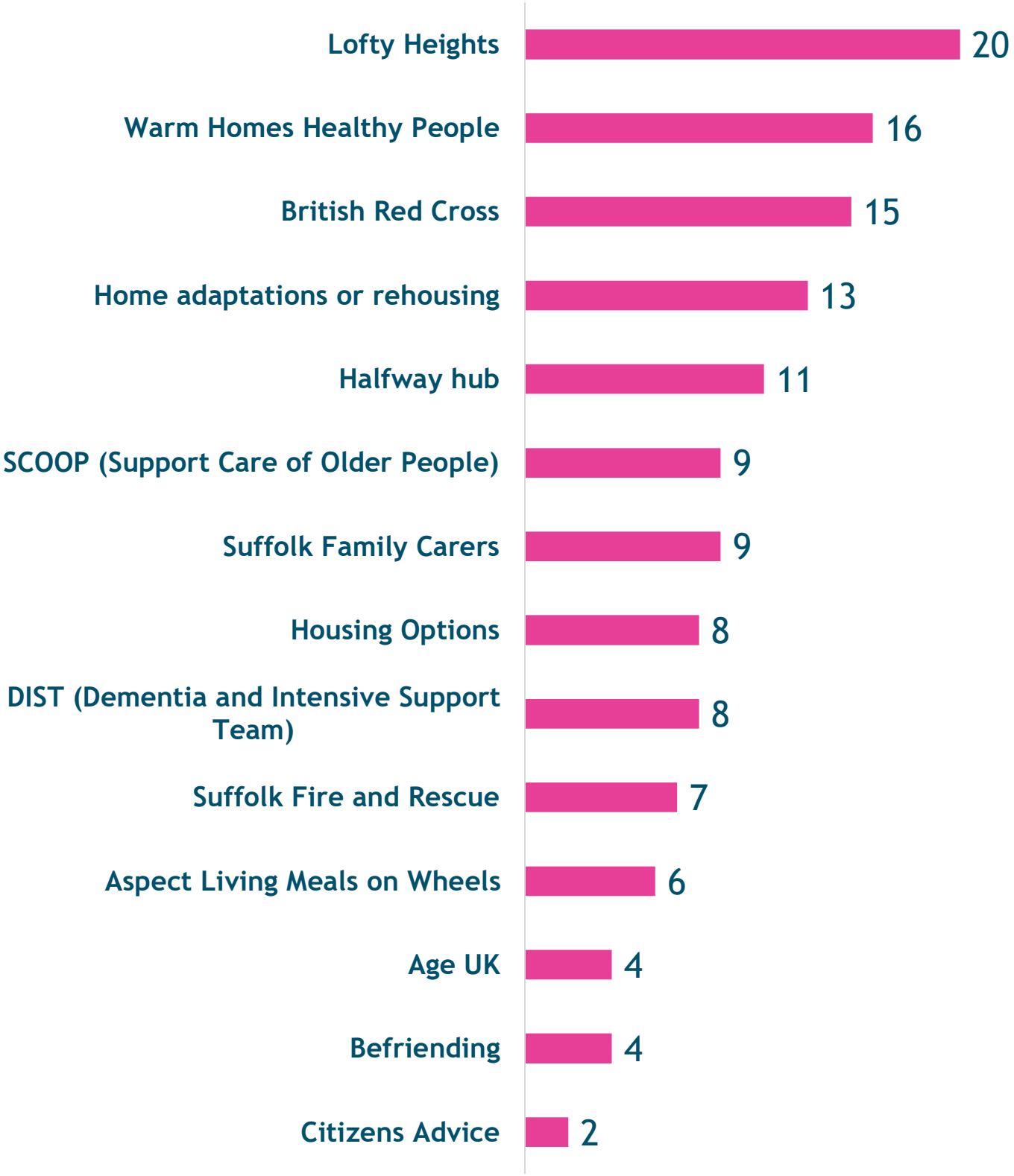
24 of 25 professionals rated their knowledge of Stepping Home services as either very good or good. One said their knowledge was neither good nor poor.

Professionals were asked what services patients were using as a result of a referral they had made to Stepping Home. The most common responses were:

- Lofty Heights
- Warm Homes Healthy People
- British Red Cross
- Home adaptations
- Staying in a Halfway Hub

Chart 3 shows the services that professionals were aware of patients using through Stepping Home.

