

# Beyond the ward:

An evaluation of a  
homeless hospital  
discharge project

February 2016

*Two years of being the bridge between  
hospital and a home in Derbyshire*

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## About Derventio Housing Trust

Derventio Housing Trust is a registered social landlord providing accommodation and support to people who are homeless or at risk of homelessness. Our successful model uses an innovative approach to make private rented housing available to people who are homeless or cannot afford market rents.

We also deliver a range of specialist projects to support people who are facing difficult circumstances to make sustained changes to their lives, including:

- ▶ **Healthy Futures:** Support for homeless people around hospital discharge and using health services in a planned way
- ▶ **Talent Match:** Mentoring and support to help homeless 18-24 year-olds access training and employment
- ▶ **Growing Lives:** Skill-building and learning opportunities with mentoring and support

Most of the people who use our services have multiple needs that go beyond homelessness. These needs can include mental or physical ill health, drug or alcohol issues, learning disabilities or offending behaviour. Many have low self-esteem and feel isolated and excluded.

All our services aim to improve health and wellbeing, increase resilience and prepare people for independent living, learning and employment.

In 2014-15 we provided housing and support to more than 1,100 people. We are based in Derby and run supported housing in Derbyshire, Nottinghamshire, Staffordshire, Shropshire and Swindon. We currently manage over 400 homes.



## Foreword

Homeless people face severe health inequalities compared with the general population, and can easily find themselves in a vicious cycle of ongoing health issues and repeat hospital admissions. This has significant cost implications to the NHS and other health, housing and social care services. Above all, however, is the impact it has on an individual's health and welfare; premature rates

of death and the prevalence of chronic and multiple health conditions among homeless people paint a stark picture of the human cost to this inequality. Furthermore, without good health it is difficult to address wider needs and move on to employment and independent living.

Healthy Futures has developed a successful model that combines coordinated discharge with practical help and holistic support to homeless people in hospital. In just two years, the project has supported 52 high-impact users of urgent care and 72 homeless patients, and provided brief interventions to 141 people. It is now a key service within Derventio Housing Trust, perfectly aligning with our mission to shape a better future for homeless people and complementing our housing and support services.

It has also received wider recognition; in 2015 we delivered workshops at national NICE and Homeless Link conferences, and have recently become a member of the National Institute for Health Research's (NIHS) Study Steering Committee which is overseeing the management of a national research project led by King's College London on the effectiveness and cost effectiveness of hospital discharge arrangements for homeless people. Healthy Futures has been externally evaluated on two occasions receiving recognition as a good service that shows value for money.

By creating a key set of principles and developing strong partnership links Healthy Futures has established itself as a valuable service that fits into the strategic landscape. Using robust monitoring of data Healthy Futures demonstrates that it meets a range of priorities set by Clinical Commissioning Groups, Public Health England and local bodies. Most of all it makes a real difference to the lives of individuals experiencing poor health and homelessness.

**Sarah Hernandez**  
Managing Director

# Executive Summary

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## a) Background

The Healthy Futures project commenced in October 2013 following a successful bid to the Department of Health's Homeless Hospital Discharge Fund. The overall aim of the project is to act as a bridge between hospital and home for people who have multiple and complex needs cross cutting homelessness, mental health and drug and alcohol issues. The objectives are:

1. To work with homeless people in hospital to broker housing and other related support in order to prevent delayed discharge from hospital and to deliver more timely and safer transfers of care.
2. To work with people who disproportionately use acute services, known as "high impact users" in order to break the cycle of repeated use and make better use of primary care

Healthy Futures offers two levels of service:

1. Full service: to secure accommodation, broker an appropriate support package, provide liaison and advocacy, support the service user during the move from hospital to the community and intensive support in the community to help them live independently and use health services appropriately. This is a 12 week service.
2. Brief intervention: to provide housing advice, advocacy, signposting, and staff support and advice to secure the accommodation plus support necessary for speedy discharge.

The project team consists of a manager and 2.5 FTE link workers.

The project has been running continuously since October 2013, with no breaks in service delivery. Ongoing funding has been secured via the local CCGs; however this is year on year and not a recurrent contract.

We initially anticipated that most of the users of the service would be high need, chaotic and entrenched homeless people, probably with alcohol as their main issue. However, as time has gone on the project has started to reach individuals who are more 'under the radar' than this cohort (who are well known to services and have access to other forms of support). This has meant that the user group is now far more diverse and the project is able to facilitate services for those who have never or rarely accessed the care or support they need.

This development has made the project less Derby-centric and improved its offer to the districts of Derbyshire. In April 2015 the case was made and funding secured to expand into Erewash and to run a pilot in the northern districts.

## b) Use of Data

Throughout the two years that Healthy Futures has been in operation, we have collected collated and analysed data on each individual in contact with the project. Each patient completes an Explicit Consent form that allows us to access their health records and take a base line data set of their use of urgent care in the 12 months prior to engagement. This

data allows us to benchmark each person's progress against his or her own history.

It is this detailed approach to data that has allowed us to evidence our outcomes and show our impact on the wider health and social economy, as well as measuring the personal achievements of each service user.

The quality of the project's data and validity of its approach was analysed by external consultants (Method Analytics) employed by Southern Derbyshire CCG to evaluate their Winter Pressures Fund allocation in 2014/15.

**Healthy Futures now holds one of the most complete local data sets on homeless patients in the country**

In addition to data linkage, we also collect more qualitative data to reflect the lived experiences of our service users. We use case studies to highlight the complexity of the issues and needs our service users' face and to provide a unique insight into our practice approach.

