HEALTH AND WELLBEING BOARD: 19 NOVEMBER 2015

REPORT OF THE DISTRICT COUNCIL CHIEF EXECUTIVE LEAD ON HEALTH AND WELLBEING

HOUSING INTERVENTIONS TO SUPPORT REDUCTIONS IN DELAYED HOSPITAL DISCHARGE

Purpose of Report

1. To bring information to the Health and Wellbeing Board about the delivery of two housing schemes by District Councils designed to reduce delays in discharge of patients from hospital.

2. The Health and Wellbeing Board is asked to:-

   (a) note the detail and progress of the two schemes;
   (b) support the ongoing evaluation of the schemes in terms of return on financial investment and understanding of outcomes for patients.

Financial implications

3. The cost of each Pilot is approximately £100,000 for the Bradgate Unit and £120,000 for the LRI Pilot this takes account of staffing costs and funding for furniture packs and rent deposits. Both Pilots run until the end of the financial year 2015/16.

Housing's Offer To Health

4. A report articulating the 'Housing Offer' that district councils can deliver to support the Health and Wellbeing Board's strategic objectives was produced in 2013 by the Leicestershire District Councils in partnership with the Chartered Institute of Housing.

5. It set out how the district councils' housing services can support the health and wellbeing of residents across Leicestershire. As a consequence of this report three main practical projects identified:-

   - Establish the First Contact scheme as a referral route in in all GP's surgeries
   - Transform the service pathway for aids/adaptations, affordable warmth, and handy person schemes to best suit service user needs and reduce demand on health and social care – subsequently called the Lightbulb Project
   - Housing services staff to support Health and Social Care colleagues in reducing delays in hospital discharge

6. This report relates to the two hospital discharge schemes that are operating across Leicester and Leicestershire.

The Bradgate Unit Housing Pilot

7. Within Leicestershire, as across the country, the acute mental health pathway is under significant pressure, resulting in patients that need in-hospital support being placed in out of county independent hospitals.

8. One of the reasons attributed to this 'out sourcing' was the delayed transfers of care (DTOC). There had been little historic research on housing factors but new analysis carried out by the Bradgate for the three month period to 21 December 2013 showed that in this period the accumulated DTOC was 1826 days and of these, 682 days (37%) were as a result of housing issues. [NHS Data]

9. The daily cost of housing a patient at the Bradgate Unit was £238 (based on the Price Activity Matrix 2014). The analysis showed that for the three month period, the housing related DTOC cost was £162,316, or close to £650,000 on an annual basis.

10. A proposal for a six month pilot, hosted by Blaby District Council, but covering the whole of Leicester city and Leicestershire County was accepted and began in October 2014.

11. In summary the pilot comprised four elements:-

    I. **Housing Options Officer -** a housing specialist (seconded from Leicester City Council) working three days a week directly with service users and hospital staff to identify housing problems that are a barrier to discharge and then putting in place the right steps address these for each service user.

    II. **Furniture Packs -** a basic furniture pack was made available where required – once other options had been exhausted and where cost effective to do so.

    III. **Rent Deposit/rent in advance -** funding was made available for service users to access the private rented sector for housing where appropriate.

    IV. **Low Level Housing Related Support -** this was offered through a Community Support Worker who would assist service users in transition from hospital to home and provide support with setting up a new tenancy or managing the existing home. Intrinsic elements of this community support was building capacity of the former patients to develop self-advocacy and social skills, taking personal responsibility for their own actions and gaining knowledge of their rights as individuals.

12. The housing officers were empowered to make decisions, across county, city and district boundaries, access funds and offer ongoing support to patients moving back to their home – or a more suitable new home.

13. The experience of the officers is very people orientated in that they know how to ask the right questions, in the right way and thereby can understand the full picture. Often patients or families are uncomfortable in acknowledging gaps in support and so opportunities to meet the actual need are missed.

14. The Pilot received 115 referrals during the 12 month period that between them accumulated 920 delayed bed days that were classified as Housing DTOC.

15. Of these referrals, 46 service users were sourced new accommodation. Other placements were arranged for 37 service users, which included living with family/friends and returns to previous tenancies. 9 of the referrals were incorrect for service specifications, 2 relapsed on the ward and 11 refused the service/AWOL/Discharged due to abusive behavior on wards. As at 30th September 2015 10 were still inpatients.

16. The age of service users referred ranged from 18 to 72 years of age (*M* = 38 years old). A total of 69 males and 46 females were referred to the Housing Support Team.

17. The average time from referral to when a service user was seen was 3.5 working days.

18. The service isn't only working to reduce the total number of DTOC bed days. Within the cases that have been referred, only 23 have had any DTOC delays at all. The other significant impact is regarding the hospital re-admissions. Of the 40 service users supported on the Community by the Housing Related Support Officer only one has been re-admitted to the Bradgate Unit; a testament in part to the quality of support provided by the worker.

