Appendix 1

Tamworth Borough Council and South East Staffordshire and Seisdon Peninsular Clinical Commissioning Group

‘Hospital to Home’ Project

6 Month Project Review

1. Introduction

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 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:

- 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 project 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.

In September 2013 Brighter Futures 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 pilot, employed by Brighter Futures, to provide ongoing support to patients with more complex needs to help prevent further homelessness or readmission to hospital.

2. Aims of this Review

The aim of this paper is to review and report on the performance of the developing project for the period of 19/08/13 to 28/02/14. It will review the development process and implementation of the approach, its documentation and working practices to explore if any changes are required and make recommendations for the future development of the scheme.

A requirement of the DoH funding was that any projects funded must be finished by the end of March 2014 and this review will inform the request to Tamworth Borough Councils Cabinet for funding from the Homeless Prevention Budget to continue the post of Complex Needs Worker for a further 6 month period.

3. How was the Review Completed?

To complete this review and make recommendations for the future of the service a full review of the following was undertaken:

- The service user data collected
- The policies, procedures and forms (all in draft form)
- Performance against targets and service standards set

4. The Service

Currently the service covers Tamworth residents over the age of 18 across all tenures of housing. There are two strands to the service, hospital discharge and admission prevention and professionals can refer people to the service through either or these strands. The pilot project has focused its delivery on Good Hope Hospital and the George Bryan unit.

Hospital patients can be referred to the service by any Health or Social Care professional working with them where their discharge is being delayed due to housing, the patient is likely to be discharged homeless or a potential housing issue has been identified.

If the person is at home and a housing issue that is having an impact on their health is identified, any Health, Social Care or support professional (whether social worker, ambulance worker, occupational therapist or other support worker) can refer the patient into the project.

A set of service standards was developed in association with key stakeholders:

- All referrals will be acknowledged within 24hours (excluding weekends)
- Housing Strategy Assistant (HSA) or Complex Needs Worker (CNW) will complete an assessment with the patient within 2 working days for urgent referrals and 5 working days for routine referrals.
- Referrers will be updated with the progress of their referral at least once a week
- Patients will be treated with dignity and respect
- Any information provided will be clear, concise and easy to understand

If any of those referred present with complex needs then the Housing Strategy Assistant will refer to the Brighter Futures Complex Needs Worker for ongoing support. See section 8 for more information on complex needs.

Where a referral does not meet the projects criteria then advice, information and signposting to a more suitable organisation will be given where possible.

This could be by the patient returning to their current accommodation or the patient seeking to be housed to more suitable accommodation.

The project will also work with Health and Social Care professionals working with people in the community to identify housing issues that may be contributing to repeat call-outs from the emergency services and repeat admissions to hospitals, alleviating pressures on hospital bed spaces and preventing 'revolving door' readmissions. This could be by improving the suitability of the home, rehousing to more suitable accommodation or ensuring support is in place to allow them to live independently in their homes

5. Promotion of the Service

The project has been widely promoted both with organisations that could refer into the service and organisations that could support the work of the project.

Poster and pens have been produced by Tamworth Borough Councils Communications Team to highlight the project and a sample of the poster is attached at appendix 1. Postcards have also been produced to leave with service users once an initial assessment has been completed to provide information on the service and contact details. This is included as appendix 2.

5.1 Referral agencies

There has been extensive hospital promotion, in Good Hope with regular meetings with the discharge team to maintain the profile of the project and since January 2014 the Housing Strategy Assistant and the Complex Needs Worker have regularly undertaken drop ins at Good Hope Hospital on a Wednesday morning visiting wards, promoting the service and advising staff how they are able to make referrals to the service. Posters and pens have been distributed to all relevant wards (i.e. not Intensive Care or High Dependency units) and contact has been made with Lead Nurses or Ward Clerks where possible so that they can disseminate information on the project to their teams. There has also been a meeting with the RAID Team at Good Hope Hospital who provide Mental Health Assessments to patients.