### c) The Healthy Futures Model

Our model has ensured the continued positive impact of the project on the health and wider social economies:

1. Housing First
2. Navigation and advocacy
3. Wraparound support and service brokerage
4. Non-judgemental and holistic approach
5. Behaviour change

6. Staff support and advice
7. Brief interventions
8. Key relationships
9. Prove the project's worth
10. Remain independent and impartial

### d) Profile of Service Users

**During the past two years, Healthy Futures has provided a service to 265 people, each one with their own unique history, needs and aspirations.**

For the purpose of this report we have analysed data held on four characteristics: older people, young people, people dependent on alcohol and those with a mental health diagnosis, the majority of subjects (95%) were either homeless at referral or in a housing crisis. The gender split between male and female sits within expected parameters when compared to other homeless data with 69% being male<sup>1</sup>. [See Box 1](#)

### e) Health and Wellbeing Outcomes

There are a broad set of priorities published by both local CCGs and Public Health Derbyshire. Healthy Futures' outcomes contribute positively to the following impact areas:

1. Improve quality of life and the management of long-term conditions – **self-determined 66% improvement in physical wellbeing**

<sup>1</sup> Homeless Link – Homeless Health Data Aug 2015

Box 1

## Profile Breakdown

### Mental Health

The average age of this cohort was 34 years and 71% were male. In addition to having a mental health diagnosis 16% were alcohol dependent and 29% self-harmed. Just over half of subjects (53%) were high impact users of urgent care.

### Under 25s

The average age of this cohort was 23 years and 58% were male. In this group 92% had mental health as their primary need and 33% self-harmed. High impact use of urgent care was a common feature, with 83% showing a pattern of inappropriate use of acute services.

### Over 60s

The average age of this cohort was 70 years and 79% were male. The most prevalent primary need was having a long-term condition (36%), and 36% were socially isolated at time of referral. High impact use of urgent care was not a common factor.

### Alcohol Dependent

The average of this cohort was 43 years and 67% were male. In addition to their alcohol dependency 53% had a long-term condition, 17% had a mental health diagnosis and 10% were veterans. High impact use of urgent care was a common feature, with 73% showing a pattern of inappropriate use of acute services

2. Reduce avoidable admissions – **88% reduction in non-planned admissions**
3. Reduce A&E presentations – **88% reduction in presentations to A&E**
4. Reduce length of stay – **average 16 days shorter stay in hospital**
5. Reduce health inequalities – **90% engagement rate with community health and treatment services**
6. Reduce harmful alcohol consumption – **91% prevention across urgent care use and 90% engagement rate with community services**
7. Improve mental health and wellbeing – **self-determined 66% improvement in mental and emotional wellbeing**
8. Improve the health and wellbeing of older people – **36% of our older service users were socially isolated, the project achieved a 66% improvement rate for health and wellbeing in this age group**

## f) Housing Outcomes

Healthy Futures works on the premise that a lack of appropriate accommodation impacts negatively on the likelihood of recovery. Without the fundamental security housing gives a person, we are unlikely to be able to impact on the health and wellbeing of that individual or change harmful patterns of behaviour.

### Homelessness Prevention

- ▶ **141 brief interventions conducted on wards**

- ▶ **56 patients receiving housing advice/ assistance/signposting**
- ▶ **36 Housing Needs Assessments (assessment of statutory homelessness duty) conducted**

#### Access to Housing

- ▶ **94 people housed overall**
- ▶ **33 people placed into social housing**
- ▶ **59 people placed into supported accommodation**
- ▶ **2 people placed into private rented sector**

#### g) Social Impact

The project aims to achieve some key social impacts:

1. Improve the physical wellbeing of individuals – we measure this through the use of EQ-5D
2. Improve the mental and emotional wellbeing of individuals – we measure this through the use of PHQ9
3. Prevent homelessness – we measure this by recording how many people we house and where
4. Improve individual’s resilience and self help – we measure this through prevention of urgent care use rates
5. Reduce harmful alcohol consumption – we measure this through engagement with treatment and community health services by alcohol dependent service users

I can't thank you enough for finding me this flat - it's perfect

#### h) Social Value (SROI)

**For a local investment of £265,000, Healthy Futures has returned nearly £3 million of social value across Derbyshire**

By using established social methodology and monetary values for good, we can map the return on investment the project achieves by using a social value tool. Once all the data and values have been inputted, the tool produces a figure that shows the social value of each pound spent on Healthy Futures in the past two years. This figure shows that for every pound invested by Southern Derbyshire CCG, Erewash CCG and the northern districts we achieve a return of £11.85 across the health/ social economy.

***“Social Return on Investment (SROI) is a method for measuring and communicating a broad concept of value that incorporates social, environmental and economic impacts. It is a way of accounting for the value created by our activities and the contributions that made that activity possible”***

**(Social Impact Scotland)**

# Introduction

Healthy Futures has been operational for two years acting as a bridge between hospital and home, assisting some of society's most disadvantaged people to find suitable, safe housing, preventing discharge onto the street and enabling people to start on the path to a healthier future. During this time the project has been evaluated twice by external bodies and has consistently demonstrated its value to both commissioners and individuals.

## Overview of Interventions

In two years Healthy Futures has received 284 referrals from hospital and community based practitioners

Staff have conducted 141 brief interventions:

- ▶ 36 Local Authority Housing Needs Assessments
- ▶ 20 Advice & assistance sessions
- ▶ 36 signposted to services
- ▶ 32 ward staff provided with advice and support
- ▶ 13 direct placements into accommodation

We have supported 124 people in the community:

- ▶ 81 people housed into appropriate accommodation
- ▶ 82 safe and timely discharges facilitated
- ▶ 59 people supported to increase their contact with primary care
- ▶ 87% prevention rate of presentations to urgent care

This report has been written to celebrate the successes of the project and to share how we continue to deliver outcomes locally for health and housing, and individually for our clients.

In the past two years Healthy Futures has worked with a total of 52 high impact users of urgent care and 72 homeless patients to develop personalised support that may enable them to lead a healthier lifestyle. Within this cohort, the use of urgent care was as follows:

**341 admissions to an acute bed**

**352 presentations at A&E**

**263 emergency ambulance call outs**

In addition to the 124 individuals who received the full 12 week community follow up and support package, Healthy Futures also provided brief interventions such as housing advice to 141 people in hospital with a housing problem.

Through this work the project has positively impacted on delayed transfers of care from hospital, excessive and avoidable use of health services and non-planned readmission rates.