Chart 3: Services patients had received through Stepping Home as a result of a referral by the professionals who responded to the survey



Professionals who answered the survey were asked to give examples of how Stepping Home has enabled patients to be discharged from hospital sooner or prevented hospital admissions. Respondents were extremely positive about the impact and effectiveness of the Stepping Home service:

"Stepping home meant **discharge** from hospital was possible **without delay."** (Occupational Therapist)

"Sue gives **excellent advice and signposting.** (Independent Wellbeing Practitioner)

"Stepping Home has enabled patients to discharge to temporary accommodation. This has proven to be an **invaluable resource."** (Suffolk Family Carers Adviser)

"By providing a **central person to coordinate complex repairs**… swift installation of key safes to **enable work to be carried out sooner** and coordinating permission and **liaison between patient, family, landlord and operatives.**" (Community service manager)

"Fitting key safes to **allow safe access for vulnerable people** on discharge." (REACT team member)

"By installing grab rails, key safes [and] helping professionals to support the patient at home and **avoid hospital admission**" (Community Service Coordinator)

"Having numerous issues in place before discharge date so **no hold up on discharges at the last minute"** (Discharge Coordinator)

"Enabled people to be discharged whilst repairs to their own property are being done" (Social Worker)

The final survey questions asked professionals what could be improved about the Stepping Home service.

Most reported a positive experience or that nothing could be improved. Four individuals felt the service needed more capacity in the Halfway Hubs, more staff or increased levels of funding. Two suggested that the service needed to be continued.

Examples of their feedback include:

> "Nil. The Stepping Home project has been extremely helpful and have prevented delays from hospital when patients are medically and functionally optimised but are unable to return home safely and need to await decluttering/renovation due to environmental/external factors." (Occupational Therapist)
>
> "They are a really good service and need to continue but they probably need more funding and maybe extra staff and some more step-down beds to facilitate earlier discharges from hospital." (Physiotherapist)
>
> "Nothing, it already is run so incredibly smoothly - very slick and courtesy and speed." (Independent Wellbeing Practitioner)
>
> "The service needs to be expanded to have more places in central locations to suit those patients needing care. Central locations are mainly relevant for the ease of accessing care, but it does seem that demand is growing" (Professional involved in preparing homes for discharge)

Two respondents made suggestions for how the service could improve operationally. These both related to making referrals into Stepping Home for patients who were homeless:

- An Independent Wellbeing Practitioner stated in a previous question that they could not access the Stepping Home flat for a patient who was homeless as Ipswich Borough Council "could not give an end date on when other housing would become available". They suggested that accommodation could be made available that did not require an end date.

- Similarly, a Social Worker stated that the service could be improved by offering support for homeless patients that had not yet been allocated housing:

  "We have a lot of customers that are considered homeless and although applications for housing are submitted until something is allocated the Stepping Home project are unable to assist. I understand the rationale for this as it could block the system but for these group of customers' it can cause further delays and inappropriate use of acute hospital bed. Many of these customers are also not eligible for ACS services and fall between the agencies." (Social Worker)

Professionals' focus groups

Three focus groups were carried out with professionals who use the service:

1. A group with four members of REACT (Reactive Emergency Assessment Community Team), including a service coordinator, occupational therapist, social worker and a representative of Suffolk Family Carers.
2. A group with seven professionals involved in hospital discharge, including occupational therapists, a physiotherapist, therapy assistant practitioner, ward sister and a discharge coordinator.
3. A mixed group of four with a representative of the British Red Cross [BRC], two social workers and an Independent Wellbeing Practitioner.

Overall, the professionals' focus groups were positive about the impact and effectiveness of the Stepping Home service. It was clear that Stepping Home staff had built good relationships with the professionals and that the service was valued.

> "**Keep whatever you're doing,** just keep doing it because it's working and it's really valuable." [Voice 2] But it's nice knowing that you've got that at the end of the phone. We need this, can you help? And they go, "Yeah. We'll get them out today or tomorrow. " And you go, "Woah." **It's a fantastic service.**" (REACT team)

Examples of non-medical or housing needs

The professionals' focus groups provided the most direct examples of how non-medical or housing needs can cause DTOC from the ESNEFT (Ipswich Hospital) or cause risk that could lead to preventable hospital admissions.

Often, these related to needs such as key safes or home adaptions, however, it was also clear that some patients required more complex interventions. Examples of patient needs highlighted by professionals included:

> "We've got, especially now, this time, when it's getting cold, people who do not have boilers. They will come to hospital, and they will sit in hospital until they sort out the boilers. And that is sometimes weeks and weeks or maybe they can't afford it to pay boiler service... So, they will come in hospital and stay here." (Hospital discharge group)

> "And again… if you've got a vulnerable person who's at home, you need to make sure that they say we can gain access without them standing up and falling trying to answer the door." (REACT team)

> "It's those people who come in who are in such a state at home that you could just not send them home because there's a tree growing in the front room or the roof is falling down or whatever the case may be… Once you've had a service, you think back what we did with those

people before. I guess they just stayed here for weeks and weeks and weeks until all of that stuff was sorted out or, probably, it would end up going to social care." (Hospital discharge group)