Close working links have been made with Trident Reach, who provide a similar service for patients from Birmingham in Good Hope Hospital. As a result of this joined up working Tamworth Borough Council were invited to deliver a presentation to Junior Doctors as Part of a wider seminar on looking at the wider needs of homeless patients. 21 Junior Doctors attended this session.

The Housing Strategy Assistant has also attended SSOTP team meetings and each area team meeting has been visited twice and additionally a combined team meeting once. An article was also put on their intranet and in their staff newsletter.

In addition to this a visit was made to the Integrated Occupational Therapists team meeting in October 2013 to advise them they can refer to the project if contact is made with a patient and their housing conditions make their property unsuitable to return home to.

Internally the service has been promoted to the wider housing team at Tamworth Borough Council by attending the TBC Supported and Sheltered Housing team

meeting and doing a presentation to the whole Housing Service as part of the monthly Housing Briefings. Information has also been provided to the Customer Services Team should any enquiries come through to the main switchboard.

5.2 Barriers to Promotion

Wider evidence suggests that there are a number of patients who regularly call ambulance services but then do not go to hospital, or make above average use of acute health services. To address this, a meeting was held with the West Midlands Ambulance Service as housing issues could be identified by ambulance crews attending patients. As a result of this meeting a list of possible criteria was then distributed to the Telemed desk and managers responsible for South Staffordshire so that they are aware of the issues that could be referred to the scheme. To date the project has received no direct referrals from the West Midlands Ambulance Service.

We have tried to access the Lead Nurse meetings at Good Hope Hospital to promote the service via our colleagues at the CCG, but have been unsuccessful.

In the George Bryan Centre we have met with the managers of the East Wing, West Wing and the Crisis Team. We made several attempts to access team meetings (particularly the West Wing) but had little response. Claire Hartland, Ward Manager for the East Wing supported us to organise 2 drop-in sessions for staff which were held on 28th January and 4th February 2014.We attended the staff handover meeting on the East wing on 28th January and on the West wing on 4th February to explain the scheme and its benefits to ward staff. We spoke to approximately 20 staff members over the two sessions

As with the Lead Nurse Meeting attempts were made to access the area GP's meeting via colleagues at the CCG but again were unsuccessful. However were able to put a short piece in the GP's comms pack.

Difficulties have been experienced generating consistent engagement from partner organisations at the Hospital to Home Project Group Meetings which has raised concerns around the level of buy-in from these organisations.

5.3 Promoting joint working

To improve the effectiveness of signposting the project has been promoted to services that could be accessed to support the patient. Agencies targeted have been:

Metropolitan (the Home Improvement Agency)
Bromford Supported Housing and Floating Support Service,
Tamworth ADSIS (alcohol dependency service)
Addaction (substance misuse service)
Citizens Advice Bureau
TamCAN
Starfish Project
Tamworth Cornerstone Housing Association (supported housing project)

Additionally an article was placed in the Tamworth Centre for Voluntary Services (CVS) newsletter, which goes out to voluntary and community organisations in the Borough.

Time has also been spent with other organisations providing similar services in surrounding areas to share information and contacts and discuss joint working possibilities. In particular Birmingham City Council's Housing Hospital Discharge Team, Revival's Home from Hospital scheme in Stoke and Trident Reach's Homeless Patient Pathway Project team. With the latter there have also been joined up ward visits.
An email was also sent to the housing managers at the three largest Registered Providers in Tamworth; Bromford, Midland Heart and Waterloo to promote the service. As a direct result of this email the Supported Housing Manager at Waterloo and the manager of McGregor Tithe came to a meeting to discuss the future of the project and presented an opportunity for joint working, based on a pilot from Birmingham.

6. Service Costs

The project is currently delivered utilising existing staffing resources within the Strategic Housing Service with appropriate support from partner organisations as required.