This has meant that it plays a small but significant part in helping public sector partners to achieve their strategic aims.

Both North and South Derbyshire CCG Units of Planning and Public

Oh, thank goodness you're here!

Social Worker, Derby City Adult Social Care



Health have identified key strategic targets for prevention. These are set out in the two Units of Planning’s 5 year Strategic Plans and Derbyshire’s Health and Wellbeing Strategy. These documents speak of:

- ▶ Building community assets
- ▶ Providing wraparound support in the community
- ▶ Reducing hospital admissions & A&E usage by having stronger community support networks
- ▶ Reducing length of stay by supporting patients to return to their community as quickly as possible
- ▶ Promoting recovery through better local services
- ▶ Adopting a whole person approach
- ▶ Promoting healthier lifestyles
- ▶ Improving mental and physical wellbeing

▶ Reducing health inequalities

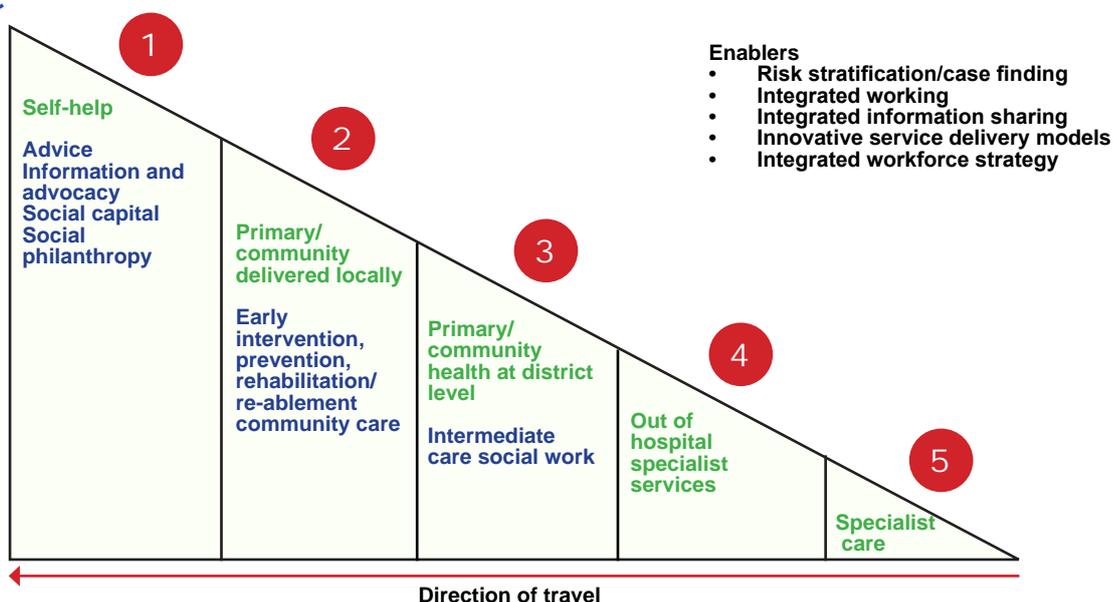
It is also important to highlight our impact on prevention and moving our clients towards self-care as visualised in the “Derbyshire Wedge” (see below).

The community support element of Healthy Futures is completely focussed on prevention, whether that is in regards to re-admission to hospital, episodes of crisis or isolation. We explore, identify and build on each person’s own networks, individual assets and resilience, assisting them to put into place the resources necessary to maintain their independence and increase their wellbeing in the community.

In the next section the Healthy Futures Model is fully explored showing how, by applying a key set of principles and treating every person as an individual, these positive outcomes can be achieved in a short space of time.

## Derbyshire Wedge

### Genetic model - Level of care



# The Healthy Futures Model

Our approach to the concept of Healthy Futures was very much influenced by Derventio's involvement with Make Every Adult Matter (MEAM). A key set of principles were identified and embedded into project delivery from the beginning:

## Housing First

Access to appropriate accommodation which meets the individual's needs is the first priority

## Navigation and Advocacy

A professional friend to steer the person through their own journey to improved health and wellbeing

## Wraparound Support and Service Brokerage

Understand that the factors which influence health and wellbeing are individual to the person

## Non-judgemental and Holistic Approach

Sourcing the best services to sustain recovery and independence

## Behaviour Change

Appropriate challenge of harmful behaviour and support to make changes for the better and make every contact count

## Staff Support and Advice

Be a resource for healthcare professionals, create pathways for dialogue and ease of access to the project

## Brief Interventions

Make the most of resources and use time effectively by providing on ward advice and signposting to in-patients and staff

## Key Relationships

Develop and maintain mutually supportive relationships with services

## Prove the Project's Worth

Collect valid, robust data and use it to show impact

## Remain Independent and Impartial

Understand that homeless people often have a fear of statutory services and that the service is there for them, the end user

I was in a bad place when I first met my support worker, I don't know what I would have done without her - probably would have given up. I can now look forward to a fresh start in my own home where I can better manage my health - she is my angel!

## Making Every Adult Matter

Making Every Adult Matter (MEAM) is a coalition of national charities – Clinks, Homeless Link and Mind – formed to influence policy and services for adults facing multiple needs and exclusions.

Together the charities represent over 1,300 frontline organisations and have an interest in the criminal justice, substance misuse, homelessness and mental health sectors.

In 2011, three pilot areas were supported to develop better coordinated interventions. These were evaluated by FTI Consulting, Compass Lexecon and Pro Bono Economics.

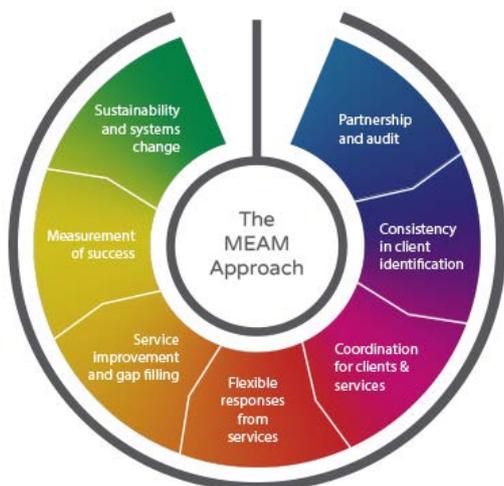
One of the MEAM pilots was in Derby, led by Derventio Housing Trust. The service still continues, integrated into the city's substance misuse services.