"We'd have to-- if their property or tenant because this also has tenancy issues, because it's not just properties with bad site repair, some people have not got property or have been evicted from the local authority housing before. If they couldn't, if there wasn't home support, we'd then have to look to put them into a care setting" (Mixed social work/ BRC group)

Faster resolution of non-medical and housing needs

All three groups felt Stepping Home could provide resolutions for non-medical or housing needs much faster than other methods. For example, through liaison with the local authority or social services. Professionals suggested that being able to refer to the Stepping Home helped to reduce the amount of time that patients would spend in hospital or lowered the risk of harm at home by facilitating solutions to problems with property or other factors. Examples of these comments included:

"We've referred quite a few of our clients to have bannisters or rails or just kind of handyman fixing things… because it's so much quicker than going down the other road. [Voice 2] If you want extra bannisters and that type of stuff you meant to refer to social services OTs depending on how its prioritised, it could sit on the waiting list for ages." (REACT team)

"I mean, there were obviously other avenues that we had to go down, but what we've got going Sue is it's almost instant. You've got a problem that needs dealing with today. You can phone them, and they will deal with it, whereas before it was a case of, "Right. Scratch your head. Well, who do we go to? Well if we're going down that avenue, that's going to take six months. If we go down that avenue, it might take two months." (REACT team)

"I think particularly if we're then having to liaise with the local authority, because I know [Stepping Home] liaises with them regarding tenancy and things like that, which is really useful because obviously that's something we try-- we used to do it in our hospital discharge, but it caused such a delay. It really did cause a huge delay to people in terms of waiting in hospital." (Mixed social work/ BRC group)

This faster resolution to non-medical or housing needs implies a potential cost saving, however, only the hospital discharge group mentioned the financial impact of the scheme directly.

"No, I guess it's just that from the patient's point of view or rather what used to historically happen, which was you can wait days for assessment and then there'd be this massive argument about who's going to fund all of these things…. And all the time, days and days would go by. Whereas now because there is this pot of money, you've probably saved yourself about three or four days there in itself of however much a hospital bed costs every night." (Hospital discharge group)

Professionals' knowledge about Stepping Home services

The professional focus group members were all aware of the Stepping Home Hospital Coordinator's role and the Halfway Hubs. However, there was some inconsistency within, and between, the groups about what other services could be coordinated through Stepping Home. For example:

- The REACT team focus group was unclear on whether some of the equipment they had received was provided by Warm Homes Healthy People or Stepping Home.

  > "I think we're all familiar with the Warmer Homes, which is where the Stepping Home project kind of falls under. I don't know that we're-- well, I'm certainly not particularly clear about what falls under the Stepping Home, and what's part of the bigger, Warmer Homes name" (REACT focus group)

- The mixed social work/ BRC focus group were unsure whether they could refer patients to Stepping Home who did not require the Halfway Hub but did need other services like decluttering or key safes.

- Both the REACT group and the group of professionals involved in hospital discharge felt that the information available about the Stepping Home service could be improved. The hospital group suggested using posters to promote the service.

All three groups agreed that the service helped to simplify how they dealt with their patients non-medical or housing needs; suggesting a phone call to Stepping Home could often address the problem:

> "And the other thing is if ever there was any issue, so if we had any issues while supporting somebody, then we would get straight on the phone to Sue or Warmer Homes themselves. Gary. And they were always there to support us. and if they got any difficulties or anything else that would present itself that needed support with, then they would ring us to see if we could give that added to the service user." (Mixed social work/ BRC group)

> "It's really so nice having that service where you can literally say, "Right, this is patient. Can I just leave you with it because we've got 27 other people to see?" And actually, the thing that that patient needs is not really an OT or a physio thing or a nursing thing… Because before this happened, we would be spending hours on these things because we don't really know what we're doing, we don't really have access to the right people. It's reduced a lot of time that we spend on these things. And Sue just takes it off your hands and she just sorts it, so it's lovely." (Hospital discharge group)

> "We just phone Sue, don't we, and say this is what we need and leave it with her or Gary to point us in the right direction." (REACT team)

Improved patient outcomes and experience in the Halfway Hubs

Both the hospital discharge and the mixed social work/ BRC focus groups discussed the impact of the Stepping Home Halfway Hubs on patient experience and outcomes. The REACT team had not made any referrals at the time of the focus group. Most of the discussion around the hubs focussed on patient experience and outcomes, rather than potential days saved in hospital.

