The Lightbulb Project: Switched on to integration in Leicestershire

Lightbulb brings together County and District Councils and other local partners to help people stay safe and keep well in their homes for as long as possible, by bringing together a range of support.

Our Vision for Health and Care Integration in Leicestershire is: “We will create a strong, sustainable, person-centred, and integrated health and care system which improves outcomes for our citizens.”

Lightbulb

Keep you and your home healthy

Written for the Housing Learning and Improvement Network by **Alison Moran**, Interim Lightbulb Service Manager, Blaby District Council.

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Introduction

The case for the Lightbulb transformation project was supported by both national and local strategic drivers, including:

- Strategic thinking about the use of home adaptations and technologies through the Better Care Fund.
- As a county, Leicestershire has an ageing population which inevitably will lead to increased demand on services, for example, the population aged 65-85 is projected to grow by 56% by 2037 and 85+ by 156%.
- The costs to the NHS of poor housing, falls and LTC are significant.
- Timely DFG work can delay the need for residential care and is cost effective, but the process was unnecessarily lengthy and diverse.
- Unified 'Prevention Offer' in Leicestershire's Better Care Fund.
- Links to the Leicestershire Adult Social Care Strategy; *preventing, reducing, delaying need.*
- Support the Home First Workstream of the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan.

When we carried out an initial customer insight project in 2015 customers told us that:

- 30% do not feel that their voice would be heard about how best to meet their needs.
- Health, housing and social care not seen as separate services; 95% of respondents wanted a joined up approach and less people to deal with.
- Customers would welcome a proactive approach.
- The local dimension to services is important.
- People are prepared to pay for what they need if the charges are fair and transparent.

The Features of the Service

The partners worked together developing a co-designed philosophy, offer and operating model with all processes agreed between all participating Districts. The approach is targeted and proactive and includes GPs and other health/care professionals including those in integrated locality teams.

The process relies on early assessment and triage of housing issues at key points of entry. This is delivered through a 'hub and spoke' model with an integrated Locality Lightbulb Team in each District Council area offering:

- Minor adaptations and equipment
- DFGs
- Wider housing support needs (warmth, energy, home security)
- Housing related health and wellbeing (AT, falls prevention)
- Planning for the future (housing options)
- Housing related advice, information, signposting
- The common, central functions (management, performance, Lightbulb development etc) will sit within the central 'hub'

A new role of Housing Support Co-ordinator (HSC) encompasses functions currently carried out across District and County Councils which is supported by Occupational Therapy and technical officer expertise in the Locality Team. The HSC job role includes a trusted assessor element, supported by a competency framework with a Countywide training package being developed. The Housing MOT checklist provides a customer focussed assessment and solutions and integrated working with other key stakeholders such as community fire and rescue.

As well as supporting people in their own homes, the Lightbulb service includes a specialist Hospital Housing Enabler Team based in hospital settings, both acute and mental health across Leicestershire. The team work directly with patients and hospital staff to identify and resolve housing issues that are a potential barrier to timely discharge and also provide low level support to assist with the transition home from hospital to help prevent readmissions, and they quickly became established as essential members of integrated discharge team. Their role is to is seek a wide variety of innovative and pragmatic housing solutions. The Team have access to budgets to help with rent deposits & furniture. The Hospital Team are linked with wider Lightbulb offer and Housing Support Coordinator roles.

Development of the Service

The Lightbulb staffing model is based on demand analysis across the county including recognition of demographic trends within Leicestershire and an assumption of some proactive uplift in demand, due to new service offer and channels.

The Funding model was based on redirecting existing resources, which currently sit across different organisations, contracts and services, including historical staffing resources associated with processing DFGs. Key funding streams were identified across Adult Social Care and District Councils that will form the ‘Lightbulb pot’, which are being redistributed based on the new offer and demand model. The Lightbulb Programme Board and Steering Group were critical to developing the model and funding approach across multiple partners.

We received a £1m Transformation Challenge Award from the DCLG spanning over 2 financial years, to support people in their own homes (Lightbulb). Making maximum use of this award, Lightbulb have developed a new housing support pathway; bringing services together across local authorities, reducing the complexity and handoffs in the current system and providing a service that will work with customers and carers to identify their own needs and solutions as part of a preventative approach.

The Impact of the Service

Formal evaluation of the service has taken place using Social Care and Health data and simulation modelling.

