**Rotherham Tenancy and Housing Support Service Specification**

**August 2024**

**National/local context and evidence base**

**Homelessness Reduction Act 2017** – particular focus for local authorities to help prevent the homelessness of all families and single people regardless of priority need.

An **integrated care and support system** with the needs of the patient as the focus with local and community based services in the driving seat.

**Housing related support** to deliver positive outcomes with vulnerable people they support based on: reducing homelessness and personal resilience and coping.

**Social value** - Social value has been defined as “‘the additional benefit to the community from a commissioned service”. Work and skills should be embedded into all commissioned services.

**The Rotherham joint health and wellbeing strategy**

With key aims:

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| --- | --- | --- |
| Aim 1: | All children get the best start in life and go on to achieve their potential. | *x* |
| Aim 2: | All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life. | *x* |
| Aim 3: | All Rotherham people live well for longer. | *x* |
| Aim 4: | All Rotherham people live in healthy, safe and resilient communities. | *x* |

**Rotherham Adult Social Care**

**The Councils vision for adult social care in Rotherham is**

*‘We will act together to support the residents of Rotherham to live full active lives; to live independently and to play an active part in their local communities’.*

Housing related support services supports other health and social care related issues such as substance misuse, debt, mental health problems to name but a few.

**Service Objectives and Outcomes**

The purpose of the tenancy & housing support scheme is to be used flexibly across system partners to facilitate swift discharge and resettlement into the community e.g. housing brokerage lead, peer support, bond contributions, tenancy environmental investment, voluntary sector support, etc… This service will include provision for all adult inpatient wards based at Swallownest Court where eligible patients are identified.

The aim and objectives of the scheme are to provide housing related support to inpatients deemed as vulnerable.

The service will support those who currently have housing related problems and are currently unable to move on from hospital for these reasons. The officers will provide support, care and a housing management service with the aim preventing issues such as homelessness and social exclusion.

a) It shall provide housing related floating support to this vulnerable patient cohort.

b) It will help people who are struggling in being discharged to a home environment due to issues with maintaining a stable home

c) It is intended to be a short-term service which aims to give individuals the skills and confidence to be able to be discharged and live independently, avoid tenancy problems.

d) Time scale and level of intervention to be agreed at point of referral and/or during assessment period. It might be needed for a wide range of reasons and should be personalised to address the issues that our inpatients are facing.

e) The following is not an exhausted list of housing related support activity:

* Where possible to return to the service users principle home supporting to ensure it is safe and habitable, addressing issues such as utilities, environmental, food, support networks etc.
* Address repairs, liaising with the landlord on the service user’s behalf.
* Sort out rent arrears, debt, and budgeting, maximizing income.
* Advice and advocacy to housing related tenancy matters.
* Securing suitable housing /accommodation for service users who are homeless or where their current housing provision no longer meets the service user’s needs.
* Resettlement support, e.g. setting up on the tenancy, utilities, furniture etc.
* Helping people understand their rights and responsibilities.
* Make appropriate referrals to other agencies.
* Connect service users with the wider community networks.
* Address isolation and wellbeing in context of the service specification.

f) When an intervention is offered at the point of discharge. The patient will be followed up by the service for a maximum of two weeks. The outcome of the follow up to be shared with the responsible community mental health team and if none the General Practitioner.

The interventions will be short term and timely interventions and will be needs led as outlined above.

**Benefits**

* Improved individual health and wellbeing.
* Reduce hospital readmission due to housing needs.
* Engaged in working skills and employment.
* Tenancy achievement, sustainability or resolution to issue.
* Greater independency and life skills.
* Reduced re-offending or offending behaviour.
* Improved quality of life.
* Support plan to be shared with care team within 5 working days.
* Outcome of assessment to be shared with care team within 2 working days.

**Provider responsibilities**

**Acceptance Criteria:**

**Individuals who are**

* Aged 18 years or above
* Have a need for 'housing-related support' to prevent homelessness, ether as a prevention, urgent intervention or resettlement. If an individual is awaiting a Care Act Assessment, then there is to be a communication and follow up plan with both The Provider and RMBC on progression of housing needs and responsibilities.
* Have the potential and the capability to achieve the desired outcomes within the short-term provision of the service expectations
* Have a willingness to engage in support
* Have a local connection with Rotherham, unless they are at risk of violence or abuse in the district of the housing authority they reside and have taken all reasonable steps to mitigate or prevent this occurring such as:
	+ - * 1. Been employed in the area
				2. Close family members living in the area (the definition of “family” is used in the Homelessness code of Guidance for Local Authorities)
				3. Been (at any time) provided accommodation in Rotherham under section 95 of the Immigration and Asylum Act 1999
* Where a referral does not meet the eligibility criteria the services should signpost to other support options and liaise with Housing Solutions.
* Where a service user is borderline as being deemed to meet Vulnerable Adults criteria the service should have a wider discussion and liaise with commissioning officers.
* RMBC has the discretion to over-ride the local connection. Where an applicant is considered to be vulnerable and at risk of homelessness The Provider will discuss this with Commissioning services without delay.

**Interdependencies with other services/providers**

* Wider community supports
* Voluntary sector organisations
* Other organisation, as appropriate
* RMBC social worker scheme

**Outcome Measures**

The Provider will adopt appropriate monitoring systems from the outset to keep accurate and up to date records, to measure and monitor the success of the service against the targets and service aims and objectives. Evaluation of success will be completed by RDaSH and The Provider.