Provision of the Complex Needs Worker is funded through Brighter Futures from the DoH grant at a cost of £22,450 for the period of November 2013 to the end of March 2014.

£313 has been spent from the Homeless Prevention grant on promotional items - £15.00 for posters, £24.00 for postcards and £274.00 on pens.

7. Evidence

This review is based on the available evidence of the service collected by Tamworth Borough Council and Brighter Futures from August 2013 to February 2014.

7.1 Progress against targets

A provisional target of 20 referrals for the duration of the pilot was initially set. At the end of February 2014 there have been 24 eligible referrals to the service. This means that the 12 month target has already been exceeded within 6 months

In addition to the eligible referrals there have been a number if referrals for patients from other areas. There have been 5 referrals for residents of Lichfield and 2 potential referrals for residents of Cannock. After discussion with the Head of Strategic Housing the decision was made to work with one of the Lichfield referrals as it was on the border of Tamworth. In all other instances the referrer was advised to contact the relevant local authority and in 3 cases the referrer was also given some basic advice. Table 1 below highlights where the referrals have come from:

Table 1: Referrals

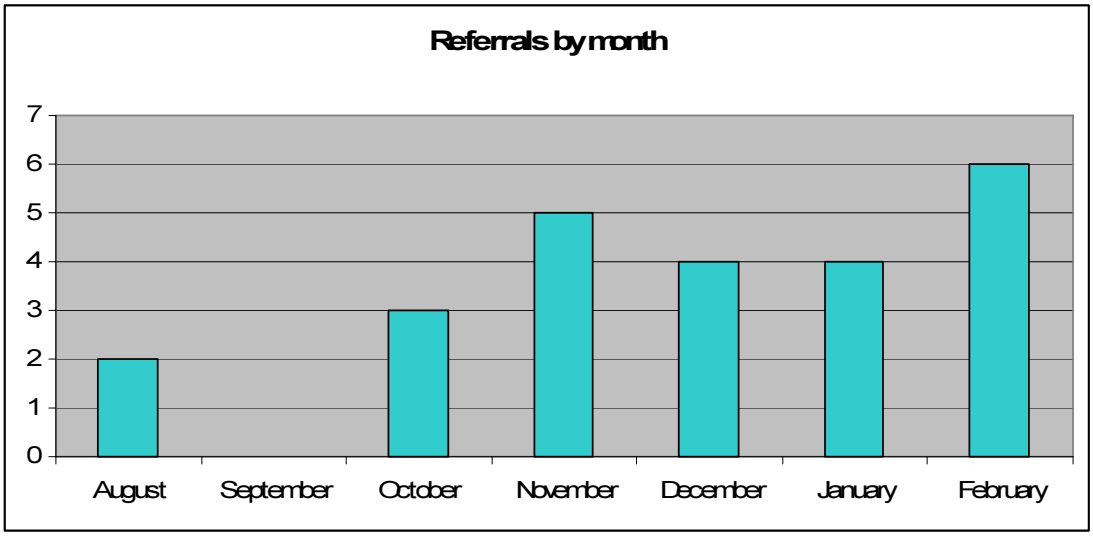
REFERRAL AGENCY	NO. REFERRALS
TBC internal	6
Hospital Discharge Team – Good Hope Hospital	6
Ward Staff Good Hope Hospital	1
George Bryan Centre	1

Hospital Discharge Team – Robert Peel Hospital	1
SSOTP	2
Health Visitor Team (part of SSOTP)	4
Lichfield and Tamworth Occupational Therapy Team	1
Trident Reach – Homeless Patient Pathway Project	2

To date there have been no referrals from WMAS or the RAID team which suggests a need to revisit these teams to ensure the project is well promoted.

