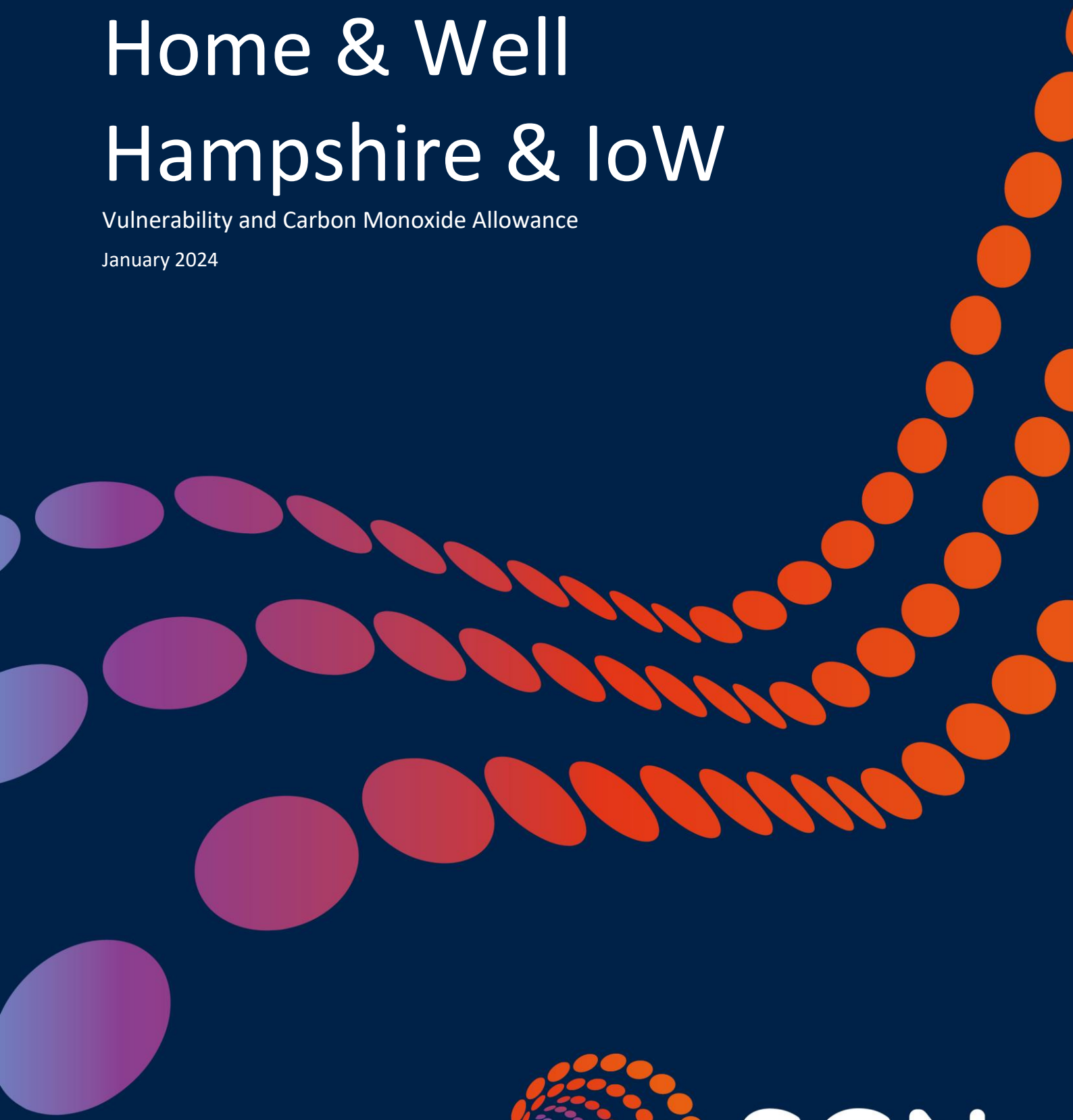
Home & Well Hampshire & IoW

Vulnerability and Carbon Monoxide Allowance

January 2024



SGN

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Contents

1 Description

Project title	**Home & Well Hampshire & IOW**
Funding GDN(s)	**SGN**
New/Updated (indicate as appropriate)	**Updated**
Date of PEA submission:	**January 2024**
Project contact name:	**Kerry Potter**
Project contact number/email:	Kerry.potter@sgn.co.uk
Total cost (£k)	£1,330,855
Total VCMA funding required (£k)	£565,995

2 Problem statement

UK's energy prices have been reported to have almost doubled since 2021, it's currently estimated that there are over 6.7 million households living in fuel poverty in the UK. Nearly half of low-income households are still living in hard to heat homes, and the rate of improvements is well below what is needed to lift people out of fuel poverty by a target date of 2030.

