Health and Wellbeing Board

Item 10

Report title:	**Homes and Health**
Date of meeting:	**30 October 2019**
Sponsor (H&WB member):	**Cllr Yvonne Bendle (on behalf of the Health and Wellbeing Board District Councils' Sub Committee)**

Reason for the Report

The report updates the Health and Wellbeing Board (HWB) on the past 12 months' activities through the HWB District Councils' Sub Committee of the Board.

Report summary

Actions were agreed across three key housing themes at the HWB in October 2018. This report identifies key levels of success and challenge alongside activity taken to support longer term prevention priorities.

Highlights across the three themes is included in section 2 and includes:

Warm and healthy homes:

- Delivery of the Warms Homes Fund is ongoing – actions are in place to ensure delivery is on target including a new communications and marketing delivery plan.

Workforce joint working:

- Pilots were established in three areas across the County. Planning is underway for an innovative solution to share learning outcomes with partners.

Discharge from hospital:

- Health and social care funding has been agreed until March 2020 for all acute trusts and central mental health trusts and community hospitals. Evaluation funded and due March 2020.

Recommendations

As the final steps proposed by the HWB District Council Sub-Committee, the HWB are asked to:

a) Endorse and facilitate uptake of the e-learning by their frontline workforce.
b) Promote the Warm Homes Fund within their organisations, drawing on support from Spring communications.
c) Agree to develop a model, based on learning from the 3 Multi-Disciplinary Team (MDT) pilots, to align housing and health within MDTs for consideration by the Primary and Community Care and Workforce STP workstream.
d) Agree to embed District Direct funding into member organisations budgets (including acute, mental health and community trusts) from April 2020.

1. Background

1.1 Previous reports in October 2018 established a formal sub-committee of the HWB comprising districts councils. It also agreed a 12 month focus on homes and health.

1.2 This approach supports the Joint Health and Wellbeing Strategy and aligned itself to tackling winter pressures via the STP Prevention work programme. It builds on the work with district councils outlined in a report to the HWB in February 2017 highlighting the opportunities to

maximise their preventative role and impact of their work within localities. It also supports the Norfolk and Waveney STP whose governance was also reviewed and established five key workstreams including “Primary and community care” (which includes prevention) and “Acute transformation”.

1.3 In April 2019, the HWB Board agreed three recommendations for further action:

i. Promote existing initiatives such as messages to stay well in winter, providing energy and money saving advice and installing central heating systems to fuel poor households.

ii. Build housing interventions into with Multi-Disciplinary Team activities and improve awareness of potential housing solutions to health and care needs.

iii. Establish a sustainable model and to extend the district offer to include discharge from mental health and community hospitals

2. Homes and Health - update

Warm and Healthy homes

Promote existing initiatives such as messages to stay well in winter, providing energy and money saving advice and installing central heating systems to fuel poor households.

2.1 The Norfolk Warm Homes Fund (WHF) has now been running for a year and has been able to support many households in fuel poverty by improving their financial position and making their home warmer with new central heating. With still over a year to run steps are in place to ensure the scheme meets all the intended outcomes. The WHF team:

- Have commissioned ‘Spring’ a market and communication consultant to help promote the programme more widely across Norfolk through a planned marketing plan including social media activity.

- Have requested engagement from all district councils in identifying vulnerable residents who would benefit from the scheme.

- Are in active conversation with the National Warm Homes funders regarding the removal of Energy Company Obligation funding for oil heating on how to mitigate any impact.

- Are in discussion with Clarion Housing Group and Saffron Housing Trust to deliver uptake of the grant in their properties.

- Are keen to engage Health & Wellbeing Board partners to maximise uptake of the grant to reduce fuel poverty across Norfolk.

Outcomes

2.2 The Warm Homes Team has received a total of 194 applications for first time central heating with £468,300 grant funding committed. In addition, 49 households have been supported with £87,400 emergency funding for boiler repairs. The value of additional benefits that have been secured for fuel poor residents through energy advice and income maximisation is £602,000.

2.3 The new communications campaign is being designed and will be launched at the beginning of September in time for the autumn period, which will increase the demand for new central heating systems going forward. At the end of July an additional nine installers were engaged by the Warm Homes Fund to increase the rate of completion of boiler installs.

2.4 Positive feedback on progress was received at a recent meeting with Affordable Warmth Solutions, the grant funders.

2.5 Switch & Save – in the two offers in Nov 2018 and Feb 2019 in BDC, NCC and SNC nearly 2,900 switched average saving pa of £120 (£350k total). For the May 2019 action, there were 295 registrations in SNC and BDC. 71% of the registrations could make a saving which equated to an average saving of £130.83. In total 119 switched. Currently a Big Switch and Save campaign is open and will close 26th November 2019.