Encouragingly there has been a continued steady increase in referrals since the pilot started. A breakdown of referrals by month can be seen in Figure 1 below:

Figure1: Referrals by month



The two months with the highest levels of referrals were also the two months with the highest levels of promotion done so it is possible that there is a link between these two factors. Ward visits to Good Hope Hospital commenced on the 22nd January 2014 and staff knowledge of the project can be seen to be increasing which has generated 3 referrals, though these later turned out not to be from Tamworth. There have however been 2 eligible referrals from the Hospital Discharge Team at Good Hope Hospital since the drop ins have started though it is unclear whether the drop-ins have impacted on this or not.

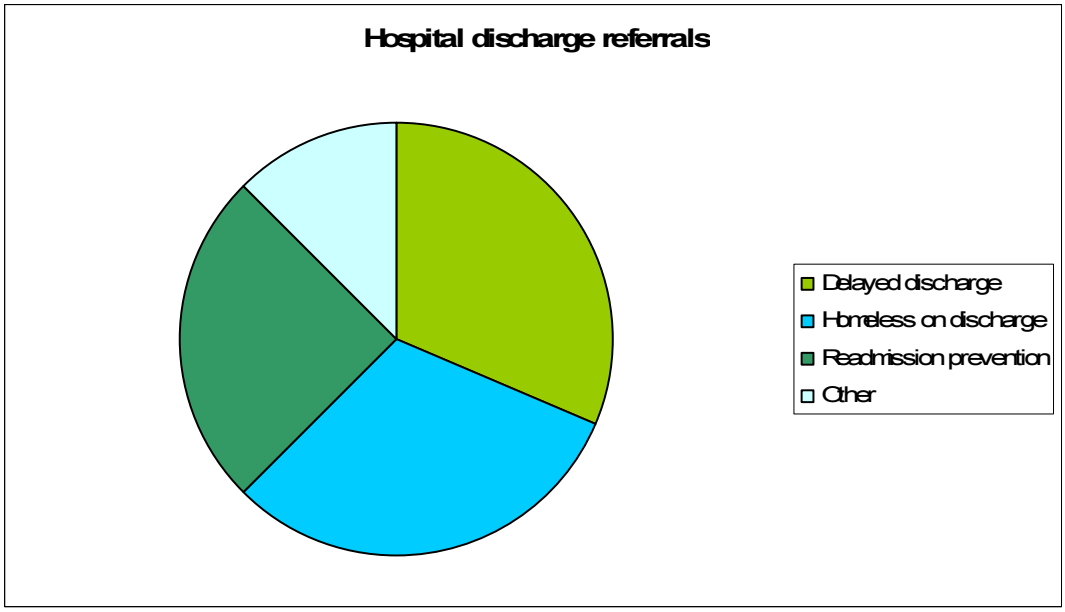
The majority of referrals received relate to discharge from hospital (16) but not necessarily delayed discharge. There have been 5 delayed discharge referrals and the KPI set was for 15 so this is not being met currently. However, given that the data provided by the Hospital Discharge Team prior to starting the pilot showed 2 delayed discharges due to housing in the previous year its possible the target is not realistic.

Overall the hospital discharge referrals received can be categorised as follows:

- Delayed Discharge
- Homeless upon discharge
- Re-admission prevention
- Other housing issue

A breakdown of the hospital discharge referrals so far can be seen in Figure 2 below

Figure 2: Breakdown of hospital referrals



The two cases where 'other' was the reason were when the service user had housing but did not want to return there (in both cases due to the threat of violence) and the ward were unlikely to delay discharge due to this.

8 of the referrals were community referrals from an admission prevention angle (33%) which is higher than the target of 5 which we set for the duration of the pilot.

Of the 4 referrals from the Health Visitor Team, extra assistance for two of the referrals was not possible (because support to deal with their rehousing was already being provided via Bromford) and with the remaining two only basic advice was able to be given. All 4 cases were then closed down. This suggests a need to provide Health Visitors with some extra information to clarify what the service can offer or maybe some basic housing advice training may be beneficial to make sure referrals are appropriate.

