London Borough of Hounslow

Memorandum of Understanding (MoU) to support joint action on improving health through the home

Hounslow

A local perspective

The Hounslow Memorandum of Understanding is an agreement between local health, social care, housing and support colleagues who are committed to working in partnership to ensure that there is cross-sector identification and awareness of the needs of the population of Hounslow.

This Memorandum of Understanding sets out a detailed action plan to demonstrate how working together across the sectors can deliver activity which ensures that the needs of all local people across the life course are met and health and wellbeing outcomes are achieved and optimised.

This Memorandum of Understanding provides the detail of how we aim to fulfil the priorities set out in our local governing strategies for housing and health and wellbeing in Hounslow through early intervention and prevention activity.

This Memorandum of Understanding has been developed alongside the local Health and Wellbeing Strategy and emerging Housing Plan to ensure there is complete alignment.

Working together, we aim to:

- Establish and support national and local dialogue, information exchange and decision-making across government, health, social care and housing sectors[1];
- Coordinate health, social care, and housing policy;
- Enable improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services;
- Promote the housing sector contribution to: addressing the wider determinants of health; health equity; improvements to patient experience and outcomes; 'making every contact count'; and safeguarding;
- Develop the workforce across sectors so that they are confident and skilled in understanding the relationship between where people live and their health and wellbeing and are able to identify suitable solutions to improve outcomes.

Context

The Health and Social Care Act 2012 introduced a number of provisions intended to improve the quality of care received by patients and patient outcomes, efficiency, and to reduce inequalities of access and outcomes. Provisions require co-operation between the NHS and local government at all levels. Health and Wellbeing Boards (partnerships of all those working to advance the health and wellbeing of the people in that area), also have a duty to encourage commissioners to work together.

The Care Act 2014 aims to improve people's quality of life, delay and reduce the need for care, ensure positive care experiences and safeguard adults from harm. The Care Act relates primarily to people aged 18 and over but young people approaching adulthood and those caring for an adult or in families of someone receiving care should also benefit. The Children and Families Act 2014 is also relevant to young people with care and support needs.

Local authorities are required to consider the physical, mental and emotional wellbeing of the individual needing care, and assess the needs of carers. They must ensure the provision of preventative services and carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services.

[1] The term 'housing sector' refers to: local housing and planning authorities; housing providers e.g., ALMOs, housing associations; housing support and care providers; homelessness sector organisations

The Care Act calls for:

- A shared vision and culture of cooperation and coordination across health, public health, social care and local authority roles, e.g. as housing commissioners, working closely with public, voluntary and private sector providers to improve services;
- A whole systems and outcomes-based approach to meeting the needs of individuals, their carer/s and family, based on a robust understanding of the needs of individuals, their carers and families now and in the future;
- Consideration to the health and wellbeing of the workforce and carers;
- Solutions to meet local needs based on evidence of 'what works';
- Services that will address the wider determinants of health, e.g. housing, employment.

Integrated health, care and support, and housing solutions could make best use of the budgets across the NHS, local authorities and their partners to achieve improved outcomes for less; for example, drawing on the Better Care Fund to support service transformation.

Housing must be considered as part of an assessment process that may prevent, reduce or delay an adult social care need. Poor housing, unsuitable housing and precarious housing circumstances affect our physical and mental health. Generally speaking, the health of older people, children, disabled people and people with long-term illnesses is at greater risk from poor housing conditions. The home is a driver of health inequalities, and those living in poverty are more likely to live in poorer housing, precarious housing circumstances or lack accommodation altogether. However, when suitable, stable and decent standard accommodation is provided with appropriate and adequate support (including local networks and access to services) in safe, clean and positive neighbourhoods and communities, the foundations are laid for improved and stable health and wellbeing throughout life.

Key features of the right home environment (both permanent and temporary) are:

- It is warm and affordable to heat;
- It is free from hazards, safe from harm and promotes a sense of security;
- It enables movement around the home and is accessible, including to visitors;
- There is support from others if needed.

The right home environment can:

- Protect and improve health and wellbeing and prevent physical and mental ill-health;
- Enable people to manage their health and care needs, including long-term conditions and ensure positive care experiences by integrating services in the home;
- Allow people to remain in their own home for as long as they choose.

In doing so it can:

- Delay and reduce the need for primary care and social care interventions, including admission to long-term care settings;
- Prevent hospital admissions;
- Enable timely discharge from hospital and prevent re-admissions to hospital;
- Enable rapid recovery from periods of ill-health or planned admissions.

At a local level the right home environment is enabled by a range of stakeholders (not exhaustive):

- Local Health and Wellbeing Boards have a duty to understand the health and wellbeing of their communities, the wider factors that impact on this and local assets that can help to improve outcomes and reduce inequalities. The inclusion of housing and housing circumstances, e.g. homelessness in Joint Strategic Needs Assessments, should inform the Health and Wellbeing Strategy and local commissioning;

- Local housing and planning authorities commission the right range of housing to meet local needs, and intervene to protect and improve health in the private sector, to prevent homelessness and enable people to remain living in their own home should their needs change;

- Housing providers' knowledge of their tenants and communities, and expertise in engagement, informs their plans to develop new homes and manage their existing homes to best meet needs. This can include working with NHS providers to redesign care pathways and develop new preventative support services in the community;

- Housing, care and support providers provide specialist housing and a wide range of services to enable people to re-establish their lives after a crisis, e.g. homelessness, or time in hospital, and to remain in their own home as their health and care needs change. Home improvement agencies and handyperson services deliver adaptations and a wide range of other home improvements to enable people to remain safe and warm in their own home;

- The voluntary and community sector offers a wide range of services, from day centres for homeless people to information and advice to housing support services.

