Somerset Independence Plus

Hospital Resettlement Service

Introduction

- The role is responsible for people who are patients in a hospital setting and whose discharge is being or is likely to be severely compromised by difficulties with their housing need
- Working alongside Somerset's Health Interface Service
- To reduce the overall length of stay and total number of occupied bed days on in-patient wards
- To prevent hospital re-admissions by working with internal departments and external agencies
- Linking health and social care, housing and other appropriate agencies to develop a discharge plan

Why Choose our service

- Somerset Independence Plus (SIP) service is the preferred service provider for the Council's in Somerset, commissioned by Somerset County Council and the District Councils. Funded through the Better Care Fund

- Our intention amongst others is to intervene at an early stage offering support to enable and maintain independence.
  - Reduces the risk of a fire to a property and reducing risk to neighbouring properties.
  - Reduces risk of statutory enforcement risking homelessness.
  - Reduces hospital admission caused by a housing related issue.
  - Reduces the risk of bed blocking
  - Improves mental health
  - Empowerment to the individual to make their own choices

How do we fit in with the strategic picture?

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Improving health and care through the home in Somerset – Memorandum of Understanding

Signatories include; Avon and Somerset Police, Health Watch Somerset, the four Somerset District Councils, NHS England, Somerset County Council, Somerset Clinical Commissioning Group, RP's

MoU recognises that the home environment is the foundation from which to build healthy and fulfilling lives. Builds on the good intentions of the Health & Wellbeing Strategy (Improving Lives)

Shared commitment to joint action across local government, health, social care and housing sectors in Somerset

Encourages effective joint working

Sets the context and framework for cross-sector partnerships, integrated and effective services that meet the needs of individuals, families, communities

Shared success criteria to deliver and measure impact

How do we fit in with the strategic picture?

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Independent Living

1. Prevent and / or delay admission to hospitals and care settings
2. Prevent delayed transfer of care or facilitate discharge of individuals from hospital/or residential care
3. Maintain older and disabled people's ability to live independently in their own home and community for as long as possible
4. Reduce chances of a life changing health event by initiating prevention policies, activities and adaptations

Component parts of the role

- Finding suitable solutions, supporting where necessary, advocating, working through the range of health options enabling the client to be as independent as possible to return home
- Actively promote the work of Somerset County Council and District Councils, Somerset Independence Plus across Musgrove Park Hospital and the Community Hospitals in the partnership area
- Where a health event or planned surgery results in an individual potentially becoming homeless, alert ASC OT's and the LA Housing Options teams from the outset to ensure accurate assessment of needs and adaptations
- Establish and maintain positive relationships with voluntary and statutory agencies, GP's and health care services, aiming to improve and assist communications

Qualities

- Julia Williamson started in Mid September – not the best time in the middle of a pandemic and going into winter pressures
- The hospital setting is frantic with many pressures coming from many different directions
- Need to work as part of a multi agency team and the ability to work independently, multi task under immense pressure
- A great deal of autonomy
- Having a housing/homelessness background has been hugely beneficial
- Skills to be able to work with clients presenting varying need and complexities – many clients have acute illnesses
- Managing expectations is important – multiple daily reporting of progress
- Managing the available resources
- A centre of focus by hospital staff

Case study #1

CP, a 73 year old gentleman was admitted to Musgrove Park Hospital (MPH) with a kidney infection and general lack of self-care. He advised ward staff early on that his home was in very poor condition and that his landlord had given him an eviction notice.

Outcome:

- This role facilitated a faster route to assistance from the local authority, by physically providing evidence of ID, liaising with a third party who although not a patient at MPH, was found to be vulnerable and equally at risk of homelessness.
- It meant the correct procedures were carried out to assess the suitability of the property. This ensured Mr P did not return to a potentially dangerous property where his health would most likely deteriorate very quickly which could have resulted in a re-admission to hospital.

Case study #2

- JP is a 29 year old gentleman who was admitted to an acute bed following an overdose of prescribed medication. Mr P is also on a methadone programme for his addiction and suffers with anxiety.
- He had been living in a hostel run by a partner agency where he was placed when his Mother asked him to leave her home, due to his behaviour. He did not like the hostel, his behaviour there was poor. He caused some damage to the property which caused the hostel to ask him to leave and then he reacted by taking enough of his prescribed medication to require a hospital admission.
- Mr P's Mother contacted the ward for an update on his health but made it clear that she did not want him to return to her home as she has her own mental health problems and couldn't cope with him. So Mr P was homeless.
- A short history of Mr P's story and current situation was gathered and the statutory 'Duty to Refer' to SW&T council's homelessness team was made. This meant an early intervention, making the LA aware at the earliest opportunity that an inpatient was homeless and potentially would require emergency accommodation.

Case study #2 Cont.

- Mr P's Mother actually came to visit him on the ward and I explained I had sent the DTR to the Council and Mr P now had a homeless application with SW&T and that he had agreed to re-engage with SDAS to seek help with his addiction which affects his behaviour. Following a three way discussion and exploring the issues with both parties living in the same house, we were able to establish some boundaries and on the basis of being for a temporary period of time, she agreed for him to go home with her.
- I was also able to establish that she has issues with hoarding herself and the chaos in the property was partly the reason for conflict between the two adults. I ascertained that the lady is a SW&T council tenant and I advised her that there is help available for difficulties with cluttering and she agreed to a referral to the SW&T estates team for some advice.

Case study #2 Cont.

Outcome

- This role has meant no nursing staff were taken away from their duties to make the referral. The information given to the Council was the right information to the right people at the right time. Liaison between the ward and the homelessness team to track progress and facilitate an interview over the ‘phone between the two parties whilst Mr P was still on the ward.
- No homeless person on the streets as a result of discharge from hospital or making first contact with the LA on actual day of homelessness which causes stress for the person and requires time consuming risk assessments and a search for appropriate temporary accommodation by the homelessness team.
- The patient was able to be safely discharged knowing he was to be assessed for his homelessness situation, that he had a plan for help with his addiction and that his Mother was also to receive some help to resolve issues at the property which he was concerned for.

Project

- Whilst there are many advantages to the post being embedded in the hospital, there are also many issues which have been identified and need resolving;

1. Increasing the number of step down beds and accommodation available for clients fit to be discharged but have specific needs
2. Managing the expectation of the hospital when it comes to available housing on discharge
3. Managing the front end of admission and the client being in control of the housing process post operation
4. Identifying potential Housing issues as early as possible to enable a Duty to Refer to be made to the Local Authority in a timely manner

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Questions?