CABINET

THURSDAY, 3 APRIL 2014

REPORT OF THE PORTFOLIO HOLDER FOR PUBLIC HOUSING AND VULNERABLE PEOPLE

HOSPITAL TO HOME PILOT PROJECT

EXEMPT INFORMATION
None

PURPOSE
To update Cabinet regarding the approach that has been developed to prevent delayed discharge from hospital that is related to housing issues. To seek Cabinet approval to further develop this approach in partnership with the South East Staffordshire and Seisdon Peninsular Clinical Commissioning Group (CCG) and other partner organisations for a six month period.

RECOMMENDATIONS
That Cabinet agrees to the further development of the "Hospital to Home" project in order that a full assessment can be made as to its effectiveness, value for money and future potential to facilitate effective partnership working between housing, social care and health.

To seek a waiver to financial regulations to deploy £25K of Homelessness Prevention Funding in order to continue joint working arrangements for the duration of the 6 month pilot of the "Hospital to Home" project.

EXECUTIVE SUMMARY
In line with the Council's ambitions contained within its Healthier Housing Strategy, the Council is actively working with partner organisations to ensure housing activity is aligned to the health agenda and contributes to improved health outcomes for local people.

As part of this approach, the Council's Strategic Housing Service has worked with health colleagues including the CCG to explore how residents might be effectively supported to return to their own accommodation and prevent expensive delayed discharge and unnecessary pressure on acute care hospital beds where the delay to returning home is due to housing related issues.

The approach developed to date aims to ensure that no Tamworth residents are discharged from Good Hope Hospital or the George Bryan Centre without their housing needs being addressed and to ensure a noticeable reduction in delayed discharges resulting from housing issues, shorter inpatient stays, reduced admissions due to housing related issues and prevention of 'revolving door' re-admissions to hospital.

This approach aims to contribute to a better understanding of local needs and issues and contributes to the national agenda on hospital admission and discharge for people who are homeless or unsuitably housed.

The approach was initially discussed with health and social care colleagues and taken forward utilising existing staff resources within Strategic Housing Services. However, in September 2013 Brighter Futures, an organisation specialising in supported housing

provision who had expressed a interest in working with the Council, were successful in a bid to the Department of Health (DoH) Homelessness Hospital Discharge Fund for funding. Working with the Council, Brighter Futures agreed to utilise this funding to add a Complex Needs Worker element to the evolving "Hospital to Home" approach. Employed directly by Brighter Futures, a dedicated resource has been committed to Tamworth to provide ongoing support to patients with more complex needs to help prevent further homelessness or readmission to hospital. This strengthened the approach being developed and ensured service coverage for residents with more complex needs that would otherwise not have been incorporated into the scheme due to the specialist nature of this type of work.

No firm timescales were initially put in place due to the complex process of setting up the project although a project plan was developed that looked to monitor project development and outcomes over a 12 month period. The DoH funding secured by Brighter Futures was for a limited, 6 month period only so this became a key driver in terms of setting up the scheme and promoting it to partners over a short period of time.

As the "Hospital to Home" approach has been developed, it has become evident that the potential to further develop this approach to incorporate a wider area of coverage of service in terms of both the number of hospitals and partner organisations engaged has become apparent. A review of the approach to date (attached at **APPENDIX 1**) has been undertaken and this has highlighted a number of key outcomes for local people and the potential for the approach to be developed further with the ultimate aim of establishing a permanent, value for money service that can serve as an effective vehicle via which pooled resources and joint agency working can further enhance the health and wellbeing of local people and utilise valuable resources in the most cost-effective manner.

To this end, it is proposed that a waiver to financial regulations is agreed in order to utilise available Homelessness Prevention Funding to enable the complex needs element of this work to be continued and the project further developed over the next 6 months. This will also allow sufficient time to fully assess the effectiveness and value for money of the service with a view to going out to tender should the pilot phase outcomes indicate the service has a longer term benefit to both residents in need and partners across housing, health and social care services.

The project will be monitored via the local Health and Well Being Board and work is underway with CCG and Public Health colleagues to devise robust assessment methodologies that will ensure the pilot achieves value for money, delivers on agreed outcomes, links to related initiatives such as the Better Care Fund and is effectively linked to locality commissioning processes and aligned to shared objectives as set out in the Health and Well Being Strategy, the Council's Corporate objectives and the outcomes identified in the Healthier Housing Strategy. Discussions via the Health and Well Being Board will ensure effective monitoring and assessment of the pilot will be utilised to plan for the longer term direction, sustainability and resourcing of this collaborative, multi-agency project.

RESOURCE IMPLICATIONS

To date, the "Hospital to Home" approach has been developed utilising existing staffing resources within Strategic Housing Services working in partnership with CCG, public health, social care, hospital staff and a range of other partners.