The Year Two longitudinal analysis of the pilots highlights the considerable wellbeing improvements and financial savings that a more coordinated approach can deliver, including the Derby pilot, which increased wellbeing for clients and reduced service use costs by 15.8% over the study period. The previous Interim report and Technical Appendix are also available to download.

In every local area, the MEAM Approach aims to ensure that people experiencing multiple needs are:

- ▶ Supported by effective, coordinated services; and
- ▶ Empowered to tackle their problems, reach their full potential and contribute to their communities.

<http://meam.org.uk/>



# Profile of Service Users

During the past two years Healthy Futures has provided a service to 265 people, each one with their own unique history, needs and aspirations.

For the purpose of this report, we have undertaken a detailed analysis of the data we hold to provide a clear picture of the complex nature of our work, and to highlight the common threads that can manifest. Outcomes achieved are noted in the following two sections.

We have chosen to analyse data for the following characteristics:

- ▶ Mental Health
- ▶ Under 25s
- ▶ Over 60s
- ▶ Alcohol Dependency

It is inevitable that some people have more than one of the above characteristics, for the purpose of this analysis they have been included in each data set applicable to them.

## Mental Health

Overall, 55% of all referrals received and 36% of all service users had mental health as their primary need. Average age was 34 years.

### Additional Needs

- ▶ 16% were alcohol dependant
- ▶ 13% had a personality disorder
- ▶ 11% had a long term condition (e.g. COPD)

### Vulnerabilities (in addition to homelessness)

- ▶ 29% self-harmed
- ▶ 11% had misused substances
- ▶ 7% were socially isolated
- ▶ 7% were ex-offenders
- ▶ 4% were victims of domestic violence
- ▶ 4% were veterans
- ▶ 4% were at risk of financial abuse

## Gender

- ▶ 27% were female
- ▶ 71% were male
- ▶ 2% were transgender

## Urgent Care Use

- ▶ 53% were high impact users of urgent care
- ▶ 36% of individuals accounted for 25% of all recorded incidents of urgent care use

This cohort benefits from the flexible and highly person-centred nature of Healthy Futures, so that those who have the most impact on urgent care receive a different focus, specific to their needs, as do those with alcohol dependency, personality disorder, long-term conditions, and people who present with less common conditions and characteristics.

## Sam's Story

Sam 21, was referred to Healthy Futures in January 2015. He was an inpatient on the Radbourne Unit following a serious incidence of self-harm. In the previous 12 months Sam had presented at A&E 4 times, called a 999 ambulance 4 times, and had been admitted 3 times. He suffered from anxiety and panic attacks which he attributed to the fact he was transgender and his step-father had physically abused him due to this. Sam admitted to self medicating on alcohol. He had no formal diagnosis.

Healthy Futures housed Sam into Derventio shared accommodation and connected him with relevant services. He had 2 further serious incidences of self-harm whilst on scheme, both leading to an admission. However as he engaged more with treatment services and reduced his alcohol intake his mood increased and he formed a close friendship with a co-resident. In response to this improvement and support network, Sam and his friend were re-housed into a shared tenancy. Sam is now back in employment.

## Under 25s

Overall, 9% of referrals received and 9% of all service users were in this age bracket. Average age was 23 years.

### Needs

- ▶ 92% had a mental health diagnosis
- ▶ 17% had a personality disorder diagnosis
- ▶ 8% had reduced mobility

### Vulnerabilities (in addition to homelessness)

- ▶ 33% self-harmed
- ▶ 25% were alcohol dependent
- ▶ 17% misused substances
- ▶ 8% were at risk of sexual exploitation

- ▶ 8% had an eating disorder

### Gender

- ▶ 34% were female
- ▶ 58% were male
- ▶ 8% were transgender

### Urgent Care Use

- ▶ 83% were high impact users of urgent care
- ▶ 9% of individuals accounted for 16% of all recorded incidents of urgent care use

Young people are very likely to face mental ill health, and to be high impact users of urgent care. Healthy Futures aims to provide targeted services to support them with their mental health issues, and to use health services in a more efficient and planned way.

Thank you very much for everything, I don't think I'd be here if not for you. I know it's your job but it's the little things you did for me that people don't see, like you got me a lamp and some curtains...



## Over 60s

In total, 11% of all referrals received and 9% of all service users were in this age bracket. Average age was 70 years.

### Needs

- ▶ 36% had a long term condition
- ▶ 35% had a mental health diagnosis
- ▶ 29% had recently had a fall
- ▶ 29% had reduced mobility
- ▶ 14% had reduced ability to self-care
- ▶ 14% had suffered a trauma

### Vulnerabilities (in addition to homelessness)

- ▶ 36% were socially isolated
- ▶ 29% were frail elderly
- ▶ 14% were rough sleepers

- ▶ 7% had a learning disability
- ▶ 7% were alcohol dependent
- ▶ 7% were at risk of financial abuse

### Gender

- ▶ 21% were female
- ▶ 79% were male

### Urgent Care Use

Only one of the individuals in this data set was a high impact user of urgent care with six presentations in the previous 12 months.

For this group, Healthy Futures focuses on long-term sustainable packages of accommodation with support and services needed to help them live independently, creating a home that will be a permanent and sustainable solution to their housing and health needs.

## John's Story

John 65, was referred to Healthy Futures in April 2014. He was an inpatient in the Royal Derby Hospital. He was receiving radiotherapy for advanced prostate cancer and was homeless.

John had been sleeping at the garage where he was employed following a relationship breakdown. He was working full time as a driver and valet. His illness had advanced quickly and he was admitted to hospital for aggressive treatment. His condition has left him incontinent and permanently catheterised.