Lightbulb delivery costs, including Hospital Housing team, are approximately £1m p/a against a potential £2m p/a saving to the Leicestershire and savings to the wider health economy. These savings are evidenced through the Pilot Lightbulb service:

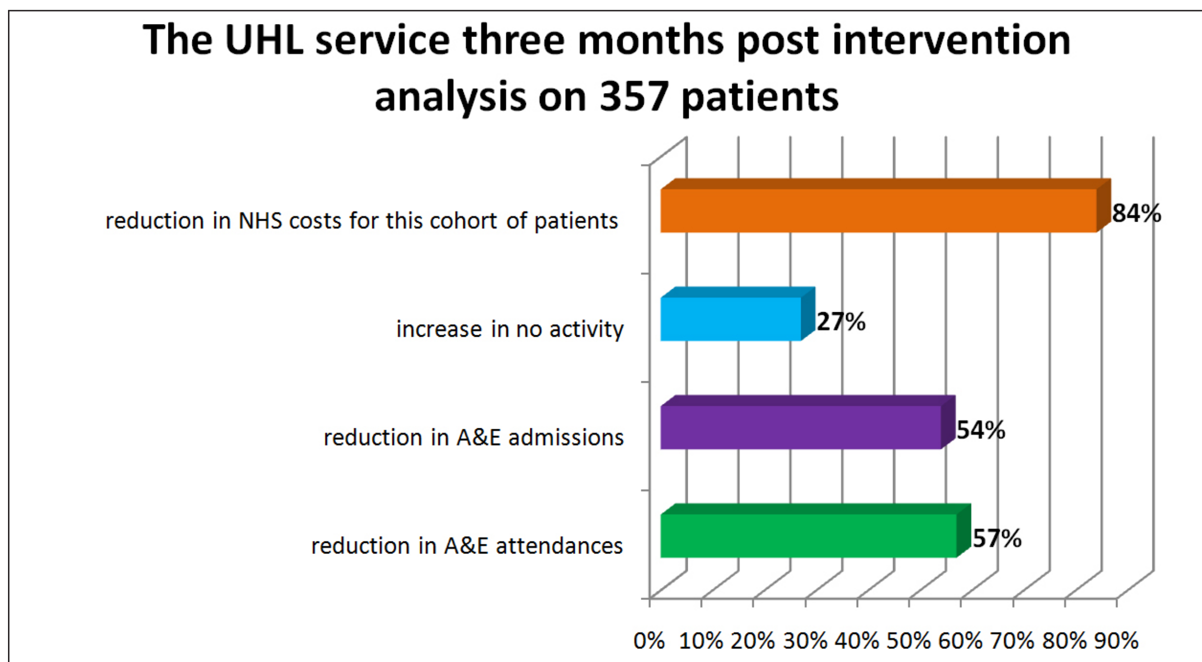
- Reduction in service utilisation (health and social care)
- Reduced admissions
- Reduction in A&E attendance

- Reduction in Delayed Transfers of Care
- Falls prevention
- Targeting patients with long term conditions
- Lower DFG delivery costs through more efficient processes and staffing efficiencies
- The wider offer through the Housing MOT checklist

11% of cases have been analysed using the NHS number and PI's Care and Health Trak tool.

- This showed a reduction in service usage of 66%
- Two months post intervention saw adult social care costs reduced by 23%
- Scaled up to include all potential Housing Support Co-ordinator cases, this could lead to cost savings of up to £250,000 to Adult Social Care per year
- Of the 18 cases analysed, where residents had previously fallen, 17 reported no falls since they received their interventions
- A reduction of 1 fall per year for these 17 people alone would result in a cost saving of £21,000 per year for the local health and care economy.
- All of these customers reported feeling safer and more confident around the home

In 2016 / 2017, the UHL service received 349 referrals and the Bradgate Mental Health unit received 151 referrals. The primary reasons for referrals for UHL were homelessness and the home is no longer suitable, and for Bradgate Unit were Homelessness and family refusing their return.



- 84% reduction in NHS costs for this cohort of patients 3 months post intervention – saving £222,000, scaled up this could mean a potential £550,000 saved over 12 months

115 patients at the Bradgate Unit analysed saw:

- 920 delayed bed days saved.
- Of 40 service users who continued to receive support in the community following discharge, only one was readmitted.
- Over 12 months the projected housing Delayed Transfer of Care costs would be £175,000 compared to £650,000; a potential reduction of £475,000.
- Referrals to the Bradgate Unit have risen by 67% in last 6 months.
- In contrast, resolution times have reduced by 60% meaning despite the rise in referral patients are receiving a speedier service reducing the chance of delays.

Key Outcomes

These include:

- Securing new private rented or social housing accommodation
- Resolving eviction issues
- House clearance or supporting family with hoarding or clearance issues
- Furniture moves for ground floor existence with package of care
- Approaching local authority for temporary accommodation
- Benefits advice such as support to apply for new claim or reapply
- Mediation to return to family or friends with long term plan for re-housing
- Negotiating with landlord for repairs
- Providing furniture packs
- Financial assistance with rent deposits and rent in advance
- Heating repairs
- Minor repairs e.g. fix loose carpet / repair locks

Case Studies

Case Study 1 - Mrs S

Dr J referred 89 year old Mrs S to Lightbulb. She is blind in 1 eye, has had previous falls and remains at risk of further falls. She uses a stick to get around her home. Mrs S had been reluctant to have any involvement from services.