7.2 Complex needs referrals

For the period under review 7 service users have accessed support from Brighter Futures. Brighter Futures allocates 15 clients to each Complex Needs Worker and this was the target number of clients that Brighter Futures submitted in the Homeless Hospital Discharge Fund bid so the pilot has currently failed to meet this target.

However, the service users that have accessed to the Brighter Futures services have proved to be very complex and time consuming cases and without the support of the Complex Needs Worker the project may not have produced such positive outcomes (as detailed on page ?).

In two of the referrals the patient has not met the criteria to allow them to access the Brighter Futures Service, but have required additional work beyond the remit of the Housing Strategy assistant whose role is a signposting and referral role within the project. In these cases referrals were made to the Bromford Floating Support Service however they are unable to start working with clients until they have been discharged from hospital which has meant that the Housing Strategy Assistant has, on these occasions, had to provide more of a support function than initially anticipated.

8. Performance against service standards

Prior to the project commencing the following service standards were agreed by the project group and performance against these standards is detailed below:

- **All referrals will be acknowledged within 24hours (excluding weekends)**

23 or the 24 referrals were acknowledged within 24hours (96%).

The one referral that was not acknowledged within the agreed time was acknowledged after 3 days due to commitments which prevented the Housing Strategy Assistant from being able to make the contact and when contact was attempted the referrer was unavailable. This suggests that there possibly needs to be a process in place for acknowledging referrals if the Housing Strategy Assistant is out of the office.

- **Housing Strategy Assistant or Complex Needs Worker will complete an assessment with the patient within 2 working days for urgent referrals and 5 working days for routine referrals.**

Of the 24 referrals 4 were not assessed. One of the referrals refused the service, one only wanted basic advice and the other two referrals were not complete referrals and no contact details were provided in order for an assessment to be arranged and were later closed.

Of the 20 referrals that were assessed 10 were classed as urgent and 10 were classed as non urgent.

Of the 10 urgent referrals 7 were assessed within 2 working days of being received (70%) and of these, 2 were assessed within 1 day and 2 were assessed the same day they were referred.

Of the 3 that were not assessed within the time frame 2 were assessed within 3 days and 1 within 7 days, however there are valid reasons as to why there was a delay. 1 of them required the service users support worker to be present and they couldn't attend within 2 days, 1 required a family member to be present and they couldn't attend within 2 days and 1 was offered an appointment within the time frame but did not attend.

This suggests that perhaps the KPI needs to be changed to "Housing Strategy Assistant or Complex Needs Worker will ***offer*** an assessment with the patient within 2 working days for urgent referrals" to reflect the fact that there may be

circumstances outside of the projects control where a client may be unable to be assessed within 2 days.

Of the 10 non urgent referrals only 3 have been assessed within 5 working days of being received (and these were assessed in 3 days or less). Again, in the majority of cases where there was a delay there was a valid reason for this. 1 of the referrals required the Social Worker and a family member to be present and we couldn't find a mutually convenient time within 5 days, with 2 of the referrals we couldn't find a mutually convenient time within 5 days, 1 referral had an assessment booked within 5 days but did not attend and with one of the referrals we are still awaiting contact details from the referrer in order to arrange an assessment.

However, 2 of the referrals were not booked within the 5 days without a valid reason. This suggests that improvements need to be made in this area.

- **Referrers will be updated with the progress of their referral at least once a week**

Anecdotal evidence and evidence from client files suggests that updates at least weekly have been taking place for active referrals and that the referrer has been made aware where any referrals have been closed down. However this information has not been included in the monitoring form so is not being formally recorded. This may be something that needs to be officially recorded in order to ensure that this KPI is being met

- **Patients will be treated with dignity and respect**

Within the project plan there was a customer satisfaction survey for the service planned after 6 months. As this time has now elapsed this is currently being worked on by the Housing Strategy Assistant and the Housing Strategy Team Leader and will be undertaken imminently. Once this has been devised and distributed, this KPI can then be reported on.