The referral was part of a planned approach to discharge, the cancer had spread to

his bones and his condition was deemed terminal. It was imperative to source appropriate housing.

Both a Healthy Futures and Housing Needs assessments were conducted on the ward. We immediately began to liaise with local Housing Associations to identify a suitable property. A ground floor bedsit was identified with in a quiet area of Derby near to the City Centre.

John settled quickly into his accommodation. All agencies liaised to ensure he had access to care, support and treatment in line with the End of Life pathway.

## Amy's Story

Amy 33, was referred to Healthy Futures in January 2014. She was alcohol dependent and a homeless high impact user with 7 hospital admissions in the previous 12 months.

Amy was a very vulnerable individual and had been the victim of physical, mental and sexual abuse. She was trying to reduce her alcohol consumption independently leading to a series of withdrawal seizures and hospital admissions.

At the time of referral Amy had lost her room at Milestone and was living in a squat with her partner. Her only social circle involved

other homeless people with chaotic lifestyles and this was impacting on her ability to become alcohol free.

A Healthy Futures assessment was conducted and she was signed up for accommodation with Derventio moving in the same day. We sourced food and toiletries to ensure she was able to settle in, have a shower and a hot meal.

Amy continued to reduce her alcohol consumption and she was visibly healthier, enjoying living in a stable environment. She reduced her contact with her social circle and re-established contact with her family.

## Alcohol Dependent

Overall, 24% of all referrals received and 24% of all service users had alcohol dependency as their primary need. Average age was 43 years.

### Additional Needs

- ▶ 23% had liver disease
- ▶ 20% had another alcohol related condition (e.g. Korsakoff's)
- ▶ 17% had a mental health diagnosis
- ▶ 10% had a long term condition (e.g. diabetes)
- ▶ 10% has a personality disorder

### Vulnerabilities (in addition to homelessness)

- ▶ 10% were at risk of sexual exploitation
- ▶ 10% suffered memory loss
- ▶ 10% were victims of domestic violence
- ▶ 10% were veterans
- ▶ 10% had misused substances

- ▶ 7% had a learning disability

### Gender

- ▶ 33% were female
- ▶ 67% were male

### Age

- ▶ 3% were under 25
- ▶ 33% were aged 25 to 40
- ▶ 64% were over 40

### Urgent Care Use

- ▶ 73% were high impact users of urgent care
- ▶ 24% of individuals accounted for 48% of all recorded incidents of urgent care use

This cohort needs support to reduce their use of urgent care, in addition to well thought-through packages of care, support and accommodation for long-term sustainability. Evidence from homelessness and health practitioners shows that this group can be resistant to change, and are prone to relapse. Long-term support would benefit them.

# Health and Wellbeing Outcomes

Healthy Futures aims to improve health and housing outcomes for individuals, and to focus on health services' priorities. Key impact areas are:

## CCG Priorities:

- ▶ Improve the quality of life for those people with a long-term condition - The project measures improvement in physical wellbeing through EQ-5D (a self-determined assessment). Current figures show an overall average improvement of 66% whilst on project (measured at start and end of engagement). This impact on overall physical health directly affects the likelihood of re-presentation to urgent care services.
- ▶ Reduce avoidable hospital admissions – The project achieves an average 88% reduction in number of admissions in comparison with records for the previous 12 months. We work with individuals to better manage their condition(s) in the community and make better use of primary care.
- ▶ Reduce A&E attendances – The project achieves an average 88% reduction in A&E presentations compared with records for the previous 12 months. Staff deploy behaviour change approaches to discourage inappropriate use of both A&E and 999 ambulance use and ensure individuals are aware of more appropriate alternatives.
- ▶ Reduce length of stay – If an individual is re-admitted to hospital during their time on the project, the mechanisms are already

in place to facilitate a swift discharge once medically fit leading to an average length of 6 days compared to 22 days prior to engagement.

- ▶ Reduce health inequalities – Healthy Futures works with some of the most excluded individuals in society. 36% of all service users have a mental health issue, 36% misuse drugs and/or alcohol, and 26% have a long-term condition. However, through targeted support and advocacy we are able to achieve a 90% community based healthcare/treatment engagement rate.

## Public Health Priorities:

- ▶ Reduce harmful alcohol consumption – 24% of all service users have alcohol dependency as their primary need. People in this group have by far the greatest impact on urgent care and 53% of these have the added complication of a long-term condition. The project achieved a 91% reduction in urgent care use and 90% engagement rate with community services with this cohort.
- ▶ Improve the management of long-term conditions - The project measures improvement in physical wellbeing by using EQ-5D – current figures show an overall average improvement of 66% whilst on project (measured at start and end of engagement).
- ▶ Improve mental health and wellbeing – The project measures improvement in mental wellbeing by using PHQ9 (a self-determined assessment). Current figures



show an overall average improvement of 66% in mental wellbeing whilst on project (measured at start and end of engagement).

- ▶ Improve the health and wellbeing of older people – 9% of all service users supported by Healthy Futures are over the age of 60. Common needs are falls and mobility issues. Many of our older service users are socially isolated (36%) and need support to re-connect with their family/social networks and establish long-term care and support.

In addition, Public Health Derbyshire has a commitment to “making health fairer” by tackling factors that influence health inequalities:

- ▶ Poverty
- ▶ Housing
- ▶ Education
- ▶ Employment

Healthy Futures positively influences these factors through its holistic approach to supporting service users. Housing must come first to assist with discharge from hospital, and then staff work to ensure each person is claiming the correct benefits and that their income is maximised. Where someone wants the opportunity to gain confidence and learn new skills, we connect them with our sister project Growing Lives. Here individuals have the opportunity to participate in physical activity and skill building sessions, aimed at improving health and wellbeing and moving people closer to work.

