Me

Simon Favell

Housing & Wellbeing

Northampton Borough Council.

Evidence

In Northampton
we have helped 307 Patients

212 in the past year

Only 16 have come back

Sound Familiar?

‘People waiting hours to be seen, demand outstripping the supply of beds, staff becoming increasingly stressed working brilliantly with limited resources; the organisation is doing everything they can within existing resources.’

Cohort

People who cannot continue their recovery at home because they have no home to go to.

Who are we dealing with?

Vulnerable People:

Anyone, who has a housing issue as a result of their admission to hospital:

- Who have been rough sleeping
- Who are made Homeless as a result of their hospital admission
- Family who can no longer or do not wish to cope

  Or
- For whom admission to hospital becomes a catalyst for other issues

My Role:

To effect a discharge that enables the person to sustain a life outside Hospital, preventing readmission:

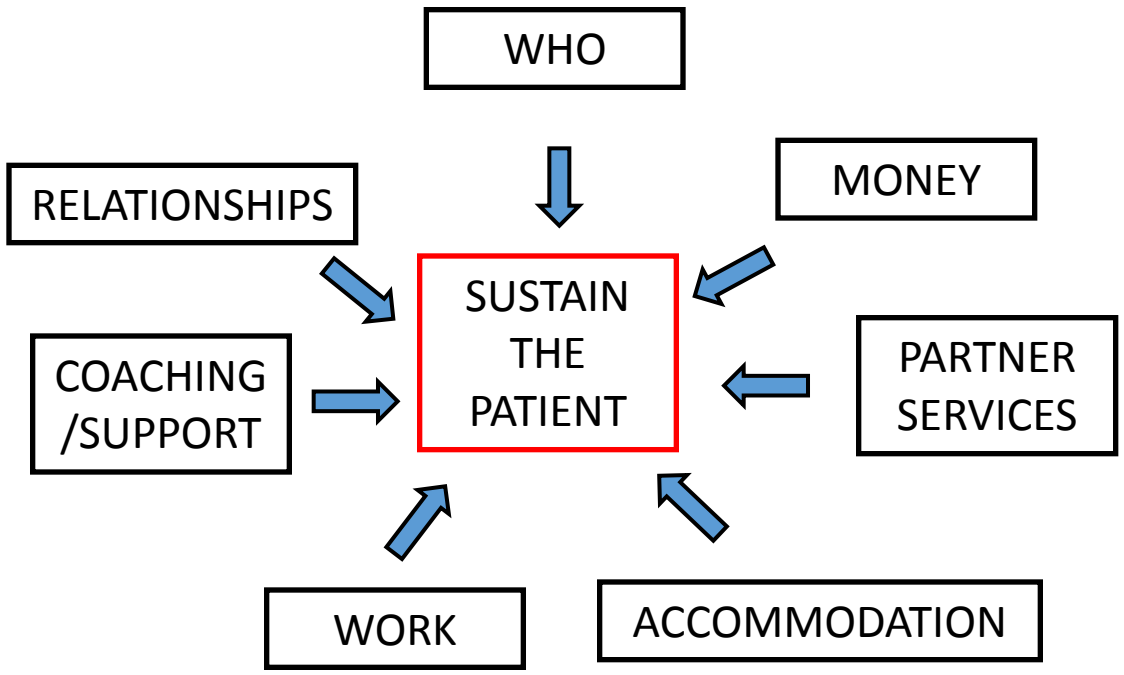
- Acting as an advocate on behalf of the person / health / housing.
- Single point of contact
- Negotiating with Gatekeepers
- Attending weekly discharge meetings
- Linking agencies together around the patient
- Informing the patient, their advocate / their family about housing options.
- Mediating / Conciliating
- Sourcing Accommodation:- Temporary or Permanent
- Building a picture of the person Matching to accommodation / Visa versa

Why it works: Build a picture of the person

- Within the family (if they have one)
- Within the community
- Their medical circumstances
- Existing support networks
- Needs: social / support / care
- Special circumstances

