To:	**Health Improvement Board**
Date:	**21 November 2019**
Report of:	**Housing Needs Manager, Oxford City Council**
Title of Report:	**Impact of Oxfordshire Homelessness Prevention Trailblazer in Health**

Summary and recommendations	
Purpose of report:	To update the Board on the impact of the Trailblazer Programme in Health
Report Author:	Paul Wilding, System Change Manger (Homelessness Prevention), Oxford City Council
Recommendation(s):That the Board resolves to:	
1. **Note the impact outlined in the report** 2. **Request a further report which shows how the extension of the embedded housing worker intervention in Health positively impacts on the time and resources of staff within the county hospitals.**	

Appendices:
Appendix One – Trailblazer case studies in Health
Appendix Two – Trailblazer data from Health

INTRODUCTION

1. The Oxfordshire Homelessness Prevention Trailblazer was a multi-agency programme aiming to tackle systemic issues in the public sector which can increase the risk of homelessness to individuals throughout the county. The two year programme ran from September 2017 to August 2019. It received £790,000 from the Ministry of Housing, Communities and Local Government, and a further £100,000 from the Oxfordshire local housing authorities, providing a total of £890,000. The county-wide Trailblazer programme has been managed by a small team based at Oxford City Council.

2. The broad objectives of the programme were to explore options for intervening as early as possible to prevent people at risk of homelessness reaching a crisis point. The first six months was spent researching homelessness in Oxfordshire and planning the programme. This included analysis of homelessness data, a qualitative stakeholder consultation exercise and piloting system interventions. A full evaluation of the programme will be published in November 2019.

PROGRAMME DESIGN

3. The design of the programme interventions was informed by stakeholder consultation which included workshops involving front-line housing staff, people with experience of homelessness and professionals from health, criminal justice and children's social care. People with lived experience expressed a sense of hopelessness about their situation and difficulties in accessing services, but reflected positive experiences of being supported by other people with lived experience. Professionals within the systems felt there was a significant need to improve connections and relationships across statutory and non-statutory services. Awareness of the housing options available to individuals and the local housing authorities' role in this process was low. As a result, early indicators of homelessness were not being acted upon.

4. Three strands of work were developed. These were the embedding of housing workers within the health, criminal justice and children's social care settings (provided by Connection Support), a community navigator service to connect people at risk of homelessness to the services they needed (provided by Aspire), and a homelessness champions network to raise the profile of housing in stakeholder organisations. The rest of this report concentrates on the embedded housing worker intervention in Health.

IMPACT OF TRAILBLAZER

5. Two embedded housing workers were based in the health system, and spent their time in all of the county's general hospitals and mental health hospitals. The embedded workers provided specialist housing knowledge to support and/or upskill health professionals in order to speed up the discharge of patients who were medically fit but where a Housing issue was preventing a safe discharge. They also acted as connectors between the Health and Housing systems across Oxfordshire.

6. The embedded housing workers in Health received 422 referrals, which led to 217 positive housing outcomes. In 137 cases, the outcome was unknown, 44 cases resulted in unsuccessful prevention of homelessness, and 24 people were homeless at the point of referral, and remained homeless. The high volume of cases where the outcome is unknown is a result of many referrals resulting in the provision of one off advice to a health professional. These are not always easy to follow up due to the fast paced nature of the hospital environment, and the changing shift patterns and turnover of staff.

7. This is a particularly good outcome given that 152 referrals related to people who were already homeless. Although the objective of the programme was to intervene early with people to prevent homelessness, health staff did not distinguish between people at risk of homelessness, and people who were already homeless. A consequence of dealing with people who were already homeless was the establishment of a stepdown house. This was for people who needed to receive some form of medical treatment, but who did not require being admitted as an in-patient (e.g. a rough sleeper who needed a dressing to be changed regularly). Dr Logan Mills, a junior doctor in the John Radcliffe, undertook some research into the presentation of rough sleepers. He found that rough sleepers who were seen by an embedded housing worker were almost half as likely to represent as one who wasn't.

8. A comparison of delayed transfer of care (DTOC) data for cases where Housing was listed as the reason for delay for the period Trailblazer was operating, and the year prior to the programme shows a significant decline in delayed discharge. There were 944 fewer DTOC days, which represented a 50% reduction. There was a greater reduction in Oxford Health (66%) than Oxford University Hospitals (38%). More detail on the DTOC data can be found in Appendix Two.