## Outcomes by Characteristic

### Over 60s

- ▶ 100% reduction rate for high impact users of urgent care
- ▶ 93% prevention of emergency re-admissions
- ▶ 100% engagement with community health services

### Under 25s

- ▶ 82% reduction rate for high impact users of urgent care
- ▶ 50% prevention of emergency re-admissions
- ▶ 83% engagement with community health services

### Alcohol dependent

- ▶ 91% reduction rate for high impact users of urgent care
- ▶ 73% prevention of emergency re-admissions
- ▶ 94% engagement with community health services

### Mental Health

- ▶ 80% reduction rate for high impact users of urgent care
- ▶ 67% prevention of emergency re-admissions
- ▶ 83% engagement with community health services

## Angela's Story

Angela, 46 had been a heroin user for 13 years and for the past ten years had experienced homelessness, lived in hostel accommodation and had frequently moved between private rented homes. She was admitted to hospital when an abscess ruptured on her groin which led to her having her leg amputated. Angela felt she was treated well in hospital by the nursing staff which had differed from previous hospital experiences:

***“Oh the nurses were brilliant, they were absolutely brilliant with me. They couldn't do enough for me, they did everything me, they bent over backwards for me.”***

During her hospital stay Angela was visited by workers from Healthy Futures and a social worker at the hospital. The hospital was going to discharge Angela to a hostel with no wheelchair but the intervention of Healthy Futures prevented this from happening. We arranged for Angela to move in to a social tenancy which was a ground floor flat and had been adapted for wheelchair use.

Angela had decided to go on a methadone programme during her stay in hospital and Healthy Futures helped her with this and being in her own tenancy was a key part of dealing with it:

***“To be blunt it [my health] was crap so was my lifestyle, I was on drugs 24 hours a day I wasn't eating I wasn't sleeping. I've been off them for 18 weeks and I'm loving it, I have reduced my methadone intake from 90 ml to 10ml yesterday.”***

Healthy Futures continued to provide support for Angela which included taking her to hospital and doctors' appointments, picking up prescriptions and helping her with her benefit claims.

*(Courtesy of Homeless Link)*

Scott does everything, he comes and picks up my prescription for my methadone and drops it off at the chemist, he does everything.



Healthy Futures helped me to get housed just round the corner from my daughter

# Housing Outcomes

***“But clearly, homelessness is not just about housing. There are huge inequalities between the health of homeless people compared to the health of the general population. While frequently, homeless people display mental and physical health problems alongside substance mis-use.”***

Healthy Futures works on the premise that a lack of appropriate accommodation impacts negatively on the likelihood of recovery. Without the fundamental security housing gives a person, we are unlikely to be able to impact on the health and wellbeing of that individual or change harmful patterns of behaviour.

## Pauline’s Story

Pauline, 60, found herself homeless following a relationship breakdown. She was admitted to the Radbourne Unit following a suicide attempt. The breakdown of the relationship hit Pauline very hard when she found herself sleeping on her daughter’s sofa with no possessions, no income and no idea what to do or where to turn.

Both Healthy Futures and Housing Needs assessments were conducted on the ward. Staff liaised with a social housing provider in order to secure Pauline a tenancy on a sheltered living scheme.

We supported her to claim for benefits as she had never claimed before, to obtain a gold card for free bus transport and to apply for local assistance with furnishing her accommodation.

Once settled in we supported her to attend her outpatient appointments at the resource hub. We helped her research activities and groups that she could join in order to keep busy and focused on her wellbeing.

## Derby City Council Homelessness Strategy 2015-19

During the past two years, we have developed strong networks with local authorities and housing providers; these relationships have facilitated direct access to permanent housing for 28% of individuals. This is a much higher proportion than would normally be expected taking into account the complex nature of our service users.

We have developed innovative practice to assist with timely discharges by conducting Housing Needs Assessments on behalf of Local Authorities. Due to staffing and time constraints, homelessness officers cannot respond quickly to ward discharge plans however Healthy Futures staff are based at the hospital and have a quick response time. This arrangement has assisted local authorities and wards on 36 occasions.

## Homelessness Prevention

- ▶ Number of brief interventions conducted on wards - 141
- ▶ Number of patients receiving housing advice/assistance/signposting - 56
- ▶ Housing Needs Assessments conducted - 36

## Access to Housing

- ▶ Numbers housed overall - 94
- ▶ Numbers placed into social housing - 33
- ▶ Numbers placed into supported accommodation - 59
- ▶ Numbers placed into Private Rented Sector - 2

# Social Impact

In response to the Government’s National Health Transformation agenda, NHS England has produced its Five Year Forward Vision (5YFV). Within the document there is a strong emphasis on prevention, more say for the individual and the value of the community in achieving the identified outcomes. This document has influenced the strategies of our local CCGs, with Erewash becoming a vanguard site for “Multispecialty Community Provider” provision.

Key priorities, expressed by local CCGs, are:

## Resilient communities and wraparound resources

A key principle of the wraparound model deployed by Healthy Futures is involving people who use services, their carers and families, and local communities to determine and sustain their long-term support needs.

## Self help and support for carers

Healthy Futures makes the connection between housing, health and community provision to increase an individuals’ resilience to cope with periodic episodes of crisis. Staff are there for both the individual and their support network to assist in the navigation of services.

## Improving emotional and mental wellbeing

Healthy Futures works to address any barriers to better mental health and wellbeing, for example access to services, poor housing, lifestyle choices, self-confidence, and self-exclusion. Staff broker services as well as looking to source the most appropriate community activities, they engage with primary care practitioners, VCSE providers, community health services and statutory services such as housing to achieve this goal.

## Adoption of a “whole person” approach

Healthy Futures proactively engages hard to reach people with complex health needs and through the provision of person-centred, wraparound support, it brings together a holistic package of interventions based on the individual’s aspirations.