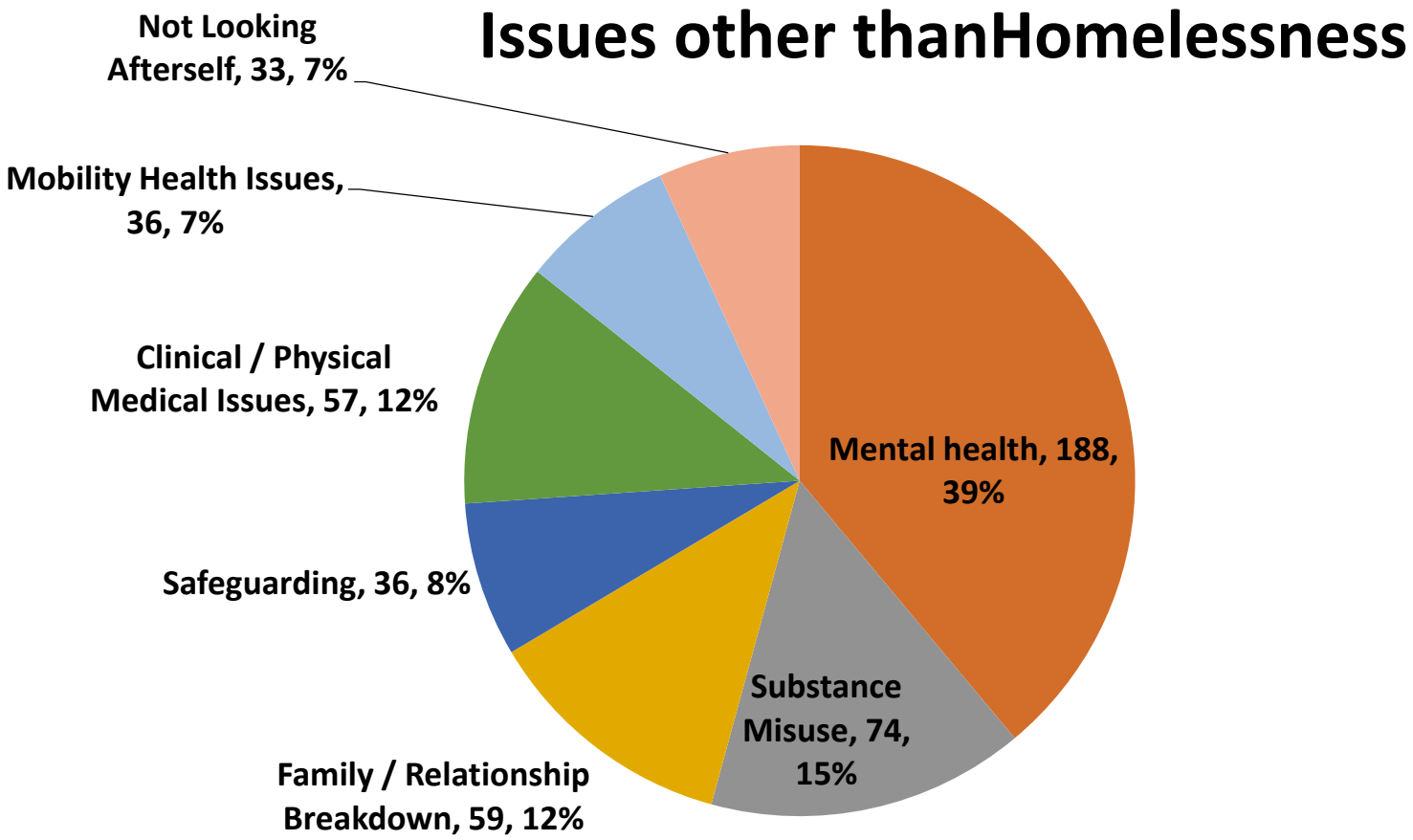
NORTHAMPTON BOROUGH COUNCIL

Plan



Real Solutions

Evidence


Issues other thanHomelessness
Not Looking Afterself, 33, 7%
Mobility Health Issues, 36, 7%
Clinical / Physical Medical Issues, 57, 12%
Safeguarding, 36, 8%
Family / Relationship Breakdown, 59, 12%
Substance Misuse, 74, 15%
Mental health, 188, 39%