The hospital discharge group stated that the Halfway Hubs helped to improve outcomes for patients and families by preventing the deterioration in health that can occur whilst in hospital or when receiving other forms of social care support:

> "Previously, before, they would have gone into a care setting which you kind of always think… debilitates people, reduces their function, whereas Stepping Home… want to keep them as independent as possible with care support that they needed." (Hospital discharge professional)

> "The longer these patients remain in an in-patient setting, I would imagine the worse their outcomes are of being successfully discharged back home again because it doesn't take very long to get institutionalised in here. It doesn't take very long to get very deconditioned in here, and so I think if we can get them into a flat environment where, yeah, they've got people around them, but they've got some independence, we are much more likely to successfully discharge those people back to the home once it's been sorted." (Hospital discharge group)

The mixed social work/ BRC focus group also explored how the Halfway Hub provided a better patient experience by promoting independence:

> "I know some people are reluctant to move into care homes, aren't they, because there's that fear that they're never going to come out again and that sort of thing so by having a place where it's more independent living is more appealing to people to leave to… and also if it's younger people, a lot of younger people don't want to go into care homes. [Voice 2] And I think from our point of view, people come out of hospital, and once they're out and back in their home, they get back into that lifestyle, and then it's really hard to get that lifestyle changed, because people just get back into their life. And then for us to come in and be like, "Right. We can help you." It's harder. Whereas I think if they can see that they can go somewhere from hospital and it's not a care home, it's more appealing." (Mixed social work/ British Red Cross group)

Finally, the hospital discharge group discussed how the hubs could provide an alternative to a stay within a community hospital such as Bluebird Lodge:

> "I think a lot of the patients also like that idea rather than going to Bluebird. They were quite sort of okay with going to somewhere like that as an in-between and they do get them in to clear the house, don't they?" (Hospital discharge Group)

Capacity

All three focus groups talked about the need for additional capacity within the Stepping Home service. The REACT team expressed that Halfway Hubs had always been full. One member of the hospital discharge focus group stated:

> "So, they need more rooms, like at Emily Bray, because two is just not enough for a massive town like Ipswich. Just think how many people are in this hospital when it's coming up to winter." (Hospital discharge group)

Patient interviews

Ten interviews were carried out with patients who had received a service from Stepping Home. Three of these interviews were also carried out with a family member or family carer present, meaning that 13 people were asked about their experience of Stepping Home.

All of the patients had been admitted to ESNEFT (Ipswich Hospital) between February 2019 and January 2020. Five patients had further stays in a community hospital. Two had been transferred to Aldeburgh Community Hospital, two were discharged to Bluebird Lodge and one had stayed at Felixstowe Community Hospital. The total length of stay in hospital for all patients, including time spent within a community hospital, ranged from two weeks to three months.

Participants had been admitted to hospital for a variety of reasons including falls, Urinary Tract Infection and other less common conditions such as liver swelling and a perforated bowel. Four of the patients had been admitted to hospital in the last two years for the same health condition.

All the patients had stayed in one of the Stepping Home Halfway Hubs at Emily Bray, Deben View or Pollard Court.

Reasons for using the service and overall experience

Patients, and their families, were highly positive about the Stepping Home service. The average rating of the service across ten interviews was 4.8 out of 5 stars.

> "I'm very, very pleased with them. Very pleased with the service" (Patient)

> "It was perfect for him at the time because he had nowhere else to go." (Family member)

Chart 4 below shows the reasons patients and families gave for their referral to Stepping Home. Three patients did not know what Stepping Home was without being prompted. Six were aware that they had received support from Stepping Home, and in one interview only the family member was aware of Stepping Home. Some were also not aware of the reasons for their referral into Stepping Home.

As described above, patients often had trouble remembering or articulating the reasons for referral to Stepping Home. The same was true when they were asked to explain more about the non-medical or housing needs that had prevented them from being discharged straight to their own home.

Those who could not recall the service appeared to be more vulnerable patients. Because of this, the Stepping Home Hospital Coordinator frequently needed to prompt patients or describe needs on their behalf. Examples of how patients and families did discuss their needs included:

> "[Interviewer: Because all the stuff that you'd collected in the lounge, and they couldn't access the front door and the stairs safely?] Well, yes there was that. There was also the fact that I

didn't have a key safe then…. I didn't have that, so they weren't able to get in. Well, the only way they could get in was by smashing the porch window, and they had to smash the bedroom window to get access." (Patient)

"It was because you'd had an oil leak when you were ready to be discharged." (Family member)

