Keep Well Collaborative

Keeping people safe and well at home

Vision 2025: What will people say?

Local People:

“I feel safe and secure in my home. My home supports what is important and what matters to me. It helps me live my life & does not hinder my physical or mental wellbeing.”

System:

“We understand that someone’s housing situation is a key determinant of their health. We use the home as a lens to wellbeing to align policy and strategy to design and deliver services alongside local people.”

Join the conversation...

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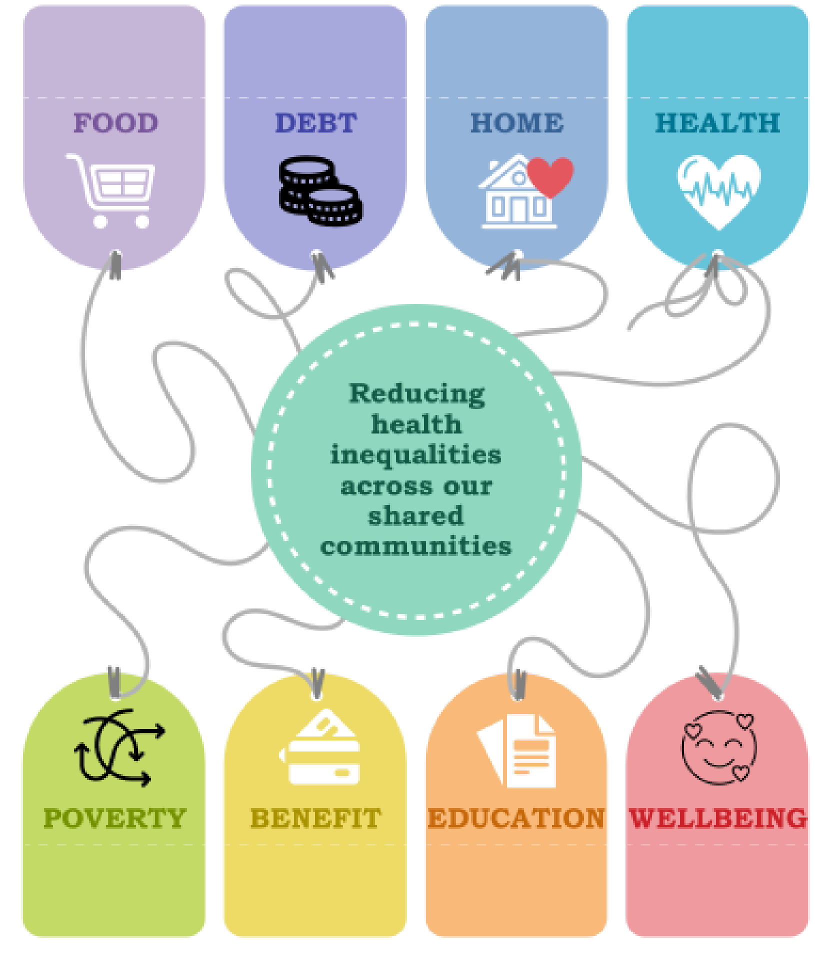
Who we are and what we do

We help build collaborative relationships between housing, health, social care, statutory and voluntary agencies breaking silos, building trust and inspiring a relentless focus on championing change, despite the obstacles.

Our radically ambitious approach shifts our focus from health initiatives which treat the symptoms of the lives we lead, to the place where we live our lives.

By recognising that 'health begins at home' we are unlocking capacity and resources, strengthening our reach beyond individual organisation boundaries and in so doing we:

1. **Maximise the impact of our collective investment in the region**
2. **Strengthen common aims and strategic cross sector strategic thinking**
3. **Enable smarter/shared cross-sector risk mitigation**
4. **Inspire a relentless focus** building trusted relationships which
5. **Keep people safe and well at home**



Our approach

We work to improve the mental health and wellbeing of our shared communities through a focus on the home by:

- Building greater community resilience
- Making better use of collective workforces
- Making better use of collective buildings, land and property assets

Directly supporting priorities within the HIOW STP Strategic Delivery Plan we have co-produced a specific Housing Programme which stretches strategic thinking and operational practice through cross-sector collaboration to:

- Reduce Out of Area Placements
- Reduce Health Inequalities of our most marginalised communities
- Unlock the social capacity of public land and in so doing, provide housing solutions for key workers

NHS Integration and Innovation White Paper … a journey we've already begun

This means that as a system we have already begun to make great strides in developing a more integrated, innovative and creative response to joining up primary, social care and support as close to home as possible, directly improving health outcomes.