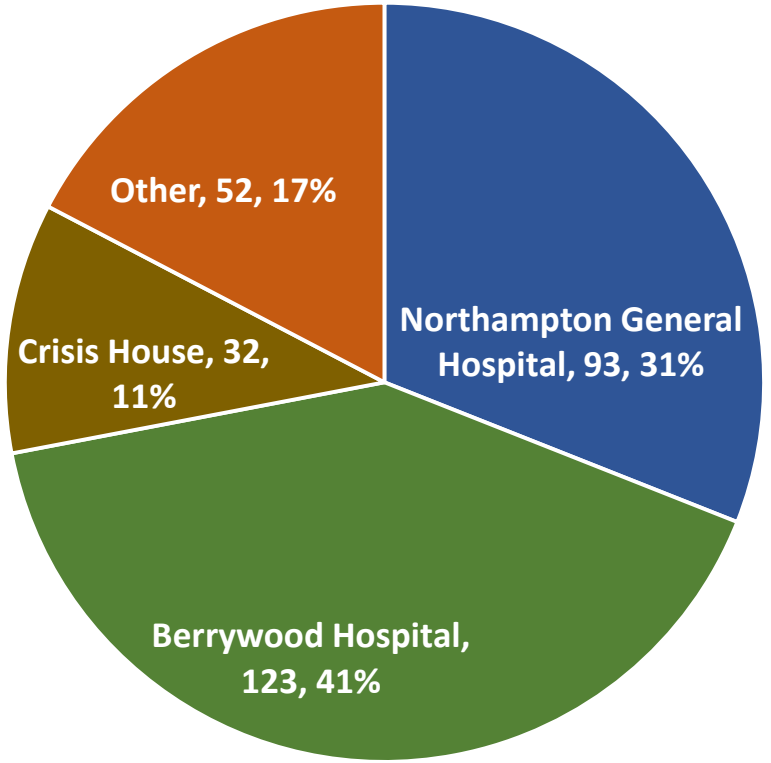
Why it Works: Key Partners

- Patient / Client
- Mental Health Trust
- Acute Hospital
- Housing
- Social Services
- Individuals

80 Services by over 45 organisations

Evidence

Referal Source



Other

- Macmillan
- Community Mental Health
- Other (out of area) acute Hospitals
- Homeless Outreach
- GP
- Social Services
- Self Referrals
- Homeless Team

Why it works: The Service

- Someone driving the concept and service
- Do and deliver what we say: Keep promises and deliver quality
- ‘Trust me’ Trust the expert
- Publicise your success; make sure your first cases are all a success
- Got around: face 2 face conversations and training
- Pushed the holistic approach
- Push boundaries and challenge
- Communication

Evidence our proposal works

Reducing Readmissions:

Only 5% of our cases have been readmitted to Hospital

Reducing Time in Hospital:

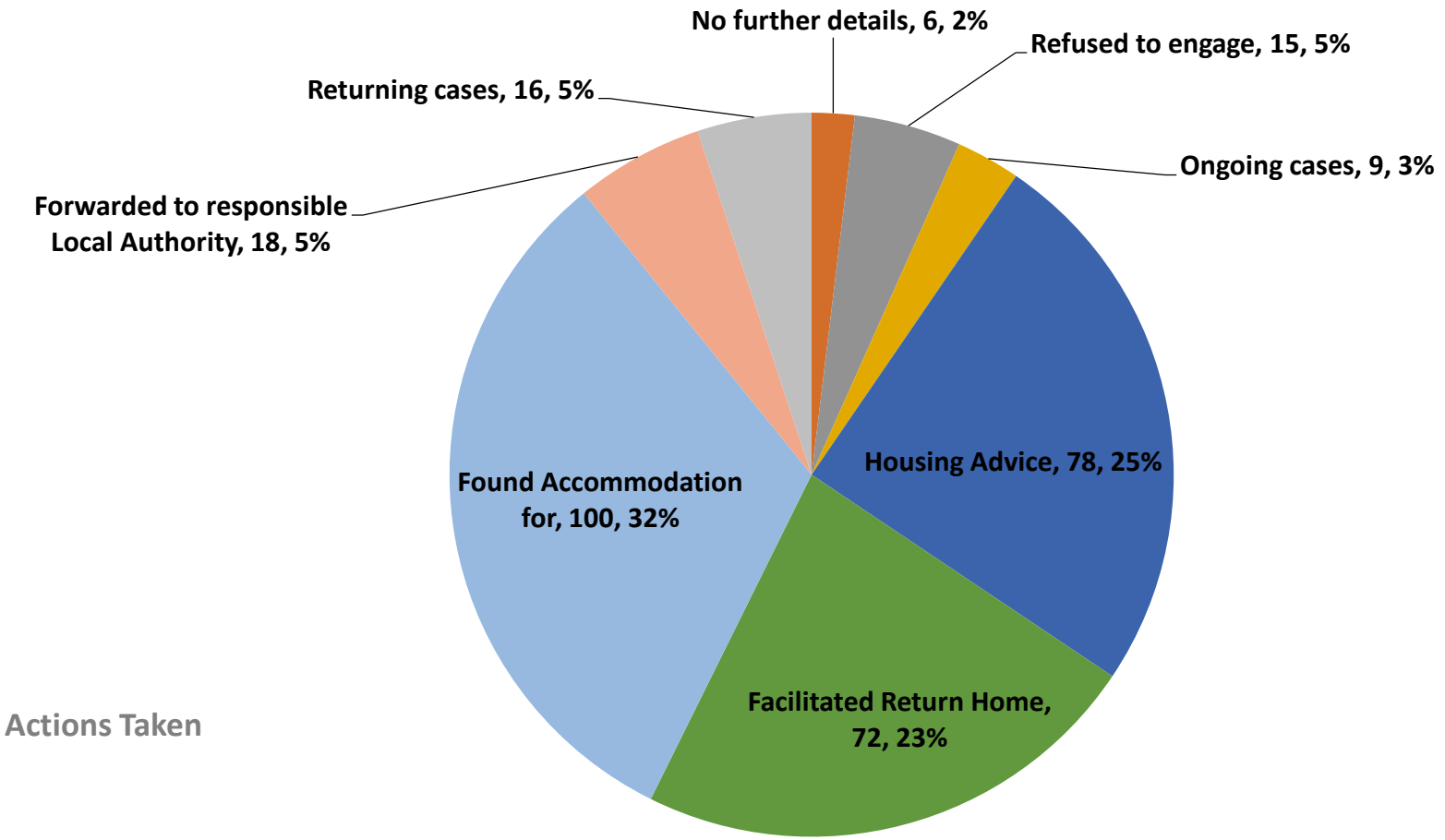
Cost avoidance based on £500per bed per night x 300 cases estimating we enabled them to leave hospital:

- a day earlier £150,000
- a week earlier £1,050,000
- a fortnight earlier £2,100,000