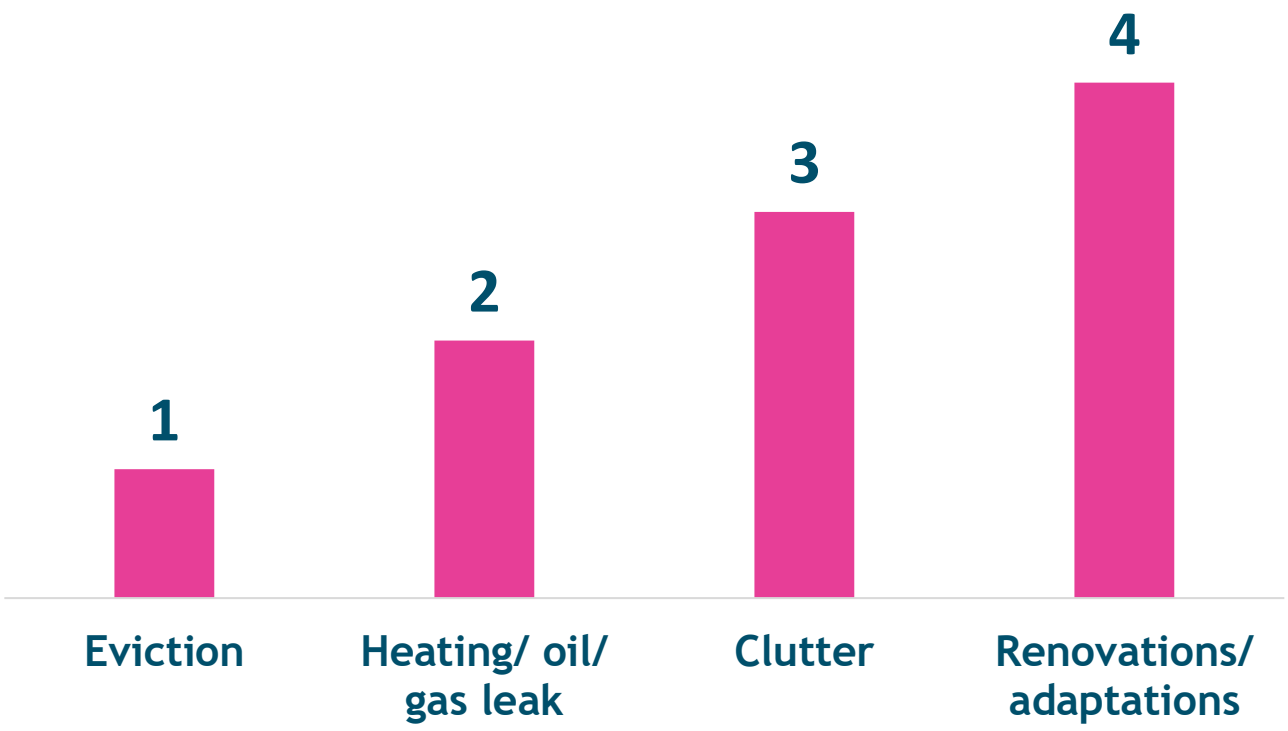
"Yeah. I think it was because the home I used to live in isn't suitable for me anymore. And this is sort of like a stepping stone to the home I hope to go to." (Patient)

“Because there's some work being done in my Bungalow… a shower, new doors, new steps, and rails.” (Patient)

The experiences of patients who did know about the service suggested that their lack of knowledge about Stepping Home was not necessarily because of a lack of information given to them. For example:

“And from the first time you saw me in hospital you gave me your card, your card with details… You took time to go over and see, tell me what Stepping Homes could do” (Patient)

Chart 4: Reasons for patients’ referrals to Stepping Home



Patient's experience of the Stepping Home Halfway Hubs

Although some were not aware that they had received support specifically from Stepping Home as a service, all had stayed in the Halfway Hub and were aware that they had been in temporary accommodation.

Six patients had stayed in Emily Bray and three had stayed in Pollard Court. One patient had stayed in both following a urine infection which caused them to be readmitted to hospital during a stay at Emily Bray. The patient was subsequently discharged to Deben View.

In eight interviews, patients and family members agreed that going to the Stepping Home Halfway Hub had allowed them to leave hospital sooner. Often, patients talked about how they appreciated being able to leave the hospital environment. In the remaining two interviews, one patient did not remember much about being discharged from the hospital, and another did not answer the question.

Examples of quotes about how Stepping Home facilitated a faster discharge for patients included:

> "You allowed me to leave sooner, which I appreciate… I don't love hospital because having been in Ipswich Hospital several times and knowing how busy they are. One of the things they are not good for is long-term care. So that's where an organization like Stepping Homes are really useful and handy because they facilitate the half-way stage of life between going back to your home and hospital care, which is a useful middle step. And I think it would have been tricky without that." (Patient)

> "Yes… the way they've been talking in hospital, I thought I was going to be in there for several weeks. And then all of a sudden, "Oh, right. That's it. You're off" (Patient)

> "Well, yes I think it did really. [Interviewer: So, if you hadn't come to the flat you'd still be in Waveney Ward?] I would. Which wasn't really a happy place." (Patient)