## Key Social Impacts

1. Improve the physical wellbeing of individuals – we measure this through the use of EQ5D
2. Improve the mental and emotional wellbeing of individuals – we measure this through the use of PHQ9
3. Prevent homelessness – we measure this by recording how many people we house and where
4. Improve individual’s resilience and self help – we measure this through prevention of urgent care use rates
5. Reduce harmful alcohol consumption – we measure this through engagement with treatment and community health services by alcohol dependent service users

Thank you for everything you have done. When I am back on my feet I want to give something back

# Social Value

***“Social Return on Investment (SROI) is a method for measuring and communicating a broad concept of value that incorporates social, environmental and economic impacts. It is a way of accounting for the value created by our activities and the contributions that made that activity possible”***

**(Social Impact Scotland)**

By using established social values, we can map the return on investment the project achieves. For the purpose of this report we have used these sources:

- ▶ HACT Social Value Calculator 2015 Update
- ▶ Shelter’s “VFM in Housing Options and Homelessness” Report (2010)
- ▶ Department of Communities and Local Government’s “Evidence review of the costs of homelessness” (2012)
- ▶ Department of Health’s “Unit Costs of Health and Social Care” (2014)
- ▶ National Audit Office’s “Probation: Landscape Review” (2014)

These values have been entered into the SROI Network’s Social Accounting tool, alongside data from the project’s records. Numbers have been adjusted for deadweight (i.e. failure rates) and, where partner agencies contributed to the outcome, their percentage contribution was removed. Where our activity contributed to an increase in demand elsewhere i.e. Primary Care appointments, this is classed as displacement and the value of this removed from the calculations.

## Physical Wellbeing

HACT values the increase in physical wellbeing at an annual saving to the wider social economy of £19,913 per person per annum. For this element, we only looked at the 32 people who used the project with a long-term condition. We know from the EQ-5D returns that we achieved a 66% positive shift in general physical wellbeing whilst on project.

## Mental and Emotional Wellbeing

HACT values the increase in mental wellbeing at an annual saving to the wider social economy of £36,827 per person per annum. For this element, we only looked at the 45 people who used the project with a mental health diagnosis. We know from the PHQ9 returns that we achieved a 66% positive shift in general mental wellbeing whilst on project.

## Prevention of Homelessness

The DCLG values the average cost of a rough sleeper to a Local Authority at £7,900. In addition, we know from the report conducted by Shelter in 2010 looking at the value for money of housing options services that the mean value of a Housing Needs assessment is £366 and that every homeless episode prevented saves a Local Authority £1,286. We housed 94 individuals in the past two years, provided housing advice to 56 patients and conducted 36 housing needs assessments on behalf of local housing options teams.

## Individuals’ Resilience

The DH produces figures on an annual basis that show the value of all of the different health and social care services. In 2014, an average stay on an acute ward (non-planned)

was £1,663, an average presentation to A&E was £147, and an average 999-ambulance call-out was £233. In the year prior to coming on scheme our cohort of 124 patients had 341 admissions, 352 presentations to A&E, and 263 999-ambulance call-outs. Healthy Futures has consistently achieved an 85%+ prevention rate. The caveat on such value calculations is that urgent care services are there and funded whatever our prevention rates. However it is important to realise that there is a resource issue within the NHS and that every prevention achieved frees beds and resources for other patients in need.

### Harmful Alcohol Consumption

HACT values the relief from alcohol dependency to the wider social economy as

Thank you so much for helping us, we didn't really understand what the doctors were saying so thank you for talking to the nurse and getting her to explain things

£24,120 (per person per annum). For this element, we looked at the 30 people who used the project with alcohol dependency as their primary need. From our own data, we can show we achieved the greatest prevention of urgent care use and engagement with primary care rates with this cohort than with any other complex characteristic.

### Other

Bed nights saved – we looked at average length of stay for all non-planned admissions prior to Healthy Futures and compared this with average length of stay for any such admissions whilst on the project. On average the project achieved a 16 day reduction in length of stay per admission. The DH puts a value of £295 on each excess bed night accrued.

Once all the data and values have been inputted the Social Accounting tool produces a figure that shows the social value of each pound spent on Healthy Futures in the past two years. This figure shows that for every pound invested by Southern Derbyshire CCG, Erewash CCG and the northern districts we achieved a return of £11.85 across the health and social economies in Derbyshire.





## David's Story

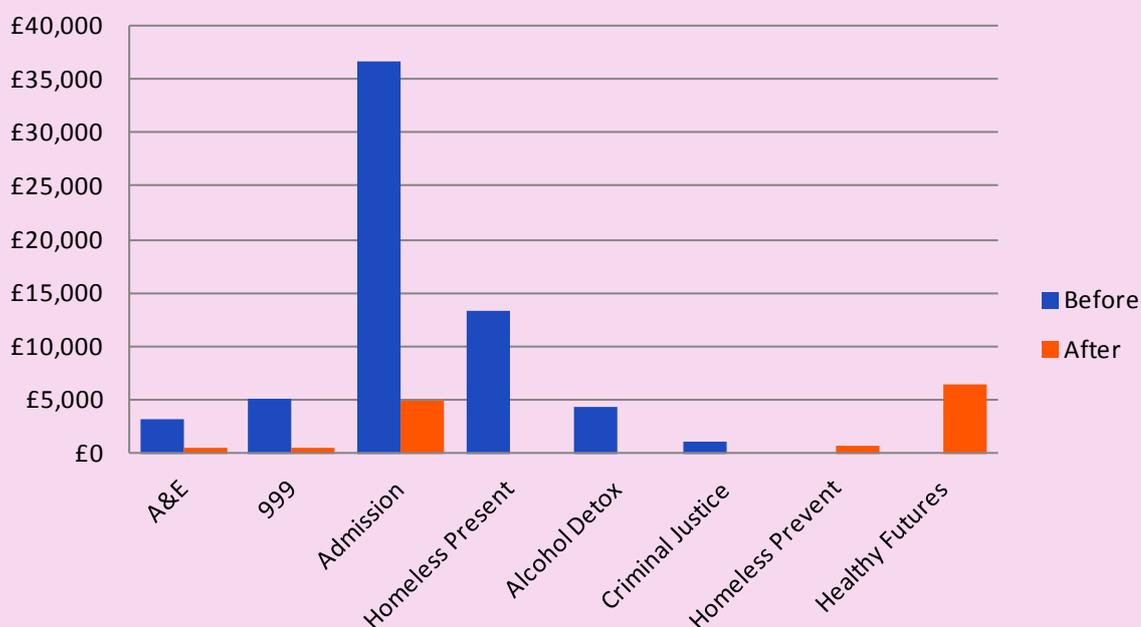
David 41, was referred to Healthy Futures in February 2014, he was an inpatient at the Royal Derby Hospital. He had a long history of alcohol dependency, cerebella atrophy, falls and suicide attempts. He had been homeless since July 2013.