Impact: Key Outcomes

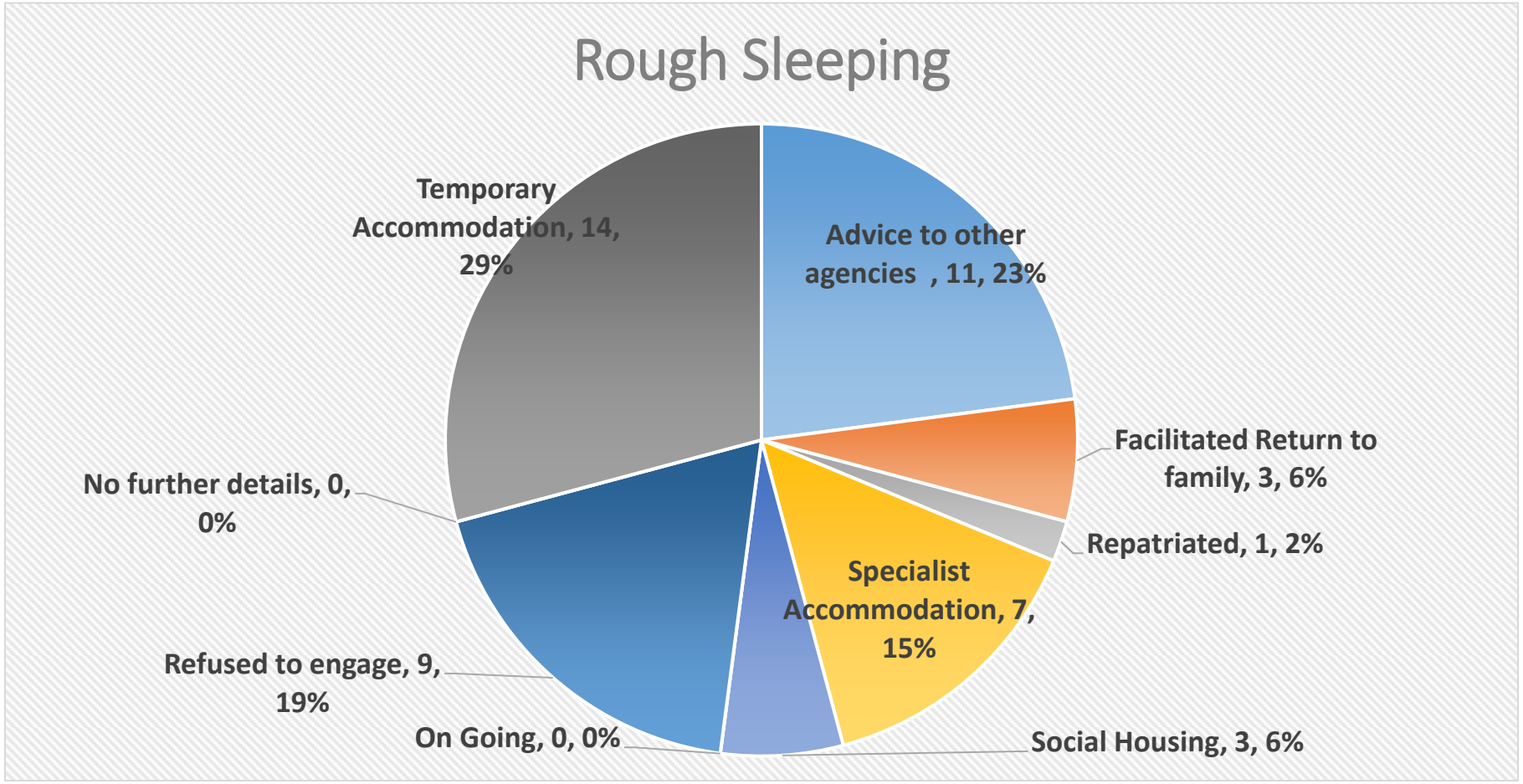
1. We reduce length of stay, consequently improve patient flows.
2. The patient, their family, health and housing professionals all are better informed and thus empowered; facilitating: BETTER DECISIONS = BETTER SUSTAINABLE OUTCOMES
3. The a holistic plan uses local voluntary and statutory agencies who are best attune to the needs of local people.
4. Communication builds trust and confidence: it has stopped people just turning up (Healthwatch 2014).
5. The service delivers an improved patient experience.
6. People get back on existing pathways.
7. Reducing Frequent fliers.
8. Stopping people going back into hospital or declaring themselves homeless.
9. Creating stability in peoples lives.

Evidence that what we are doing works



Actions Taken

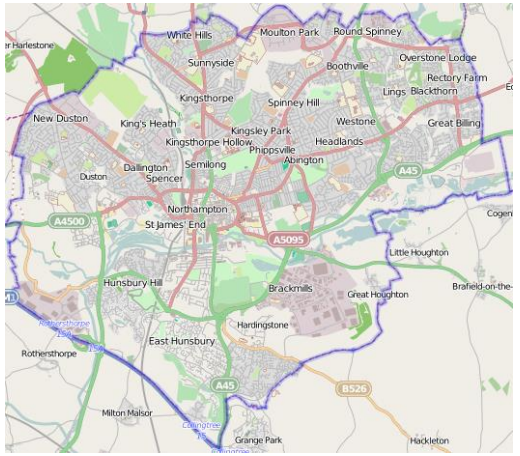
Evidence


Rough Sleeping
Temporary Accommodation, 14, 29%
Advice to other agencies , 11, 23%
Facilitated Return to family, 3, 6%
Repatriated, 1, 2%
Specialist Accommodation, 7, 15%
Social Housing, 3, 6%
On Going, 0, 0%
Refused to engage, 9, 19%
No further details, 0, 0%

Challenges

- Commissioners:

  ‘We are NOT efficient we are creating opportunities for more spend.’
- Silo Mentality
- This is how it’s done
- Staff Turnover
- One Size doesn’t fit all
- Language
- Financial Resources
- Pretend Partners