Patients were often positive about their experience in the Halfway Hub and thankful for their stay. In nine of the ten interviews, they agreed that staying at the Halfway Hub was safer and more manageable than if they had returned straight to their home environment. The one patient who did not agree when asked said *"I don't think so, really… I can get up and down stairs if I walk up sidewards."*

Examples of patients and family members positive comments about the Halfway Hubs included:

> "I cannot really thank these people enough for allowing me to stay here… it probably wouldn't be for everybody, but I think this is really a good place for people." (Patient)

> "I suppose I had somewhere to live, somewhere safe. [Interviewer: And warm?] Oh yeah, it was warm. I got a bed." (Patient)

> "I didn't want to move out." (Patient)

One patient mentioned how going to the Stepping Home Halfway Hub helped them to feel as though they had retained their independence, and talked about an experience of "deconditioning" in hospital:

"Yeah… I mean, I'm quite sick, I'm very sick, but I still got an independence, and I will not have that independence taken from me… It's like a little respite place. And I love my home, and it's very hard for me to stay away from it. But I felt much safer in here than I did in them other two places [in hospital] … when I come out of there I was a lot worse than when I went in" (Patient)

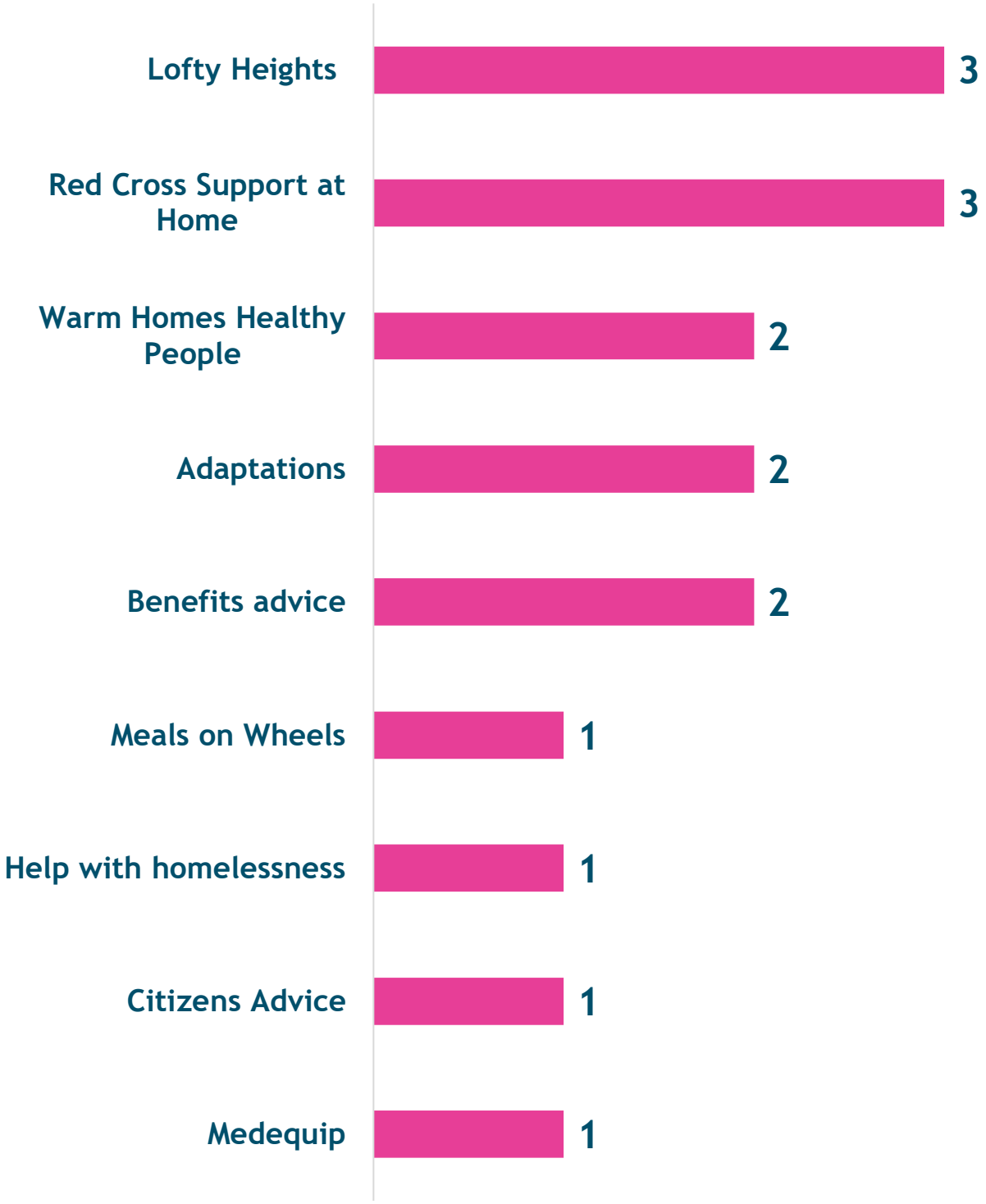
All the patients felt Stepping Home had provided services promptly.