9. During the period of Trailblazer there were other interventions taking place to reduce DTOC, so these outcomes are not solely attributable to Trailblazer. However the Adult Mental Health team attribute much of the reduction to the role played by the embedded worker based with them who gave the team the knowledge and confidence to resolve Housing issues for their clients. They say that as a result of Trailblazer they no longer have to place people who are sectioned out of area (which has included placing people as far afield as Aberdeen). It is now common for their to be available bed spaces at the start of the weekend for this client group, which was not the case prior to Trailblazer. Staff in the mental health hospitals are now able to carry out the work, previously undertaken by the embedded housing worker. Appendix One contains two case studies which demonstrate the impact of the embedded workers.

TRAILBLAZER LEGACY

10. Although the programme ended in August, Oxford University Hospitals NHS Trust has funded the embedded housing worker intervention until the end of March 2020. During Trailblazer, the work of the embedded housing workers was monitored in terms of their impact on patients. However in order to build a case for funding the workers beyond this year, there is a need to monitor the impact of the embedded workers on the hospital staff. A monitoring proposal was submitted by the Trailblazer programme team to the commissioning manager which would enable this to be done.

11. Work undertaken during the programme will leave a legacy in Health. Discharge protocols are in place for the effective management of patients with housing issues. This is supported by simple procedures designed by the embedded workers which are available in all relevant departments across the county hospitals. This content is also available on the hospital intranet. A Housing eLearning course, designed for non-Housing professionals is available on the OSCB website to allow staff to refresh their knowledge and to induct new starters. The homelessness champions network referred to in paragraph 4 will be continuing for another year, which allows relevant hospital staff to access training and support with housing issues.

12. The general hospitals are the one environment within the programme in which it is considered that ongoing specialist housing support is required. Within children's social care, criminal justice and the mental health hospitals Trailblazer has supported a change in approach which has led to a prioritisation of housing issues. It has been harder to achieve this in the general hospitals because in the other systems, there is often one individual who has the lead responsibility for the service user for the duration of their journey within that system (e.g. a social worker or resettlement officer). As such there is a concern that if the embedded housing worker intervention ends, the improvements in discharging patients will be lost.

13. A member of the discharge liaison hub summed up the impact that the embedded housing workers have had:
"The embedded housing workers save us considerable time which we are able to spend supporting ward staff and patients with routine and complex discharges. EHWs can efficiently unpick a patient's current housing situation and liaise with councils by directly contacting the relevant teams/team members using their extensive knowledge and experience. My team, who do not deal exclusively with housing issues have less direct, immediate knowledge and will spend significantly more time unpicking and dealing with the same issue. Having the support of a specialist in this challenging area allows us to use our time and our own specialist skills to support the wards, who turn to us for the very same reason – more efficient

resolution of issues which are to us often everyday but are to the wards very challenging and time consuming, taking them away from bedside care."

Appendix One – Case Studies

Case Study One

A woman who was vulnerable because of a learning disability was admitted to hospital in a state of distress following the death of her partner. The patient was a social tenant and had been advised by her landlord that she should not return to the property because they had concerns over her ability to manage the tenancy on her own. The hospital staff believed that the patient did not have the right to return to her home so she remained in hospital whilst a resolution was found. This resulted in the individual becoming a DTOC case.

The patient was referred to the embedded worker who advised hospital staff about the tenant's legal rights and confirmed that she was able to return home. The embedded worker identified sources of support, including tenancy sustainment services and money management, and worked with hospital staff to make the appropriate referrals.

As a result of this intervention, the patient was discharged to her home with ongoing support in place to help her maintain her tenancy. This reduced the delay in her discharge and the hospital bed was made available at a time of peak demand.

We have estimated that the total cost of this prevention was somewhere in the region of £700 based on the time cost of the professionals involved. Using the New Economy Manchester model Unit Cost Database we have also estimated that the potential total cost to the public purse if no action had been taken was approximately £8,250. This is based on an additional delayed discharge of 14 days and the individual relinquishing her social tenancy resulting in a homeless approach to a local housing authority. As such the public sector has foregone having to expend somewhere in the region of £7,500.

Case Study Two

In this example the embedded worker was able to draw together professional expertise to prevent the homelessness of a young man who was admitted to a hospital under section. He had built up significant rent arrears with his social landlord and had been threatened with an eviction notice.

A referral was made by a Community Psychiatric Nurse (CPN) highlighting the rent arrears but also that financial exploitation had been taking place. The CPN had very little understanding of housing issues or benefit entitlements so the embedded worker supported them to start unpicking the case. With the agreement of the man in question the embedded worker called a multi-agency meeting to include the individual, the CPN, the individual's tenancy manager and members of the rents team.