All stakeholders understand the needs of their customers and communities; their knowledge and insight can enable health and wellbeing partners to identify and target those who are most in need.

Sustainability and Transformation Plan (STP)

The NWL Sustainability and Transformation Plan provides an opportunity to explore the potential to maximise benefits of the estates in Hounslow. The Local Authority and CCG have ambitious plans to develop extra care housing and key working housing.

Action Plan 2017/18

	Objective	Action	Lead	Completion
1.	Hospital discharge review – work with hospitals and adult social care to: a. Reduce number of delayed discharges caused by housing; b. Identify housing issues earlier in the hospital admission pathway; c. Simplify referral routes into housing services upon identification of issues.	Agreed hospital discharge protocol in place between Housing and West Middlesex. A telecare home from hospital pilot scheme has been in place since October 2016 as part of the hospital discharge process for patients most at risk of falls - a telecare device is provided free for 6 weeks during which time the discharged patient will have a full telecare assessment to evaluate whether they require telecare devices long term. Evaluation of the pilot is due April 2017. The Handyperson scheme also works closely with the Integrated Community Response Service (ICRS) around hospital discharge to provide equipment that will enable a patient to return home.	Housing Client Services Managers	July 2017
2.	Review housing and mental health protocol to incorporate new primary mental health care service and address issues making referrals.	Draft mental health protocol done and meeting with key health professionals took place in March 2017. Meeting with housing Registered Providers scheduled for May 2017. Launch with frontline staff on 14 June 2017.	Head of Division Resident Services	June 2017
3.	Review pathways for referrals into housing from health services, simplifying where possible and addressing issues raised by health services (begin with GPs and Navigators).	Pilot Supporting Independence Worker based at hospital. Develop specification for HELP service under LIFE programme for consistent Information, Advice and Guidance, Brief Interventions and Access to Support and Supported Accommodation including GP and Locality Teams and Hospital. Implement new HELP Service.	Senior Joint Commissioning Manager Preventative Services and Supported Housing	April 2017 July 2017 January 2018
4.	Engage Partners and other Registered Providers with health and housing agenda and identify projects that they can deliver/support.	A regular Registered Providers Forum has been set up and next meeting is scheduled for May 2017. Need to agree terms of reference and ensure agenda plan for the year at the meeting.	Head of Division Resident Services	May 2017
5.	Develop bespoke repairs services tailored to health needs of individuals for council tenants.	This is something predominantly for next year. We have had discussions with the Disability Forum about how repairs are delivered. All our efforts at present are directed at making the Lamptons/LBH split effective.	Head of Repairs and Estate Management	December 2017
6.	Establish telecare as part of the council's core offer to residents to help promote and maintain independent living in the community, provide reassurance and,	The Hospital Discharge pilot was launched in October 2016 and an extension of the pilot into Accident and Emergency at West Middlesex Hospital is under consideration to those not admitted as an inpatient. An agreement to issue patients with a basic telecare kit and within the first 6 weeks of discharge	Head of Specialist Housing	July 2017

	utilised effectively, to assist in reducing the overall cost of social care to the council.	conduct a full telecare assessment to speed up discharges and prevent hospital readmissions is now in place. The numbers of residents with additional telecare packages have increased since the start of the pilot. A pilot in conjunction with Adult Social Care using the 'just checking' monitoring systems has commenced with the first devices installed. These systems will monitor the movement of clients and carers within the home over a period of time. The data gathered will assist Social Work teams to decide if the current care plan requires the same number of carer visits and/or if these visits can be better targeted to meet the client's needs. Evaluation of the pilot is due April 2017.		
7.	Extra care	Continue to develop extra care accommodation in Hounslow for vulnerable people that require specific accommodation to support them to live independently in the community. CCG, Housing and Adult Social Care colleagues will work together to design the accommodation, agree the service specification and identify suitable residents for the accommodation.	Senior Joint Commissioning Manager Preventative Services and Supported Housing	Ongoing
8.	Falls	Housing has been working closely with the Falls Prevention Co-ordinator to assist in this work and assisted in organising a workshop as part of the Falls Agenda to other professionals and provided a demonstration of telecare. We refer clients for falls assessments and the Handyperson Scheme, Housing officers and Sheltered staff have a tailored assessment tool to identify those at risk of falls and make the appropriate referrals to the Falls Prevention Co-ordinator.	Joint Commissioner Older Persons	Ongoing
9.	Develop the Supporting Independence Service into the HELP service under LIFE, providing a joined up information, advice and access service across housing, health and social care aimed at maximising potential for prevention and supporting vulnerable people to live independently.	Design specification for the HELP service bringing together the Supporting Independence Service and Care Navigators Hospital Service. Consult with residents and stakeholders, agree model and specification. Mobilise new HELP service.	Senior Joint Commissioning Manager Preventative Services and Supported Housing	July 2018 January 2018
10.	Making Every Contact Count	To support people in the community we will work together to ensure every contact counts. Staff working in the community will be encouraged to identify issues such as risk of falling, nutrition, hydration and neglect and involve the appropriate service to ensure early action is taken to maintain the person's independence in the community.	Director Joint Commissioning	Ongoing