During the previous 12 months David had been admitted to hospital 22 times, each time via 999 ambulance and A&E. He had received 4 hospital detoxes and had presented as homeless to the Local Authority twice. He had committed a theft and was awaiting pre-sentencing report.

Derventio supported David over an 18 month period (he was accommodated in a supported housing unit). During this time he had a further 3 admissions, 3 A&E presentations, 2 999 ambulance calls and came back onto Healthy Futures twice.

The financial impact on services of such a chaotic lifestyle is considerable.

### Cost Comparison



**Total Cost Reduction from 2013/14 to 2014/15 = £50,686**

# Conclusion

Despite the uncertainty of funding Healthy Futures faces every year, the project continues to have a substantial positive impact on the priorities of our strategic partners. Priorities such as some of those contained within the two local Health and Wellbeing Boards' strategies:

Derbyshire:

- ▶ Develop sustainable approaches to keep people healthy and living independently
- ▶ Develop a collective approach to social capital

Derby City:

- ▶ Shift care closer to the individual
- ▶ Reduce inequalities in health and wellbeing

More importantly the work we do assists people facing the greatest health inequalities live healthier, happier, more stable lives. We take our service to them, we wraparound them and support them through their crisis, and then we work with them to build their own assets and resilience. And this approach works, time and again, whatever the presenting health or social need.

Although Healthy Futures was born from the Homeless Hospital Discharge Fund, this evaluation proves it is far more than a hospital discharge project.

The Healthy Futures Project has made a significant impact since its inception in October 2013 for patients facing discharge from hospital to either no accommodation or unsuitable accommodation. The Healthy Futures team have utilised their expertise in housing and support, co-ordinating a patient and customer focussed plan with health and housing professionals to achieve outcomes that have been difficult to achieve previously. The patient and customer benefits are possibly immeasurable whereas the financial benefits and reduction in further presentations at hospital are proven.

**Matt Palmer, Housing Advice Manager,  
Derby City Council**

## Cornelius' Story

Cornelius served in the army for 25 years, serving in the Falklands, Afghanistan and Bosnia. When he left the army, his marriage broke down, and his drinking, which had started because of the stress of army life, continued.

Over time he moved around the country, often living off the land and taking shelter in disused buildings or barns. His heavy alcohol use caused a chronic liver condition, and Cornelius was admitted several times to different hospitals, depending on where he happened to be living at the time.

Last July Cornelius decided to stop drinking - but a few months later was admitted into the Royal Derby Hospital, homeless and seriously ill.

***“Giving up alcohol so quickly and going cold turkey had a big impact on my body. Ironically not a positive one. I was told if I got through the night I may have a chance of surviving. And I did.”***

Derventio Housing Trust's Healthy Futures team visited Cornelius in hospital to assess his needs. We found him a suitable ground floor flat close to his sister and with good transport links to the hospital so he can easily attend his out-patient appointments. As well as making sure the right benefits are in place, the team also contacted SSAFA, an organisation that supports people who have worked in the forces, to provide additional support.

Today Cornelius is settled into his flat and has been attending all medical appointments independently. He has been put in touch with an alcohol support group, and says he has no desire to drink again.

***“I am so much better now. I really want to get back out there and get a job and I have absolutely no need for a drink, I really don't want one.”***

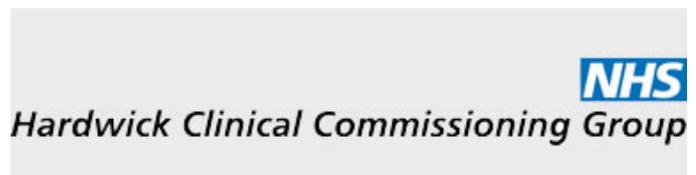
Cornelius is determined to get fit enough for a liver transplant and hopes that once he has recovered he will be able to get a job. As well as completing some Learn Direct courses, Cornelius has made a training video with the NHS about his time in hospital.

***“It was the light at the end of the tunnel. It was so uplifting when Healthy Futures staff came to visit me in hospital. I am better, fitter and healthier now. I just wouldn't be here now if it wasn't for the help I have received.”***

**Update:** Four months after we spoke to Cornelius for this article he had a successful liver transplant and is doing really well.



# Thank you to our partners



# Acknowledgements & Sources

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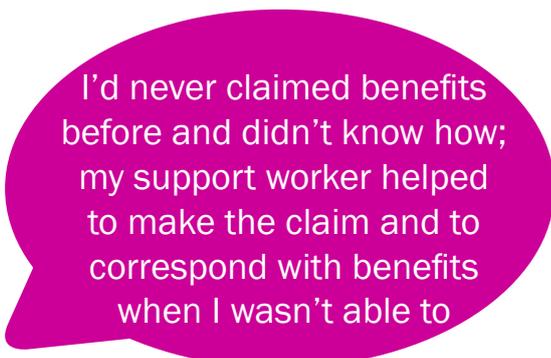
## Acknowledgements

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- ▶ Dr Michelle Cornes of Kings College London
- ▶ Dr Michela Tinelli of the London School of Economics
- ▶ Homeless Link
- ▶ Making Every Adult Matter (MEAM)

## Sources

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- ▶ Derby City Health and Wellbeing Strategy 2012-19
- ▶ North Derbyshire CCG Clinical Commissioning Strategy 2013-16
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- ▶ HACT Social Value Calculator 2015 Update
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- ▶ Department of Health's "Unit Costs of Health and Social Care" (2014)
- ▶ National Audit Office's "Probation: Landscape Review" (2014)



I'd never claimed benefits before and didn't know how; my support worker helped to make the claim and to correspond with benefits when I wasn't able to



**[www.derventiohousing.com](http://www.derventiohousing.com)**



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