19. As at 30th September, 103 of the cases had left the unit with 12 still on the unit. Of the 103 cases that had left, 40 needed ongoing support and were seen by Housing Related Support Officer. 24 cases were still being supported and 16 cases had been closed.

20. Having housing officers based at the Bradgate Unit has fostered positive relationship, enabled ward staff and the In Assistive In-Reach Team to have quick and easier access to expert housing advice and delivered a culture of referring patients earlier for housing advice.

Leicester Royal Infirmary (LRI) – part of the Leicester Royal Infirmary University Hospitals of Leicester NHS Trust (UHL).

21. Within the LRI, DTOC rates were 4.7% against a target of 3.5%, even though the Trust had already established an Integrated Discharge Team (primary and secondary care nurses and social workers) using Discharge to Assess and Non Weight bearing pathways. In September 2014 a review was undertaken to understand the reasons for DTOC continuing to run above target. This review found many other reasons (unrelated to health or social care) and based more on housing, finance or support issues but was unable to quantify

the numbers or costs for these 'other reasons'. The Urgent Care Programme Team was tasked to look into the review's findings. The initial difficulty was a lack of clear data – as patients' housing issues were masked behind other reported delays, such as care packages or family and often not picked up until the patient was medically fit for discharge.

22. The Urgent Care Team was aware of the pilot at the Bradgate Unit and working with the District Council Lead, and her team, the Urgent Care Team drew up a proposal for a similar combination of housing expertise and community support to be based within the LRI.

23. In December 2014, to test out this type of role and collect some data on the size of the issues within the acute Trust, a six day 'taster' of the role was put in place on the medical assessment wards. This entailed an experienced housing officer undertaking a housing and welfare assessment on a robust sample of patients, alongside nursing and medical assessment on admission. This identified that 42% of all patients seen over the six days had housing or welfare issues that would have an impact on their discharge:-

    - 62% of these were housing related: problems with heating, disrepair, unsuitable housing, homelessness etc
    - 38% were welfare related: patients being too scared to go home due to harassments or loneliness, family problems or financial concerns.

24. In February 2015, as a result of the findings from the 'taster' the Trust made the brave decision to implement a 12 month pilot, with housing and a community officer, working closely with the Integrated Discharge Team but concentrated on patient's housing/welfare needs. The Funding awarded by the Trust would also establish what resources would be required going forward and enable the collection of robust data on the true size of the issues patients and the LRI were facing. As with the Bradgate pilot, resources were made available for basic furniture packs and rent deposits – again these were only to be used if all other options had been exhausted and where it was cost effective.

25. The service was delivered initially through one Hospital Discharge Enabler and one Community worker - both posts are filled by experienced officers who work closely with nursing and therapy staff on the assessment wards, social workers and Discharge Sisters. They also link with the seven District, and City, council services to provide long term solutions.

26. With a matter of weeks, the impact of this work on DOTC and patient welfare was evident and the Trust agreed to fund a third housing officer, who has been placed within the Integrated Discharge Team and takes referrals housing and welfare issues from the rest of the Trust and local Community Hospitals.

27. As with the Bradgate model, the officers are empowered to make decisions, with support provided by Blaby District Council's Community Services Team. Critically their work at both hospitals is not mere 'signposting' but providing

practical individual end to end solutions for patients. This does mean that at times the officers need to have robust conversations to remind other services and authorities of their responsibilities.

Conclusions and Next Steps

28. Having Housing Officers based at the Bradgate unit has fostered positive relationships, enabled Ward Staff and the InReach Team to have quick, easier access to expert housing advice and has engendered a culture of referring patients earlier for housing options and advice. This coupled with the Housing Officers being empowered to make decisions, access funds and offer ongoing support to patients when the move back to, or into their new home has made a difference to how patients perceive their move from hospital.

29. The Pilot is working with LPT and commissioners to provide evidence of its impact on DTOC for housing related cases and it is proposed that the project is mainstreamed.

30. The housing support elements of the Better Care Fund (BCF) are being evaluated and considered in the refresh of the BCF for 2016/17 which is being led by the Integration Executive

31. Decisions on funding arrangements for the BCF for 2016/17 will be made in conjunction with CCG Boards and Leicestershire County Council Cabinet (via the Medium Term Financial Strategy), and milestones for this have been developed so that the planning work is approached jointly between December 2015 and March 2016.

Case studies

32. Three case studies relating to the Bradgate scheme and two case studies relating to the LRI scheme can be found in Appendix One.

Officer to Contact

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Appendix One – Case Studies

CASE STUDY ONE

Name: Mr A

Diagnosis: Depression

Admission Date: 05/11/2014 Referral Date: 12/11/2014

Local Authority: Leicester City Council Discharge Date: 25/11/2014

Case Summary:

Prior to his admission, Mr A lived in a privately rented, two bedroom house in Leicester City. Unfortunately, the property is unaffordable for Mr A, his son moved to live with his mother around two years ago, which caused a reduction in his Housing Benefit. Over this 2 year period, his rent arrears have continued to accrue and he is currently in arrears of £6000. This was a major factor in the deterioration of Mr A's mental health and the necessity for admission.