Cold homes and poor housing conditions have been linked with a range of health problems in children and young people, including respiratory health, growth and long-term health. In older people, cold temperatures increase the risk of heart attack, stroke and circulatory problems, respiratory disease, flu and hospital admission. They also lower strength and dexterity, leading to an increase in the likelihood of falls and accidental injuries. Home temperatures also have implications for mental health because cold is linked with increased risk of depression and anxiety.

Cold homes have a negative impact on our NHS resources due to people taking longer to recover from illnesses, particularly those recently discharged from hospital.

The UK's health service is stretched and under increasing pressure. More people than ever before are being admitted to hospital, staying longer, and are being re-admitted as they are unable to maintain healthy independence. Since 2006, the total annual number of hospital admissions has increased by 28.1%, from over 11 million admissions in 2006/07 to over 14 million admissions in 2015/16. In February 2023 there were between 13,000 and 15,000 patients remaining in hospital each day who did not meet the criteria to reside. The graph below shows the weekly bed occupancy data over the past 5 years.

Hampshire & IoW ICB are reporting that occupancy rates across the system are high, in excess of 95% (operating target is 85%). Ongoing work streams continue to improve flow throughout the 8 trusts and ensure patients do not stay in hospital for any longer than absolutely necessary. Flows into and out of hospitals are pivotal. Delays in discharging patients are impacting admissions and ambulance handovers, causing waits for those needing care in the Emergency Department or waiting for a hospital bed. Demand in the Emergency Department remains high, with 4 hour breaches the highest seen, resulting in the lowest 4-hour attainment, throughout September Hampshire & IoW ICB sat at just 55.52%, the lowest aggregate month seen.

Nationally published data showed Hampshire and IoW ICB had 611 patients who no longer met criteria to reside (CRT), but at the end of the day had not been discharged from a hospital bed, this accounts for 20% of total occupied beds at the moment on average at any one time. This was the worst regionally, accounting for almost 30% of all regional non-CTR patients. Nationally Hampshire & IOW ICB sit 3rd out of 42 ICBs highlighting that this community requires additional focus and support.

Data shows that patients staying longer than 7+ days account for over half of our occupied beds. Non-CTR cohort over 21 days is growing at a faster rate, averaging 311 in October, up notably on levels seen in the summer, and now accounting for 9% of system beds:

- 27% of our non-CTR cohort with LOS over 14 days were awaiting resource for start of a care home placement
- 25% were awaiting a rehab bed in community hospital or other bedded setting
- 16% were awaiting a permanent nursing home placement

Citizens Advice Hampshire have completed a recent review of need, and what they are seeing is a significant change in who requires help. In a comparison of Q1 2021-22 with Q1 2022-23 the percentage of people with long term health conditions including those with disabilities that sought support from Citizens Advice increased from 45% to 51%.

It is understood that the cost-of-living pressures are worse felt in these more deprived areas and by people within vulnerable groups, as they are more likely to be socially and/or digitally excluded and unable to resolve issues by themselves.

The cost-of-living crisis has exacerbated pre-existing intersectional exclusions related to ethnicity, gender, language, or disability, this has been where we have seen vulnerable customers experiencing greatest hardship. Figures from the Department for Business, Energy and Industrial Strategy show 42,161 households in Hampshire were in fuel poverty in 2021.

3 Scope and objectives

Home & Well has the aim of engaging and supporting patients awaiting discharge, or those identified as facing a barrier to positive health outcomes due to living in or returning to a cold unhealthy home. The team are linked in with the NHS services in hospitals, Social Prescribers and other voluntary sectors to help people achieve a safe, affordable and warm home.

The ambition of the partnership is to achieve a reduced hospital stay, reduce the number of hospital readmissions and increase the health and wellbeing of the patient by addressing the financial costs of essential services including utilities, rent and food, and the social isolation by linking people up to appropriate wellbeing services.