Work with system 'early adopters' has already levered in excess of £900K into the health economy in additional value.

Some examples of our impact

Reframing our existing map of the world, presents game changing opportunities

Specialist mental health in-reach service at Queen Alexandra Hospital, Portsmouth

Building on the early successes of our specialist housing in-reach work last year, we continue to enable collaborative action supporting QA Hospital, Two Saints, Solent NHS Trust and Portsmouth City Council, to secure winter funding to provide on-site support for inpatients or visitors to the Emergency Department (ED) who have a mental health support needs.

The service, which went live on the 18 January 2021 for six months, covers all patients who access QA living in Portsmouth, Fareham, Gosport and South East Hants. It provides help to access/navigate services and support and guidance around housing – avoiding people self-discharging before completing their treatment and ensuring no one is discharged on to the street.

The service is provided by two members of staff from Two Saints, and runs on-site Monday to Friday, 10am-6pm with out of hours emergency on call support.

Queen Alexandra Hospital (porthosp.nhs.uk)

Some examples of our impact

Reframing our existing map of the world, presents game changing opportunities

The success of our specialist in-reach collaboration is also extending to support our ambulance colleagues.

Similar to the in-reach service at QA, we are also mobilising a new collaboration with South Central Ambulance Service (SCAS) to provide rapid mental health and housing support when NHS colleagues are called to attend people who are sleeping rough, those in mental health crisis and/or people living in temporary/hostel accommodation to support their access to appropriate primary or secondary services.

We anticipate the benefits of both QA and SCAS collaboration to:

- Reduce ED waiting time
- Support timely discharge
- Reduce hospital (re)admission
- Reduce Out of Area Placements
- Prevent people self discharging
- Prevent people being discharged no fixed abode

Some examples of our impact

Reframing our existing map of the world, presents game changing opportunities

Enabling people to 'step out' of the system

Working with our partners Abri, Southern Health and the Society of St James, we've brokered a growing pipeline, initially of five permanent homes, pepper potted around a local a community café enabling patients to 'Step Out' of MH acute and rehab facilities – improving inpatient flow and reducing the need for out of area placements.

Staff report:

- Patients leave with feelings of joy and happiness
- Increased staff morale seeing people step out of the system into true independence
- Patients were able to be discharged an average of three months earlier than expected
- Achieving bed cost savings of ~£27K per person + reduced costs/cost avoidance with zero readmissions plus wider public purse savings

Early evaluation with residents finds:

- Improved optimism and hope for the future
- Sustained mental wellbeing
- Settled, secure lives back in the local community

"… I have come on leaps and bounds from where I was a year ago and having my own flat has played a part in that. My flat feels secure and it's so nice to have my own home; it gives me a sense of wellbeing and being in control."

- Step Out resident, February 2021

Some examples of our impact

Reframing our existing map of the world, presents game changing opportunities

Keeping people safe and well at home

We've also brokered pioneering collaborations between Solent NHS Trust:VIVID and Southern Health NHS Trust:Winchester City Council to develop housing led Wellbeing Services which keep people safe at home.

Our community mental health hospital colleagues provide monthly cross sector mentoring and support to three Wellbeing Workers employed by housing partners who support people living in the community with mental ill health.

VIVID's Wellbeing Service launched in December 2018 and was a finalist in the national Housing Heroes Awards 2019.

With a caseload of around 30 residents at any one time, the Wellbeing Service has already helped turn lives around and in just one case alone saved the NHS £17,000 a year through reduced GP appointments and repeat calls to 111 and 999 services.