After a short stay in hospital, Mr A was assessed as medically fit and was discharged back to his previous address. The project aimed to assist Mr A with a move to more suitable and affordable accommodation. To facilitate this, the Discharge Enabler pursued both private renting and council properties as potential options and was able to have Mr A placed on the priority banding with Leicester City Council. Unfortunately, an issue arose with Mr A's benefits and both his Housing Benefit and ESA were suspended. This added financial pressure took its toll on Mr A's mental health and he began reporting suicidal ideation and intent. The community support provided by the project was vital in preventing a readmission for Mr A. The Housing Support Officer worked alongside the key professionals in Mr A's case to do this; working with the Assertive Inreach Team to resolve the issues with Mr A's benefits and Mr A's CPN to ensure his safety in the community. The Housing Support Officer also worked directly with Mr A to build his resilience and confidence in working towards solutions. The projects funds were also utilised to provide Mr A with basic necessities such as power during this crisis period, ensuring his home was habitable.

Through this multi-disciplinary work, Mr A was able to remain in the community, his benefits were reinstated and he has received an offer of accommodation from the City Council. Work on this case is ongoing.

Case Summary Update**:**

Mr A has now moved into a Housing Association property. The property is affordable and Mr A reports that he is much happier. The removal of the stresses surrounding his housing situation has improved his mental health. Mr A has also moved into a property that is closer to where his son lives, increasing the amount of time he gets to spend with him. Mr A continues to receive support from the Housing Support Officer in developing his independent living

CASE STUDY TWO

Name: Mr D

Diagnosis: Depression, Personality Disorder

Admission Date: 12/11/2014 Referral Date: 23/12/2014

District Authority: Blaby District Council Discharge Date: 25/01/2015

Case Summary:

When Mr D was admitted to the hospital, he was living with his parents. Due to his mental health problems, they could no longer house him and Mr D became homeless whilst on the ward. To prevent a long over-stay in hospital, the Discharge Enabler was able to secure private rented accommodation in the area of Mr D's choice.

As this was Mr D's first tenancy that he had held himself, the HSO supported him to establish routines for independent living and ensure his finances were kept in order. Mr D has maintained the tenancy since his discharge with no issues. Mr D has also been able to build and maintain a relationship with his son, who lives nearby with his ex-partner.

Recently, Mr D has applied for a place at university and has been successful. He will start his course in September. The HSO will support him in the transition and will support Mr D's referral to student support.

CASE STUDY THREE

Name: Mr E

Diagnosis: Depression

Admission Date: 17/01/2015 Referral Date: 29/01/2015

District Authority: Hinckley and Bosworth Discharge Date: 18/02/2015

Case Summary:

Mr E has spent many years in either hostels or sofa surfing. In that time he has had three separate admissions into the Bradgate unit. Mr E has also been addicted to drugs and has a past history as an offender. On Mr E's third admission, he was referred to the Housing Support Service. The Discharge Enabler was able to get Mr E private accommodation in Leicester City. With the support of the HSO, Mr E has been able to maintain his tenancy for almost six months with no issues. Mr E is also engaging with drug and alcohol support.

Mr E also has a daughter, who he had very limited contact with. By maintaining his tenancy, this has given him the ability to see his daughter on a regular basis. The HSO and Mr E are now working towards Mr E gaining enough confidence to undertake some voluntary work

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CASE STUDY ONE

Single Female - Leicester City

A patient had identified via a relative that she was worried about her home and job while she was in hospital. The relative was not based in the UK and the patient did not speak English. The community support officer was able to gain the patients trust and speak to her in her own language. She was able to visit the landlord of the property (who was also her employer) and explain the circumstances and assist the patient to apply for housing benefits. The patient had come into hospital as an emergency and had no papers with her and no relatives or friends to help. The community support officer was able to get consent to collect essential papers and the woman's mobile phone so she was able to contact friends to help her. The officer liaised regularly with the landlord so that he knew what was happening and when he would get his rent and she was able to provide support following discharge to ensure that benefits were in place and to help the patient return to her job.

CASE STUDY TWO

Single Male – County

The project was able to resolve a long running and highly complex case that had seen multiple admissions to hospital in the last 5 years, and several referrals to the local multi agency forum due to agencies recognising his vulnerabilities and service requirements but being unable to engage with him. The resolution included gaining the trust of the patient, offering services that removed barriers to discharge (in this case facilitating delivery of a specialist mattress as the patient had no other person to do this) and providing practical services (a full clean and provision of floor covering to the bedroom) to meet minimum requirements for a package of care to be secured.