Service led outcomes:

* Decrease ward bed capacity and delayed discharges of care
* Utilisation of service by number of accepted referrals
* Throughput
* Resolution of housing related issues in a timely fashion
* Readmission rate or failed discharge
* Discharge follow on outcomes

By:

Collation of performance data by The Provider for throughput, number of referrals, resolution of housing related issues and discharge follow on outcomes. RDaSH for bed capacity, delayed discharges and readmission/failed discharge details.

Service user led outcomes:

* Improved individual health and wellbeing.
* Reduce hospital readmission due to housing.
* Engaged in working skills and employment.
* Tenancy achievement, sustainability or resolution to issue.
* Greater independency and life skills.
* Reduced re-offending or offending behaviour.
* Improved quality of life.
* Support plan to be shared with care team within 5 working days.
* Outcome of assessment to be shared with care team within 2 working days.

By:

Collation of qualitative measures including questionnaires, case studies, partnership meetings, incident reporting (Including the number of safeguarding alerts made) and employment information by The Provider.

Outcomes to be reported to RDaSH on a quarterly basis until the contract end.

**Provider Reporting**

**Key Performance Targets**

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| --- | --- | --- | --- | --- |
| **Ref**  | **Performance Requirement** | Threshold | Method of Measurement | Monthly or annual application of consequence |
| **KPI 1** | Referrals received that are appropriate for the service are accepted. | Standard is:>98% acceptance | No. of referrals received by ward.No. of referrals accepted by ward. | Quarterly  |
| **KPI 2** | Breakdown of number of patient discharges and interventions for each ward. | Standard is:>20 discharges per quarter | No. of discharges by ward. No. and Type of intervention by ward.  | Quarterly  |
| **KPI 3** | Support plan to be shared with care team within 5 working days. | Standard is:>95% within 5 working days | No. of care plans shared with care teamNo. of care plans shared with care team within 5 days | Quarterly |
| **KPI 4** | Outcome of assessment to be shared with care team within 2 working days  | Standard is:>95% within 2 working days | No. of outcome of assessments shared with care teamNo. of outcome of assessments shared with care team within 2 days | Quarterly |
| **KPI 5** | No. of delayed discharges due to housing | Standard is:<5% of discharges delayed due to housing | No. of dischargesNo. of delays due to housing | Quarterly |

**Local Quality Requirements**

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| --- | --- | --- | --- | --- |
| **Quality Requirement** | **Threshold**  | **Method of Measurement**  | **Period over which the Requirement is to be achieved** | **Applicable Service Specification** |
| Case study examples – Pen portraits | N/A | N/A | Quarterly |  |
| Patient Experience Feedback | 95% Excellent/Good experience | Patient Feedback Survey | Quarterly |  |

**Appendix A**

**Proposed Crisis Alternative Admission/Discharge Process**

**Access/Referral**

Referral process to be promoted by The Provider association with daily contact to the acute adult mental health inpatient wards either in person or by telephone. The RDaSH Rotherham Care Group (RCG) staff from the acute adult mental health wards based at Swallownest Court will refer on a referral form to a secure email address during the operating hours of 9am-5pm Monday-Friday (excluding bank holidays).

The referral will be screened, acceptance of the referral will be confirmed within 2 working days by The Provider housing support worker to the referrer and this will be documented on the RDaSH electronic patient record by RDaSH ward staff. Referrals to contain information on clinical risks, and key areas identified for support needed. A consent disclaimer will be included on the referral form.

An agreement of approximation of length of assessment and intervention to be agreed at point of acceptance.

Once a referral is accepted, The Provider staff will complete holistic assessments which will be utilised to identify the full range of individual needs including housing related support and wider support needs.

Where wider support needs are identified The Provider will ensure necessary referrals are made.

Upon assessment the patient will be requested to provide written consent for a data sharing agreement between parties.

There will be regular (twice weekly) updates on patient progress and a progress report recorded in RDaSH electronic patient record (TPP SystmOne). The Provider will attend weekly Clinically Ready for Discharge (CRFD) meetings with the ward managers and patient flow team to share progress. A formal weekly report will be sent to the ward manager/deputy ward manager.

RDaSH will look to support The Provider member of staff to be able to access the electronic patient record system as per Trust policy so that the member of staff can ensure entries are made in the patients’ clinical record.

The Provider staff will be required to ensure contemporaneous records are maintained, recording updates on progress so that these can be shared with the wider MDT.

**Population covered**

This service specification covers the delivery of service to those individuals for whom NHS Rotherham CCG is the responsible commissioner, as outlined in the NHS England guidance, “Who Pays? Determining responsibility for payments to providers” (August 2013) and later SharePoint guidance.

**During stay**

The Provider will produce a support plan in consultation with the service user with a clear goal to achieve independent living and a reduced dependency on formal care.

The Provider will follow the agreed discharge support pathway detailed in Appendix B working with external providers where identified.

**Discharge**

**Discharge plan from ward will need communicating with housing officer**

* Service exits must be planned and agreed with service users. The service user will be provided with access to key contacts and who to contact if there is an emergency
* This service is a short-term provision. There is an expectation that the service will actively work with people to achieve independence and exit from the service.
* The Service will undertake checks after the service user has exited support to check on tenancy sustainment and wellbeing of service users.
* The Service will contact ex-service user’s 2 weeks after discharge.
* The responsible mental health professional (Care Coordinator/Lead Professional) in the community MH team or GP when none identified to have a shared copy of the exit plan from The Provider.

**Monitoring process**

* RDaSH to review the service provision on a regular basis and to ensure that the requirement is being met. Clear channels identified for escalation of any operational issues with leads from the provider and RDaSH present.
* Any issues with the provision of this service are to be raised with RDaSH Leads.

**Appendix B**

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