2.6 District attendance at Flu Clinics in place for Autumn/Winter 2019. Targeted engagement at those surgeries that experience the greater levels of fuel poverty.

Case Study

Case study 1:
Mrs D had a visit from a Warm Homes Fund Support officer regarding her energy bills. She was paying £99 per month direct debit for her gas and electricity. The support officer called her energy company on her behalf and her tariff was changed, reducing her payments to £66 per month plus they sent her a refund of £1,300 as she was in credit.

Case study 2:
Mrs C originally contacted the WHF for help with their energy bills. A Warm Homes Support Officer helped Mrs C with claiming Attendance Allowance, and also suggested that Mr C was also eligible for attendance allowance. These additional benefits mean that they also received pension credit and council tax reduction, increasing their annual income by more than £10,000 per year. Mrs C said “The Support Officer was brilliant, absolutely brilliant, a lovely lady. Her help has had a massive impact, we were really struggling before. Our bills are now much more manageable. We can spend much more on weekly groceries and petrol than before. It’s had a really big effect on us. If someone is struggling since they retired, then the Warm Homes team can really help”

Case study 3:
Mr R in his late 70s, was living in a cold bungalow and struggling to heat his home with a solid fuel stove. Due to his ill health he was finding it increasingly difficult to bring in coal and wood to light the fire and so he applied for a WHF grant for central heating. As Mr R was receiving benefits he was eligible for a grant for a new oil central heating system and working with a WHF support officer he was successful in securing an additional £3377 charitable funding to bridge the gap in oil grant funding to enable him to have new central heating in time for winter.

Integration with Multi-Disciplinary Teams (MDTs)

Build housing interventions into with Multi-Disciplinary Team activities and improve awareness of potential housing solutions to health and care needs.

2.7 In 2018, £36,000 was received from Health Education England to support closer work with health and social care professionals. This funding was split equally across 3 district councils (South, Broadland and West) to pilot 3 projects to develop MDTs and involve primary,

community and social care staff with district council housing officers and other community organisations to prevent hospital admission.

2.8 As part of this programme, funding was allocated to share learning on housing and health, drawing on the pilots. This was also sighted as a recommendation by the HWB in April 2019 - “To hold a county-wide learning event to increase knowledge of potential housing solutions to health and care needs.”

2.9 A steering group with representatives from Norfolk County Council public health, South, Broadland and West Norfolk District Councils is working to deliver “A suitable response to this recommendation which will maximise the sharing of knowledge between professions”.

Outcomes

2.10 Pilots undertaken in Broadland, South Norfolk and Kings Lynn & West Norfolk:

- Broadland DC - Attendance at MDT meetings within GP surgeries and community mental health hospital wards. Further plans to reprint council information to support surgeries but has to be shaped by GP/surgery feedback. The current City 2 Community FICS (Fully Integrated Care & Support) meetings are hosted by Broadland at the Council Offices.

- King’s Lynn at QEH – 98 referrals received, e-form developed, and remote working enabled; training and marketing materials distributed across the acute trust. Reported increased activity within the hospital and report improved referrals into the home adaptation service and link with broader dementia care services.

- South Norfolk Council - Working within one larger surgery to provide tailored personal budget-based interventions for 11 patients as well as training for 11 staff within the practice.

2.11 The three key overarching learning outcomes remain as follows:

- Duty to Refer under the Homelessness Reduction Act beyond statutory minimum across health and social care.

- Better understanding of the impacts of homes on health and social care and with particular reference to spotting and referring potential category 1 health hazards as defined in law.

- Testing the timing of early intervention e.g. when in the elective surgery cycle is best time the intervene if there will be a need post-surgery for example and how potentially do we "front load" support address future increasing frailty in target populations.

2.12 The group have consulted with colleagues in Public Health and have developed an idea to deliver the wider learning outcomes by creating an E-learning/training resources enhanced with webinars and integration with existing events.

2.13 This would help to overcome some of the challenges in engaging with frontline staff such as accommodating work patterns and cover of provision and will ensure greater reach and longevity of sharing knowledge from the three pilots. The involvement of frontline healthcare workers in the development of the package would be essential.

2.14 An established working group are undertaking investigative work with NCC partners, learning pool, and colleagues who have worked on similar packages to establish feasibility and cost.

Case Study

Ms B is an 87-year-old woman who lives in a two bedroom privately rented bungalow. She is in receipt of housing Benefit but there is a £200 shortfall each month as her Housing Benefit was considerably lower than the cost of the rent. Ms B was having to cut back on food etc. to meet the rent cost. Ms B's health is declining and is now housebound as daughter who lives locally doesn't drive. However, she is in receipt of low rate Attendance Allowance which is used to pay a friend to take her out and also clean.