A repayment plan was put in place, a benefits check was undertaken and the financial exploitation was considered. The man felt extremely vulnerable and feared it would happen again so the embedded worker requested the support of a Police Community Support Officer (PCSO) and Turpin & Miller for legal advice. Trailblazer agreed to pay off some of the arrears using the allocated prevention pot but only on the agreement that the individual would adhere to the remaining payment plan.

At the point of discharge the individual was supported to return home by the CPN, his tenancy manager and the PCSO. The individual felt supported in his home and not at risk from further exploitation. All benefits were put in place and the repayment plan was adhered to. The individual is no longer at risk of eviction and the CPN is better aware of both housing and benefit legislation and procedures.

It is estimated that the costs of this prevention was around £1,250. Using the New Economy Manchester model Unit Cost Database we have also estimated that the potential total cost to the public purse if no action had been taken was approximately £9,250. This is based on an additional mental health care provision, the individual being evicted from their social tenancy and a homeless approach to a local housing authority. As such the public sector has foregone having to expend somewhere in the region of £8,000.

Appendix Two – Trailblazer data from health

Delayed Transfer of Care (DTOC)

The DTOC data has been obtained from the Oxfordshire Clinical Commissioning Group (CCG) and highlights the amount of DTOC that has taken place over the past 2 years as a result of a known housing and homelessness issue.

That data has been split between the two NHS trusts in Oxfordshire to highlight the varying degrees of impact. Overall we have seen 26 fewer DTOC cases where 'housing' has been given as a reason for delay when compared to the year before Trailblazer. This accounts for 944 fewer days of DTOC since the introduction of the EHWs.

There has also been a significant reduction in the use of hub beds for DTOC patients with housing issues. There has been a big drive across both trusts to reduce the use of hub beds, particularly in instances where there was no plan for move on (not a Trailblazer initiative). In 2017/18 the average hub bed stay for an individual where housing has been given as a DTOC reason was 62 days. In 2018/19 this was reduced to 29 days.

Oxford University Hospitals NHS Trust

2017/18	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	18	432	0	24.00
Housing (inc Hub)	10	95	607	70.20
Multiple Reasons	14	485	0	34.64
Multiple (inc Hub)	3	139	207	115.33
TOTAL	**45**	**1151**	**814**	
2018/19	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	16	388	0	24.25
Housing (inc Hub)	8	85	249	41.75
Multiple Reasons	4	193	0	48.25
Multiple (inc Hub)	3	51	69	40.00
TOTAL	**31**	**717**	**318**	
Reduction on previous year	**14**	**434 (38%)**	**496 (61%)**	
2019/20 (April to July)	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	1	1	0	1.00
Housing (inc Hub)	0	0	0	0.00
Multiple Reasons	2	191	0	95.50
Multiple (inc Hub)	0	0	0	0.00
TOTAL	**3**	**192**	**0**	

Across OUH we saw a 38% in the number of DTOC days (434 less) as a result of a known housing issue when the data for 2018/19 was compared to the previous year. However, there remains a relatively high number of cases where housing is provided as a reason for delay. Because of the broad definition of this category it is likely that a number of these cases actually relate to individuals that are single homeless with no fixed address.

The data connected to 2019/20 indicates that there appears to be a continued reduction in the number of DTOC cases being seen across the trust (3 cases in 4 months). However, the cases that still result in a delay appear to be complex cases owing to the length of DTOC.

Oxford Health NHS Trust

2017/18	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	12	454	0	37.83
Housing (inc. Hub)	1	88	55	143.00
Multiple Reasons	4	227	0	56.75
Multiple (inc. Hub)	0	0	0	0.00
TOTAL	**17**	**769**	**55**	
2018/19	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	2	33	0	16.50
Housing (inc. Hub)	0	0	0	0.00
Multiple Reasons	3	226	0	75.33
Multiple (inc. Hub)	0	0	0	0.00
TOTAL (11 months of data)	**5**	**259**	**0**	
Reduction	**12**	**510 (66%)**	**55 (100%)**	
2019/20 (April to July)	Number of Cases	Total DTOC Days	Hub Bed Days	Average Delay
Housing only	2	29	49	39.00
Housing (inc. Hub)	0	0	0	0.00
Multiple Reasons	0	0	0	0.00
Multiple (inc. Hub)	1	20	0	20.00
TOTAL	**3**	**49**	**49**	

The numbers above suggest that housing DTOC cases have been almost eliminated across the Oxford Health NHS trust, save for a few complex, intractable cases that have resulted in lengthy delays. The 510 less days of DTOC in 2018/19 represents a 66% reduction on the previous year.