- **Any information provided will be clear, concise and easy to understand**

Again this KPI is to be measured by the customer survey

Performance against KPIs

The following outcomes targets were suggested and are reported against monthly and performance against these targets is detailed below:

- **Of the delayed discharge referrals: 80% of cases where a delay is prevented or reduced**

There were 5 referrals relating to potential delayed discharge, outcomes are as follows:

Patient 1 – delayed discharge prevented
Patient 2 – delayed discharge probably reduced (3 days)*
Patient 3 – delayed discharge possibly reduced but unlikely **

Patient 4 – Ongoing - placed in interim bed space (2 weeks as at 07.03.14)
Patient 5 – Ongoing – 6 weeks delayed discharge as at 07.03.14

* The Discharge team at Good Hope Hospital felt that the delay would probably have been longer without the involvement of the project (as the ward cannot confirm they would have allowed the patient to stay longer).
** After 19 days working with the patient the family decided a care home would be more suitable so referral was closed.

If it is assumed that patient 2's discharge was in fact reduced then 40% of the referrals had their delayed discharge prevented or reduced which is below the target set.

4 of the 5 referrals related to the patient's housing being unsuitable to return to and in three of these cases the delay was due to the condition of an owner-occupied property, which is not as easy for the Council to assist with and is not a quick process to rectify.

Where the referral related to someone being homeless on discharge the patient required wheelchair accessible accommodation which made temporary accommodation unsuitable to meet identified needs and bidding on find a home was the only option. Whilst the Council worked speedily to obtain the evidence and have placed the patient in Band 1 within a week there is a lack of suitable accommodation to meet identified need therefore the patient remains in hospital.

The only way these delayed discharges could have been prevented would have been if suitable temporary accommodation was available to house patients who need time to secure permanent accommodation or to make their current accommodation more suitable.

- **Of the admission prevention referrals: Hospital admission prevented in 70% of the cases**

The data collected so far suggests that none of the admission prevention referrals have gone on to be admitted to hospital (100%)

8.1 Cost effectiveness

In terms of value for money, the average cost of a bed day in hospital is £225 and the average length of stay for a hospital admission is 4 days. Based on the project costs of £27,693 for the first 6 months, the project would need to have prevented at least 123 days in hospital within a 6 month period to be cost effective. This can be as a result of reducing the length of stay of the initial hospital admission or as a result of preventing future admissions.

9. Progress against the Project Brief

As well as the KPIs outlined above the Project Brief outlined further proposals for the scheme:

The Project Brief proposed *"a minimum of 2 workshop sessions delivered by the Housing Strategy Assistant and Homelessness Education Officer. These workshops*

would be around challenging the stereotypes of homelessness and sharing information on the support available"

Despite efforts being made to organise these with the help of the CCG there has been resistance from the lead Nurses. However, the Housing Strategy Assistant participated in the seminar to Junior Doctors with Trident Reach (as detailed on page 4) which covered all of the requirements as listed above. Therefore it could be argued that one of the 'workshops' proposed have been delivered

The brief also proposed *"Resource packs containing good written information about homelessness and housing options (including key contact details) for hospital staff"* and *"Resource packs containing good written information about housing, care and support options from a range of partners, as much for relatives as the patient"*

At present the resource packs have not been completed. Information to be included in the resource packs has been collected and is either stored electronically or paper copies of the information are kept in the project folder or the information relevant to each particular service user is selected and given to them.

10. Outcomes for Service Users

As well as preventing and reducing delayed discharges for hospital referrals and preventing admission to hospital for community referrals the project aimed to reduce homeless presentations at TBC directly after discharge from hospital, ensure people are supported to maintain their health, wellbeing and independence at home and to prevent hospital discharge referrals from being readmitted to hospital due to their housing.

No specific targets were set around these areas as outcomes will be specific to the individual but the outcomes recorded so far are detailed below.