A referral was made from the Integrated Care Coordinator (ICC) based in the GP surgery to the Home Improvement Agency Officer to look at whether current property meets B'S needs and look at their finances. The HIA visited and completed a budget sheet. High rate attendance allowance was applied for and a blue badge so when Ms B is taken out by her friend they can park near to the shops. The HIA Officer discussed housing options with Ms B who decided she wanted to apply for sheltered housing. The HIA Officer completed a sheltered housing application and carried out a housing needs report identifying Ms B's need for a level access property and level access shower.

Discharge from Hospital

Establish a sustainable model and to extend the district offer to include discharge from mental health and community hospitals

2.15 The District Direct (DD) service is a dedicated Housing Officer resource working over the Norfolk and Waveney Sustainability and Transformation Partnership (STP) footprint, in the Norfolk and Norwich University Hospital (NNUH), the Queen Elisabeth Hospital (QEH), the James Paget University Hospital (JPUH), and across the district and borough council offices in Norfolk and Waveney. The service works with patients who are identified as those who could potentially experience a delayed transfer of care or bed block, or who can be supported at the Emergency Department (ED), preventing admission.

2.16 The combined DD schemes have dealt with around 30 referrals per week, almost one thousand in total.

2.17 Around 20 percent of this activity has been at the front door and prevented an admission, the remainder has prevented or reduced Delayed Transfers of Care (DTOC) in all cases, with an average reduction in length of stay of around 3.5 days.

2.18 Further evaluation of the service is due to be conducted with development of a single evaluation model across the three acute hospitals before April 2020, to provide a view of the value this provides across the wider system, but early indications from follow-up interviews suggests a significant reduction in re-admission and reliance on formal care.

2.19 The service is hosted by South Norfolk Council in the central area, Great Yarmouth in the East and Kings Lynn and West Norfolk in the West, however the service works on behalf of all districts including those out of area. Regardless of health setting all district direct services are badged under the same name and providing the same service, regardless of health setting. This supports the consistent messaging and offer available across the County.

2.20 Referrals have been made from all departments, wards and levels of staff across the hospitals and range in age from 18 to 98 years.

2.21 The service is highly regarded by hospital staff, with one ED consultant commenting “really impressed with how quickly DD attended & how quickly they worked with patient in helping with multiple housing issues ensuring help once she goes home…. greatly appreciated that within just under 2 hours this was all done & patient discharged home with plan in place”.

2.22 Prior to the DD scheme, the acute hospitals found it challenging to meet the statutory duty to refer under the Homelessness Reduction Act 2017- one of the STP acute hospitals had not referred a single person since the act came into force. Over 30% of these District Direct referrals have been under the act and have ensured that the trusts are compliant with the legislation.

Outcomes

2.23 Achieved a single model with common interventions across Norfolk.

2.24 344 referrals NNUH (June-Dec); 98 at QEH (June-Dec).

2.25 63% referrals are for the target 65+ age group.

2.26 Main barrier to discharge lack of access and need for adaptation.

2.27 Secured winter resilience funding to move the model into mental health and community hospitals for Central Norfolk from November to April – support in the East and West still outstanding.

2.28 £7,000 funding secured for academic research, scope will include all acute and community trusts taking place between November 2019 – March 2020.