On their visit the Housing Support Co-ordinator carried out a Housing MOT which identified a range of support needs and solutions. These included equipment such as a perching stool for the kitchen to enable her to make meals and wash up more easily; minimise the risks of falls with minor adaptations and sensor lights used at nights; assistive technology in the form of 'Lifeline', giving freedom to Mr S to go out without worrying about his wife; Home Safety checks which identified a faulty smoke alarm and provided a CO2 alarm; garden clearance to reduce the risk of crime, falls and enable Mr and Mrs S to enjoy their garden once more.

From referral to completion took 4 weeks and just 2 visits from the Housing Support Co-ordinator who arranged all the work to be undertaken.

Case Study 2 - Ms B

Ms B was admitted to hospital after being found by police wandering and confused. In order to be safely discharged Ms B required a package of care, however, the carers would not go into the property because it was very cluttered and unclean. A referral was made to the Hospital Housing Enable Team from the social worker within the hospital and a mutli-disciplinary team meeting was arranged including Housing, Social worker and a specialist Discharge Nurse. When Ms B was medically fit to be discharged an interim residential care placement was found while the Hospital Housing Enabler Team worked with her so the property could be deep cleaned and for the main access areas to be cleared, enabling the care package to be put in place. The Team were able to access a small budget for this work.

The work of the team meant that Ms B only spent 5 days in interim residential care before being able to safely return home with a care package in place. The team also provided additional support following the first few weeks after discharge. Without the work of the team Ms B would have remained in residential care potentially costing £8,500, enforcement action would have been taken regarding the condition of the property at cost to the Local Authority, and further anxiety and upset may have caused and already confused individual to be readmitted to hospital. Instead Ms B was able to return home at the earliest opportunity.

Case Study 3 - Mr T

Mr T was discharged from hospital following an aortic valve replacement. Mr T's wife contacted the Customer Service Centre for assistance with bathing. The holistic assessment also included support to claim attendance allowance and falls prevention advise. In the Lightbulb journey there were just 2 visits at a cost of £200 approximately and it took just 6 weeks to complete all the works, this is in comparison to the traditional number of 5 visits costing approximately £400, 14 weeks or more to complete the works and which only dealt with a single issue of bathing.

Key learning points

There have been a number of factors which the project needed to better understand in developing the service in order to give the best outcomes for customers. We are still learning and changing the service to overcome issues, and challenges.

We recognised that there were differing local factors to delivering this service with partnership working and clear communication being all important in developing and delivering new services across a number of public sector organisations. Be prepared to work across structural, administrative and, geographical boundaries.

It is important to have an active Leadership made up of Partners who oversee the project, meeting regularly, providing strategic direction, picking up issues and removing barriers. This includes getting agreement on Information Sharing and how we deploy IT, including access to other authorities systems, and trying to understand what is required. This was essential to this project and none of this could have been achieved but for the willingness of partners and colleagues to look for solutions to problems and how systems can be improved.

Uncertainty around funding has played a part, as it has across the whole public sector. The Lightbulb project is about ensuring a customer centred service while providing value for money for the public purse. Our hospital enablement service is an example of providing the best service to patients, allowing them to have a timely discharge to accommodation that meets their needs, offering support and assistance with rent and to purchase furniture packs etc, while actually saving money for hospitals. However, funding uncertainties also have a knock on affect on capacity. The size of the team limits the number of patients or customers that can be worked with at any one time. When exploring the possibility of extending the project it is limited by team capacity, along with the lack of available private and social rented accommodation, which can limit the service's ability to assist patients who are homeless or have no suitable home to return to and extends the time taken to resolve the situation.

Robust performance monitoring and reporting is essential in being able to demonstrate the impact of the project to health and social care, generating 'buy-in' and positive engagement to funding.

Lastly, everyone must adopt a flexible approach. Our staff are willing to work innovatively and pragmatically to resolve issues and find solutions. But embedding a new project like this in a busy hospital setting or across different District authorities can take time and tenacity but once people begin to see results and benefits, it can go from strength to strength.

Note

The views expressed in this paper are those of the author, and not necessarily those of the Housing Learning and Improvement Network.

About the Housing LIN

The Housing LIN is a sophisticated network bringing together over 40,000 housing, health and social care professionals in England and Wales to exemplify innovative housing solutions for an ageing population.

Recognised by government and industry as a leading 'knowledge hub' on specialist housing, our online and regional networked activities:

- connect people, ideas and resources to inform and improve the range of housing choices that enable older and disabled people to live independently
- provide intelligence on latest funding, research, policy and practice developments, and
- raise the profile of specialist housing with developers, commissioners and providers to plan, design and deliver aspirational housing for an ageing population.

For information about making the connection between health and housing, visit the Housing LIN's dedicated 'Health Intel' at: www.housinglin.org.uk/Topics/browse/HealthandHousing/

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