- **Preventing homeless application directly from hospital**

There have been 3 homeless presentations directly from hospital since the pilot started. All 3 were patients at the George Bryan Centre who were identified as homeless at the point of discharge and sent to Tamworth Borough Council in order to make a homeless application.

For this reason significant efforts have been made to access ward staff at the George Bryan Centre to promote the project and request that housing be discussed at the earliest opportunity after admission so that if any issues were identified then the Council could be notified in advance to allow time to work with the patient and arrange suitable accommodation.

At the time of writing the first referral from the George Bryan Centre has just been received 5 days before the patient was due to be discharged. Although the patient was not homeless it does suggest that ward staff are willing to work with the council on the pilot which should hopefully prevent any further homeless discharges.

There have been no homeless presentation from Good Hope Hospital since the pilot began though of the 5 referrals received that related to someone being homeless on

discharge, only 1 was referred before they were ready to be discharged, allowing the Council time to arrange accommodation for them before discharge.

- **Preventing hospital readmission**

A hospital readmission is defined as an emergency admission to hospital within 30 days of the last, previous discharge from hospital.

16 of the referrals were for someone who had been in hospital and as at 28 February 2014 only 2 of them had been admitted to hospital again.

1 service user was admitted to hospital 1 week after his previous discharge due to injuries sustained in a fight whilst in temporary accommodation, which would count as a readmission (and possibly housing related).

1 service user was admitted to Hospital for a second time but this was nearly 4 months after his last previous discharge and this was in relation to a pre-existing condition that is not affected by housing.

Therefore 94% of our service users were not readmitted to hospital

Maintaining health and wellbeing at home

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

- Temporary accommodation secured (2 service users)
- House cleared and made habitable. Service user supported to ensure property remains habitable
- Rehoused into TBC Sheltered Accommodation
- Rehoused into Derventio Supported Accommodation
- Rehoused into Saltbox Restart Project accommodation (for ex offenders)
- Housing provider (Bromford) improving the condition of current property and giving preference on a transfer to Sheltered Accommodation
- Referred to (and now working with) Bromford Floating support (2 service users)
- Supported to apply for Sheltered Accommodation likely to be rehoused soon
- 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
- Home visit from HEAT secured
- Supported to apply to the Staffordshire Crisis Support Scheme for funding (awaiting outcome)
- Now confident bidding on find a home
- Reporting reduced feelings of anxiety
- 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 have been achieved through the work of the Complex Needs Worker which demonstrates the value of their role to the project.

11. Paperwork review

The referral and assessment forms appear to be working as anticipated and are collecting the necessary data.

The option to refer over the phone is working well with busy hospital discharge teams. To date we have had no issues with people being referred without their consent via this method.

The procedure and accompanying flowchart is working as intended. A slight change was made after Brighter Futures became involved in the project in that, where it is clear at point of referral that the service user has complex needs the referral can go straight to the Complex Needs Worker rather than having to be assessed by the Housing Strategy Assistant first. It was felt that to do two separate assessments and/or arrange a joint visit could slow the process down and presented a duplication of work.

The flowchart still needs to be updated in order to reflect this and information also needs to be shared with the Housing strategy Assistant for recording and monitoring purposes including the date of referral and date of assessment.

Conclusions and Recommendations

The project has been extensively promoted which has contributed to higher than expected levels of referrals. A good proportion of these referrals have come from Hospitals (in most cases Good Hope Hospital) and there has been a higher than expected level of community referrals.

Brighter Futures' involvement in the project has been invaluable and the Complex Needs Workers have supported their service users to create positive outcomes for themselves such as being re-housed and engaging with Primary Healthcare and Mental Health Services.

Across all service users the project is beginning to demonstrate evidence of improved housing and health outcomes.

In terms of negative's the project has encountered difficulties accessing hospital staff but efforts have been made to find alternative ways to access these staff and improvements are starting to be seen. The service standards have not quite been met but with valid reasons in the majority of cases and the KPIs have not been met in all cases though this review has argued that the KPIs originally set may need to be reviewed to check they are realistic.