Key to the development of the approach is the work with residents with more complex needs that has been undertaken by staff at Brighter Futures. Utilising funding received from the Department of Health following a successful bid to the Homelessness Hospital Discharge Fund, Brighter Futures dedicated a full time post for 6 months to work alongside Council staff and other partner organisations to contribute to the further development of the "Hospital to Home" approach. Having deployed the £22,450 for this purpose, positive outcomes for service users have been achieved (as detailed in **APPENDIX 1**). Additionally, the expertise and skills of Brighter Futures workers have been key in facilitating a collaborative approach and ensuring linkages are effectively made across organisations and disciplines to generate

positive outcomes for residents.

In order to further refine and fully assess the “Hospital to Home” approach in Tamworth, it is proposed a waiver to financial regulations be agreed to enable Brighter Futures workers to continue their engagement in the project for a further 6 months. It is intended that the utilisation of £25K of Homelessness Prevention funding for this purpose will assist in the development of a fully formed, effective and value for money service that could then be subject to a formal tendering process with regard to putting in place permanent partnership arrangements and associated resources. This would be subject to securing longer term funding and commitment from partners and subsequently, makes this a key element that will be fully explored within the proposed 6 month pilot period.

Should the approach prove successful there would be scope to further develop the approach to be delivered on behalf of other local authorities. In time, it is intended the approach will facilitate the pooling of resources across organisations with the intended outcome being to better deploy ever decreasing public resources to generate positive, value for money outcomes in line with Government, CCG, Social Care and the Council’s aims and objectives.

LEGAL/RISK IMPLICATIONS BACKGROUND

There are no identified legal risks within the proposed approach. As Brighter Futures secured DoH funding that was in turn directed to support the “Hospital to Home” approach, it would be impracticable to engage another organisation at this juncture as this would disrupt the development of the project and established relationships with partners and residents build up over time. The risk of legal challenge can be tempered by this position and the re-assurance that should the pilot develop into a more permanent service, this would be subject to a formal tendering process in line with the Council’s agreed policies and procedures. It is important to note that a transparent tendering process would be essential so as not to put Brighter Futures at an unfair advantage against other potential service providers. To this end, scheme documentation, case files and publicity material will remain in the control of the Council and would be made available to all potential service providers expressing an interest in the scheme should a tendering exercise be undertaken.

A key risk is to have a poorly planned and executed exit strategy should the pilot not represent value for money or generate desired outcomes. Customers being assisted on the pilot will need to have outcomes successfully achieved or have alternative arrangements in place should the scheme not continue. This will be considered as a key element of the project and an exit strategy will be formulated and agreed within the 1st month of the 6 month pilot period.

Reputational risk to the Council may occur if the project does not continue beyond the 6 month pilot period. Work with partners will continue to mitigate this risk and it is anticipated that more effective joint working will become more prevalent and permanent regardless of the longer term fate of the project.

All partners involved to date (as listed below and within **APPENDIX 1**) are supportive of the project and governance arrangements are in place via the local Health and Well Being Board to ensure an approach is developed that meets both organisational requirements and achieves the best use of resources to deliver positive, shared outcomes

SUSTAINABILITY IMPLICATIONS

For Tamworth People:

Residents will be able to be discharged from hospital in a timely fashion and be enabled to return to their home. On going support can be provided and housing issues effectively dealt with to ensure those residents requiring this assistance are supported to live independently within a suitable and safe environment.

For Tamworth the Place:

Assistance is provided to residents to help them return back to their own home thus addressing issues of disrepair, reducing the number of potential empty properties, enhancing the environment and contributing to sustainable communities in which residents in need are supported to live independently.

Aspire and Prosper:
By assisting in improving the health and well being of resident and dealing with housing related problems and issues, a more preventative approach can be embedded that will encourage greater confidence in the community and a return for some residents to independent living that allows them to participate fully and contribute to the development of sustainable and more prosperous neighbourhoods.
Healthier and Safer:
Ultimately the scheme will contribute to enhancing the health and well being of residents by enabling them to be discharged from hospital in a timely fashion and supporting them in their home to prevent re-admissions in a home environment that is safe, decent and appropriate for their needs.

Additionally, it is anticipated the scheme will, in time, facilitate the pooling of resources across organisations with the intended outcome being to better deploy ever decreasing public resources to generate positive, value for money outcomes in line with Government, CCG, Social Care and the Council's aims and objectives. The development of a longer term, sustainable project will consequently link to related initiatives such as the Better Care Fund and be effectively linked to locality commissioning processes and aligned to shared objectives as set out in the Health and Well Being Strategy, the Council's Corporate objectives and the outcomes identified in the Healthier Housing Strategy.