Services that patients received through Stepping Home

Patients often had to be prompted about services Stepping Home had coordinated on their behalf (e.g. decluttering or housing adaptations such as ramps, heating).

Chart 5 shows the other services that Stepping Home coordinated in patient's homes.

Chart 5: Services patients received through Stepping Home



In nine of the interviews, patients and family members agreed that the arrangements made for them by Stepping Home gave them more confidence about returning home. The one family who did not agree talked about their experience of discharge from ESNEFT (Ipswich Hospital) rather than their experience with Stepping Home.

Examples of feedback from those who felt that the arrangements had given them confidence included:

> "You know the fact in the sense you took me… Stepping Home took it out of my hands. And you liaised with everybody that needed to [be involved], Lofty Heights, you know?" (Patient)

> "You gave me confidence going home.... You really did. When I saw you that day, I wasn't sure what to expect because [laughter] I just had a bad day with the doctors and the nurses and everybody. I mean you come in and you were like a little ray of sunshine... I wasn't really sure what to expect but you made me feel that it was going to be all right." (Patient)

> "I did think everything was going to be okay because of the help I had." (Patient)

Discussion of discharge on the ward

Seven participants talked about how their discharge was discussed with them by ESNFEFT (Ipswich hospital) ward staff.

Two said they were completely happy with the way their discharge was discussed. Two felt there had been some discussion of their needs on discharge by ward staff, but that there could have been more. Three patients or family members were dissatisfied or said their needs on discharge had not been discussed with them at all. In two interviews, patients reported a positive experience of discharge from Aldeburgh Community Hospital.

Examples of feedback included:

> "[They] discussed whether I could climb stairs... What my mobility was like. They gave me a booklet with the exercise I could do for my feet especially, and generally provided me with a load of high calorie shakes or yoghurts, whatever they are. And that was basically it, really." (Patient)

> "I mean, the consultants were very good but you had to have to sort of, and I'm a bit of a shy retiring type… you actually have to ask them the questions because they did volunteer information but they used to have to go around so quickly. The pressure was on. So, I think in your question did the staff plan your outcomes? Yes and no, really... 50%." (Patient)

> "I think if it had not been for myself and [my paramedic friend] going to hospital to make a statement, I believe the hospital would have sent him home even though I had said, "Under no circumstances should he be released home without some kind of care and assistance within the community to help him," because I was struggling to look after him. And I obviously wasn't the best person. I was doing my very best." (Family member)

Communication with Stepping Home

Family members and patients spoke about the coordination of their discharge between Stepping Home, the hospital and family members.

Despite the feeling some had, that there had been insufficient opportunity for discussion about discharge, a number of patients and family members agreed that this part of the process had worked well for them. Two felt that this could be improved, however, these comments related to coordination by the hospital rather than Stepping Home.

In one interview, the Stepping Home Hospital Coordinator indicated the patient had arrived at the Stepping Home Halfway Hub with a higher acuity of need than had been expected. In another, a patient had experienced issues with receiving domiciliary care provided by Home First whilst in Emily Bray. This appeared to be because of an error by ESNEFT that the patient's address would be the Halfway Hub, rather than their home address. The family member of this patient explained:

> "We had a glitch, didn't we? Do you remember the first night you were here, nobody turned up? So, I got you all safely into bed? And then the next morning, still nobody turned up. So, I rang up, and said, "What's happening?". And the woman who came, bless her, she'd been sent to your old address, not here." (Family member)

In all ten interviews, participants said Stepping Home's communication with them had been good. It was clear that the Stepping Home Hospital Coordinator had built up good relationships with families and some were grateful that Stepping Home had helped them to negotiate the discharge process.

> "Yeah, you were brilliant, Sue… You're the only person that has been." (Patient)

> "[Interviewer] And everything was communicated to you well?] Yes… Oh, Sue is very friendly" (Patient)

> "No, I just really appreciate everything you did, Sue because you helped me out with various things, like phone calls and people, I appreciate that." (Patient)

Patient's views on how to improve the service

Some interviewee's made comments about how the facilities at the hubs could be improved. All the comments related to the Halfway Hub at Emily Bray. Two mentioned the need for a phone. One patient felt they could have been taught more about how to use the kitchen gadgets and utensils, however other interviewees said that they had been shown how to use these. One said that a disabled shower would improve the hub. Examples of these comments included:

> "I thought it was very well self-contained, it was good. It had everything he needed really. I mean an oven would have been good, but I suppose he couldn't have cooked anyway, but just to grill a bit of toast or… But no, that was fine." (Family member)