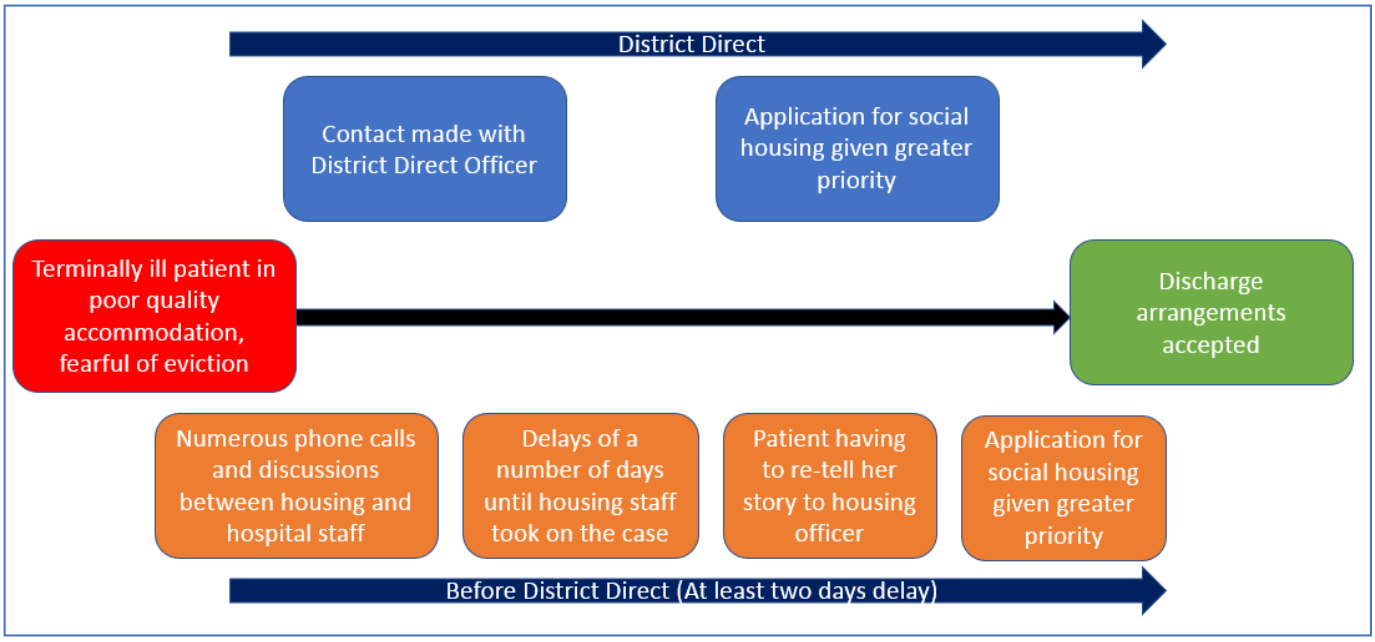
Case Study

Case study 1:

Terminally ill patient referred to therapy team due to “fear of returning home”. The therapist discovered that she and her husband were in low quality rented accommodation and that the landlord would not allow alterations to improve her safety. They feared the landlord wished to have a reason to evict them. One phone call to a District Direct officer led to her attending the ward that afternoon, she supported the patient her husband with their application to enhance her banding for rehousing. Due to the support and knowledge of the officer, she was discharged on the same day.

Before DD, housing officers would not have been able to visit the patient on the same day, and there would have had to be have been numerous discussions and phone calls, with a conservative estimate of at least two days delay.

This was a very distressed patient whose concern was unfixable within the hospital setting. The therapist would have had no direct access and therefore a considerable time would have been taken to find an officer who knew about the case in the community. One phone call to the District Direct officer led to a visit within hours. The patient was so grateful for the intervention and discharge could proceed.



Case study 2:

Mrs Y collapsed at home and was unable to get up. It took several ambulance crews to attend and help get her to hospital due to very limited room to get her out of the property.

Mrs Y did not want to return home due to issues with her current property which had significant fire escape risk issues. Mrs Y was also unable to access her bathing and toileting facilities and unable to climb upstairs to her bedroom, putting strain on her disabled husband and creating a significant risk of carer breakdown.

Mrs Y was referred to the District Direct officer, who visited Mrs Y on the ward within the hour, discussing the need to assess the home environment with a view to assisting a move through to the housing register. Mrs Y was reassured as she knew how to move forward, so was happy to return home.

Following her referral, a Housing Needs Assessment was completed. Mrs Y and her husband have been successful on the housing register and have moved into a suitable bungalow. The patient and family expectations were managed by the District Direct Officer. This allowed a smooth discharge and has given Mrs Y and her husband an improved quality of life, in addition to preventing potential future admissions or escalation and potential carer breakdown.

3. A lesson for future working

3.1 The homes and health work has been a vehicle for district councils - working together - to have impact across the county. Some examples, flowing from the homes and health work, include:

- Based on specific learning and capacity concerns arising from the WHF work, proposing a strategy to develop the local labour market and supply chains to facilitate the switch to a non-carbon energy future in line with government ambitions, while supporting the local economy and building the capacity of the local workforce.

- Building on the existing skills of the warm homes fund team (currently only funded for two years) to continue to seek cross organisational funding for and to deliver energy and home solutions for the vulnerable on behalf of all districts across the county.

- Agreeing a way in which proposals for multi-agency funding can be streamlined – for example to support joint working between frontline district council and health staff across the county.

3.2 It has also highlighted that the HWB District Council Sub-Committee could take a more strategic approach to leverage impact for health and wellbeing across boundaries. At the last meeting of the Sub-Committee in September 2019 it was agreed that the sub-committee would support a coordinated district council approach to the delivery of the Health and Wellbeing Strategy through:

- Describing and developing the joint health and wellbeing offer of the district councils with relevant partners.

- Identifying activities and strategic areas of influence where collaboration across district councils adds value.

- Peer to peer support and learning to add to knowledge and understanding of 'what works'.

3.3 Over the next month, the HWB District Council Sub-Committee will develop a compact to support this activity setting out its purpose, priorities, actions and delivery.

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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