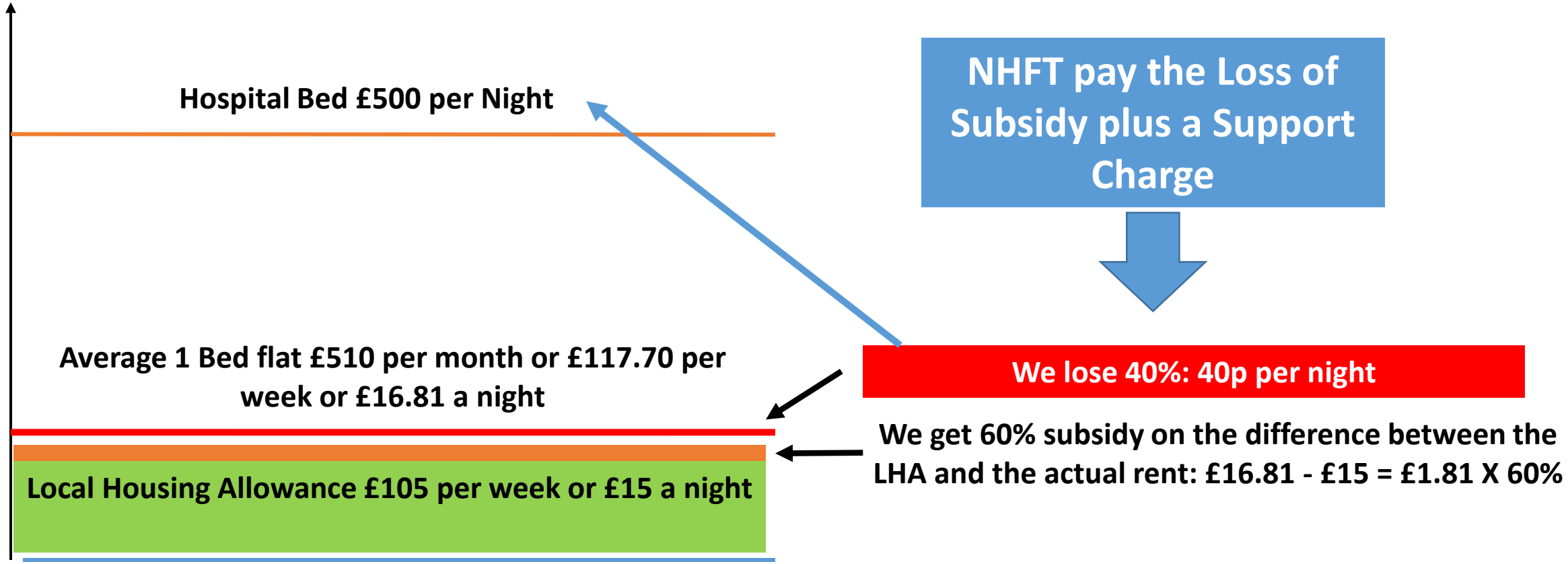


Local Housing Issues

- Housing Benefit
- University
- Demand
- Type of Homes
- Proximity to London
- Access for our clients

Next Steps

NHFT Funded Temporary Accommodation (Northampton)



Things we could be working on: Burnt Bridges

- We have frequent fliers within this cohort, who have nowhere to live because they have burnt all their bridges with service providers along the way.
- Why not pay a provider who could manage these clients a bit extra to provide a roof and manage them whilst they recover?

It could cost £200 per week , which compared with £500+ per night is a bargain

Things we could be working on: Disabled Facilities Grant

Bert is 50+ has lost his leg below the knee:
The Borough Council worked with NGH and the OT, had a specification drawn up and the **works costed £5,285**.
But regulations mean he earned too much in the last year to get a Disabled Facilities Grant. So he has to pay himself but he has no savings and unlikely to work again for a while.
He's been in Hospital since July, the works could have been done by the end of September and he's still in hospital.

So an average nightly cost of £500 x the 5 weeks he's been in hospital too long = **£17,500**
And he's going to be in longer!

It doesn't make sense does it?

Things we could be working on: More Communication & Knowledge

- Training of Student Nurses should include ‘Social Awareness’.
- We should be part of new medics / new intakes induction.
- Move the point of knowing about the client to the earliest point possible

Impact

'Better Together' really does deliver continuous cost effective service improvements and better access and experiences for patients.’