VIVID has now gone on to appoint volunteer counsellors and introduced mental health champions into their contact centre to provide dedicated support to customers with mental health issues.

Some examples of our impact

Reframing our existing map of the world, presents game changing opportunities

Working to reduce Health Inequalities

We have been instrumental in bringing together District and Unitary partners alongside NHS, Public Health and community partners to enable a system response to the impact of the Covid19 pandemic upon our homeless communities.

We have built trusted cross sector relationships and continue to develop shared appetite to change the way we work together, proactively addressing the health inequalities of some of our most marginalised communities.

For the first time we know that ~1700 (May 2020) people across Hampshire and the Isle of Wight are currently homeless, with the largest concentrations in Portsmouth, Isle of Wight and Southampton. Across Hampshire Districts

- 77% have mental ill health; 80% misuse substances
- 61% have co-occuring mental health/substance misuse – with the largest numbers in Fareham & Gosport
- Average age circa 31 years old
- 88% of shared accommodation settings do not have a linked GP practice
- Although many are registered with a GP, in some areas engagement with primary healthcare services is challenging and many have unmet health needs

Homelessness costs the Hampshire & Isle of Wight system an estimated additional £38m a year. Quite simply it costs more to keep someone homeless, than it would to house and wrap around support.

Some examples of our impact

Reframing our existing map of the world, presents game changing opportunities

As part of our collaborative action to develop a system response to homelessness prevention we have:

- Shaped the development of a **primary level Homeless Healthcare specification** which will, once approved by CCGs, provide consistent healthcare to people experiencing homelessness across the HIOW footprint
- Supported the **development of the 111 service to ensure call handlers are aware of the Duty to Refer** people who may be at risk of homelessness to LA partners
- Shaped the implementation of **acute hospital discharge pathways** to ensure that people without a home are not discharged with no fixed abode; reducing hospital readmissions
- **Facilitated co-production which in turn supported a successful bid securing circa £250K** from Public Health England to implement a bespoke homeless healthcare offer in Portsmouth.
- **Chaired and developed a system wide peer support** network, encouraging cross sector peer mentoring
- Joined up cross sector teams and networks enabling partners to **extend their reach beyond organizational boundaries** with the potential to make better use of collective staff resources
- Continued to build appetite for a system wide response to homelessness prevention including:
  - The development of a **regional homelessness dashboard**
  - **Housing First** approaches
  - A **whole system review of transition/discharge points** to prevent people experiencing multiple disadvantage falling through the gaps in services

Keep Well Collaborative

Strategic Delivery Plan 2020-2025

3 priorities:

1. Reduce Health Inequality
2. Key Worker
3. Reduce OOA placement

3 core strands:

1. Community Resilience
2. One Workforce
3. One Estate

Reduce Out of Area Placements

Reduce Health Inequality

Sector Engagement Strategy (Thought Leadership)

Change Agents (Thought Leadership)

Key worker (housing solutions framework)

OE2: Enable mixed accommodation offer: step up; step down; move on

OE3: Aids and Adaptations reducing DTOC

OE4: 'Clearing House' model

OW4: Framework of training and support enabling work at scale

OW5: Rehab project

OW6: End OOA placements to ensure MH patients are able to actively maintain links to their home

MH metrics ie readmission, LOS

OE1: Reduce No and LOS of families with children living in temporary accommodation

OW3: Develop a health begins at home dashboard (real time homeless data)

OW2: Extend Voluntary Duty to Refer to end discharge NFA

CR2: Peer Support Network

CR1: Social housing supports PCN development - collaborative asset mapping, Gosport, WHCCG

OW1: Improve homeless healthcare

Keeping people safe and well at home

R&R metrics

Community Resilience

One Workforce

One Estate

OE5: Collaborative OPE revenue/capital bid

OW7: Implement range of short/medium term key worker housing solutions

OE6: Strategic approach to homes for health - keyworker & community based housing solutions

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Queries?

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Join the conversation...

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