BACKGROUND INFORMATION
Tamworth Borough Council (TBC) working in partnership with the South East Staffordshire and Seisdon Peninsular Clinical Commissioning Group (CCG) developed a Health Link project in 2013, set up to explore the potential to provide a co-ordinated pathway for patients over the age of 18 to return to their own accommodation and prevent expensive delayed discharges and unnecessary pressures on acute care hospital beds, where the delay is due to housing conditions.

The approach has been developed between key agencies in Tamworth working with people who may be homeless or have unsuitable housing and have had a stay in hospital. These agencies include:

- Heart of England NHS Foundation Trust – Good Hope Hospital
- Lichfield and Tamworth Hospital Discharge Service
- South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
- Staffordshire & Stoke on Trent Partnership NHS Trust (SSOTP) - Tamworth Locality Adult Care Team
- Tamworth Borough Council Strategic Housing Service
- Brighter Futures

The approach developed to date aims to ensure that no Tamworth residents are discharged from Good Hope Hospital or the George Bryan Centre without their housing needs being addressed and to ensure a noticeable reduction in delayed discharges resulting from housing issues, shorter inpatient stays, reduced admissions due to housing related issues and prevention of 'revolving door' re-admissions to hospital.

Initially, the scheme was developed with CCG and Public Health colleagues and utilised existing resources within Strategic Housing Services. However, in September 2013 Brighter Futures, with the support of Tamworth Borough Council, were successful in a bid to the Department of Health (DoH) Homeless Hospital Discharge Fund for funding to add a Complex Needs Worker to the emerging project. Employed directly by Brighter Futures, a dedicated resource has been deployed to provide ongoing support to patients with more

complex needs to help prevent further homelessness or readmission to hospital.

Service standards have been developed and effective promotion of the service has resulted in partner agencies contributing to the scheme to develop a co-ordinated approach within a multi-disciplinary context. The project review (as attached at **APPENDIX 1**) highlights progress against targets and performance against service standards and Key Performance Indicators (KPIs). The review also began to address the cost effective of the scheme and assesses outcomes for service users to date in terms of:

- Preventing homeless application directly from hospital
- Preventing hospital readmission
- Maintaining health and wellbeing at home

Some of the key outcomes achieved for service users are detailed below:

- Temporary accommodation secured (2 service users)
- House cleared and made habitable. Service user supported to ensure property remains habitable
- Re-housing into TBC Sheltered Accommodation
- Re-housing into Derventio Supported Accommodation
- Re-housing into Saltbox Restart Project accommodation (for ex offenders)
- Referred to (and now working with) Bromford Floating support (2 service users)
- Supported to register with Primary Health Care
- Supported with healthcare appointments
- Supported to engage with Mental Health Services
- Supported to engage with Probation
- Supported to make contact with Pathway Project
- Referred to, and now working with, Tamworth Victim Support
- Referred to the Citizens Advice Bureau's Money Advice Service (2 service users)
- Referred HEAT and Metropolitan for help with heating
- Supported to apply to the Staffordshire Crisis Support Scheme for funding
- Evidence of improved mental health
- Reduction in self harm
- Information provided to service users family on support available re benefits, dementia services and carers services. Service user reported that prior to this she felt 'lost' and that this had relieved a lot of worry.

Many of these outcomes above (and others detailed in **APPENDIX 1**) have been achieved through the work of the Complex Needs Worker which demonstrates the value of their role to the project. Many of the outcomes to date may not have been achieved had this scheme and the expertise of the complex needs workers been in place.

The review clearly articulates conclusions and recommendations that support the further development of the "Hospital to Home" approach over a further 6 month period in order to fully evaluate and assess the scheme to determine a longer term approach that can be fully resourced and further developed to incorporate:

- A continuation and further development of a co-ordinated approach for customers with more complex needs
- The use of specialist temporary accommodation options
- Enhanced promotion of the service to facilitate effective engagement of partners and their front line staff
- The potential to expand the scheme to cover additional hospitals, other local authority areas, engage with a wider range of housing providers and support agencies, work on a sub-regional basis in partnership with other similar schemes

In addition, the local Health and Well Being Board will oversee the delivery of the pilot and

work is underway with CCG and Public Health colleagues to devise robust assessment methodologies that will ensure the pilot achieves value for money, delivers on agreed outcomes, links to related initiatives such as the Better Care Fund and is effectively linked to locality commissioning processes and aligned to shared objectives as set out in the Health and Well Being Strategy, the Council's Corporate objectives and the outcomes identified in the Healthier Housing Strategy. Discussions via the Health and Well Being Board will ensure effective monitoring and assessment of the pilot will be utilised to plan for the longer term direction, sustainability and resourcing of this collaborative, multi-agency project

REPORT AUTHOR
Steve Pointon, Head of Strategic Housing Services

LIST OF BACKGROUND PAPERS

APPENDICES
"Hospital to Home" Project: 6 Month Project review