The review has generated some recommendations for the next 6 months to further develop the project in partnership with partners and guided by the local Health and Well Being Board:

Recommendation 1 – Continue to fund the Complex Needs Worker Role

A previously stated Brighter Futures' support with the project has been valuable, with positive outcomes for their 7 service users. The Complex Needs Worker secured accommodation for 3 of their service users provided advice and support with re-housing options for another 3 service users. This is time that would originally have been spent by the Housing Advice Team, which represents a saving to them in terms of staff time. Also by ensuring appropriate support is in place it is hoped that service users will remain housed, which could represent future savings to the service.

Also as previously stated, the 12 month target of 20 referrals has already been exceeded within the first 6 months and if the referral rate continues as it is the project could received double the number of referrals planned for. This suggests that the extra support provided by Brighter Futures will be required for the next 6 months.

Recommendation 2 – investigate temporary accommodation options

Since the inception of the project there have been 4 service users who have been in need of temporary accommodation but there has not been anything suitable for their needs. If temporary accommodation suitable for someone with mobility issues had been available the delayed discharge in 3 cases could have been prevented.

Waterloo Housing Group have discussed the option of Tamworth Borough Council renting a room in their Extra Care Scheme, McGregor Tithe, at their weekly/monthly rental cost. This option would provide fully adapted accommodation with an on site carer. This could be explored further along with the potential to utilise void properties within Tamworth Borough Councils own Sheltered Housing Schemes.

Recommendation 3 – revisit organisations where promotion has already been targeted

There appears to be a need to revisit the Health Visitor Team (possibly attend a team meeting) so services provided can be clarified to prevent inappropriate referrals and ensure resources not being duplicated (some of the referrals from SSOTP could be better directed towards Bromford - in some cases they were already working with Bromford).

We have also received no referrals from WMAS or RAID which suggests a need to revisit these teams.

Recommendation 4 – Investigate options for expanding the pilot

There have been 7 out of area referrals in the first 6 months of the pilot; 5 referrals for Lichfield residents and 2 for residents of Cannock. There may be some scope to approach these local authorities to make them aware of the issues we have been approached with regarding their residents.

There has also been no promotion undertaken with any other hospitals where Tamworth residents may go such as Queens, Heartlands and George Elliot. All of these may receive Tamworth patients and the option to extend the pilot to these hospitals could be explored. There has been 1 referral from Trident Reach for a patient at Heartlands which suggests there may be some value in promoting with these hospitals.

Finally only limited promotion has been undertaken with Robert Peel because evidence suggests that they very rarely have discharge issues due to it being used primarily for out-patients and as a rehab facility. However 1 referral has been received from the Robert Peel, so again there may be some value in promoting further with them.

Appendix 1: Hospital to Home Poster

Appendix 2: Hospital to Home postcard

FRONT


YOU'RE READY TO GO HOME...
...BUT IS YOUR HOME READY FOR YOU?
HOSPITAL
TO HOME
You have been referred to the Hospital to Home scheme because a professional you are working with wanted to make sure that your home is supporting your health and wellbeing.
We can help you with:
• Information on making your home safer to live in
• Assistance with applying for more suitable housing
• Referral to other agencies that might be able to help you
• Ongoing support, where eligible, provided by Brighter Futures

BACK


WANT TO KNOW MORE?
YOU OR YOUR FAMILY CAN CONTACT HOSPITAL TO HOME
Contact: Housing Strategy Assistant
Telephone: 01827 709469
Email: housingstrategy@tamworth.gov.uk
Visit or write to us at: Marmion House,
Lichfield Street, Tamworth, B79 7BZ
Please note: It is not possible to self refer to this service. All referrals have to come through a professional.
If you require this information in another format or language please contact us on the details above.
Tamworth Borough Council
brighter futures
NHS
HEART of ENGLAND
(8/13) 1539