> "I probably need a wider door and maybe a little shower in the room so I can do it myself. A disabled shower. But to be honest with you, I wasn't here that long." (Patient)

"Well, once you're here, you're here. But the only means of contacting anybody else is either your mobile which I'm not very good at perhaps, or else there's the red cord. I don't know what other means there would be." (Patient)

One patient and one family member mentioned that the capacity of the Stepping Home Halfway Hubs could be increased. Examples of comments from these interviews included:

"Yeah, to only have one or two in Suffolk over here or this area. I understand it all comes down to money at the end of the day. Everything does, and it's never enough, but I think there really needs to be more because I'm sure there are more people exactly the same as him, in the same situation. They need to be there for somebody because, end of the day, these accommodations don't come up all the time… When he first went there, there wasn't any, they were all fully booked, which they said was unusual for them, but…" (Family member)

“I just think it has been really good, and I think it should be open to everybody to be able to have this, not just old people. Young people. People with MS. People with other sicknesses and the rest of it that need be.” (Patient)

Conclusion

The views of patients and professionals suggest that the Stepping Home project is meeting several of its key objectives:

- **Facilitating earlier discharge:** Consistent references by patients, families and professionals suggest there has been a reduction in bed days required within the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) by patients with complex non-medical or housing needs.

  One group of professionals involved in hospital discharge referenced the service saving costs directly. Two professionals' focus groups also mentioned that the service could reduce time spent within community hospitals or the length of social care support. Professionals within all three focus groups mentioned the ease of being able to call Stepping Home to seek resolution for non-medical or housing needs.

- **Improving patient experience:** Patients, families and professionals felt that both the Stepping Home Hospital Coordinator and the Halfway Hubs had a positive impact on patient experience.

  Patients were positive about having somewhere to stay that was safer and more manageable than their own home environment, and where they could maintain their independence after a stay in hospital. Patients also expressed that the Coordinator was friendly and helpful in navigating them through the discharge process.

  Within focus group sessions, professionals reported that facilitating earlier discharge led to improved outcomes for patients by preventing a potential deterioration in their health condition.

- **Reducing risk of preventable admission in the community:** The REACT team focus group and respondents to the professionals' survey were able to give concrete examples of where services provided by Stepping Home could reduce a patient's exposure to risk of harm at home.

HWS also found suggestions for Stepping Home service improvement. These were:

- **Increase capacity:** Patients, families and professionals all suggested that the service could be improved by increasing the number of beds available within Stepping Home Halfway Hubs. It is noteworthy that the service has expanded slightly whilst this research has been conducted, starting with beds in one sheltered housing scheme and expanding to three in East Suffolk at the time of this report (April 2020).

- **Improve information for professionals:** There were inconsistencies in professionals understanding of how the service links with other organisations to resolve non-medical **or** housing needs. Two focus groups of professionals suggested that, whilst they did not need to know full details of all services and functions offered by
  Stepping Home, information available about the service could be improved. There was recognition that the service offers solutions to problems that healthcare staff would not have the knowledge or information to resolve.

- **Improve facilities in the Halfway Hubs:** Four people felt that minor improvements could be made to facilities at the Emily Bray Hub, for example, the installation of a disabled shower or additional provision of cooking equipment.

Overall, patients, families and professionals' experiences suggest that the Stepping Home project in the East of Suffolk has been successful. Participants in the research reported that the service saved bed days in ESNEFT (Ipswich Hospital) for patients with complex housing needs. Additionally, participants highlighted that this had associated positive impacts on patient experience and rates of deconditioning. The service appears to offer several other financial and subjective benefits to patients, families, professionals and the wider health and social care system.

The project is now being expanded to include discharge from the West Suffolk NHS Foundation Trust. With this in mind, there is learning from this evaluation that should be considered and applied to the new service. This includes the provision of better information for both patients and professionals to aid awareness of the service offer. Stepping Home should, as far as resources allow, also ensure that the West Suffolk Stepping Home service has the right capacity for the number of patients with complex non-medical needs.

Patient interviews found that people's understanding or recollection of the service could often be patchy or varied. For this reason, it was difficult to obtain significant insights into the impact of the service on their home life. The West evaluation offers further opportunity to find out more about this.

If Stepping Home has a similar impact in the west of Suffolk, there may also be a case for expanding or trialling the model in other areas of the country. Stepping Home will need to continue to gather data from both ESNEFT and West Suffolk NHS Foundation Trust to demonstrate the model's effectiveness. However, patient and professionals' experiences in this evaluation appear to show that the current project has been effective at addressing non-medical and housing needs that would have otherwise led to delayed hospital discharge and possibly poorer outcomes for the patients involved.

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