This partnership was established in 2020 and brought together Citizen Advice Hampshire, the regional utility networks and Southampton & IoW Partnership of Clinical Commissioning Groups to deliver an in person, on-site wrap-around service that helps vulnerable patients address the challenges and barriers they face in returning to a safe and warm home. This client group, often located in hospitals and in Primary Care settings, can present with energy and poverty related needs and/or require advice or signposting for their social/wellbeing needs. The Home and Well service aims to equip vulnerable people with the necessary support to live safely and independently.

Since launching the partnership in 2020 the team have grown to provide a county level partnership that provides dedicated Home and Well advisers in three hospitals with teams based on the Isle of Wight, Gosport, Havant, Portsmouth and Southampton.

In addition, the team will support the 15 regional Citizens Advice teams to support and provide services via telephone, email, webchat and in person in the clinical environment to ensure that each patients' needs are met using the extensive skills of the broader group.

This blended delivery model of in person and remote support, including support for hospital discharge teams will be expanded as restrictions are lifted, we will pilot and evaluate the use of tablets at scheduled times to try and maximise Home and Well's reach for remote and face-to-face Home and Well support countywide.

The partnership will deliver:

- A dedicated 'utility' team of Home & Well experienced Citizen Advice client advisors across 15 regional CA offices and clinical environments with the skills to provide utility services not limited to industry initiatives, including; PSR, Warm Home Discount, Winter fuel payments, emergency crisis funds for those in energy crisis, debt support, information on smart meters, gas safety, Locking Cooker Valves, and who to contact in an emergency (0800 111 999 and 105)
- A joined-up service between NHS and Citizens Advice Home & Well team to support those in primary and secondary care (clinical / social prescribing) with barriers that impact independent living, especially those linked to essential services (energy, water, housing and food) with the outcomes of improving the quality of people's lives, their mental, physical, and financial wellbeing.
- A broader social impact as we alleviate the pressures on the NHS, avoiding the need to use hospital services and where needed transitioning to in home services
- A robust network of regional and relevant secondary key partnerships to ensure health and wellbeing services are specific and local to client need – current network includes Age Concern, Age UK Portsmouth, Gosport Food Partnership, Gosport Voluntary Action, Solent Mind, Help in Bereavement, Walking for Health, and carer and regional care support teams.

4 Why the project is being funded through the VCMA

This partnership service goes above and beyond our core responsibilities as a Gas Distribution Network and is eligible under the VCMA funding criteria as it will provide energy crisis support, access to energy efficiency and CO advice, empowering vulnerable households to use energy safely, efficiently, and affordably.

This partnership aligns to SGNs commitment to deliver support services customers aligned to our shared four strategic pillars:

1. Services Beyond the Meter
2. Supporting Priority Customer Groups
3. Fuel Poverty & Energy Affordability
4. Carbon Monoxide Awareness

This project aligns to strategic pillar 2 as its focus is on supporting those with health conditions made worse by living in a cold and unhealthy home and those who are financially vulnerable. In addition, the partnership aligns well to Pillar 3 and Pillar 4 for its broader community engagement providing both energy advice services and carbon monoxide awareness sessions and alarm provision.

5 Evidence of stakeholder/customer support

5.1 Home & Well – Stakeholder feedback

Tim Cooling, Head of Strategy, Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups said, "*The Home & Well service continues to provide an important and timely intervention to keep people safe and well at home following a stay in hospital. With concerns about the overall cost of living the service is well placed to offer the right help at the right time, so It's been great to see the scheme expanded across more hospital sites allowing more residents to benefit from the support. One of the core ambitions for us as a new Integrated Care System, and as partners working together, is to tackle health inequalities and the Home and Well service supports this ambition by equipping vulnerable people with the necessary support to live safely and independently.*

The ICB has some key objectives when it comes to enabling people to return home safely with appropriate interventions which include reducing length of stay in hospital and increasing the number of people who are

discharged to their own homes. Over 20% of people in hospital are deemed fit to go home but for a variety of reasons don't have the right support at home. The Home and well service is helping us to meet these objectives by providing a valuable wrap around offer supporting individuals with debt advice, benefits and issues with housing and utilities. Importantly, by ensuring that vulnerable people are signed up to the Priority Services Register means that those who need access to power and water as part of their health recovery needs are given additional support. The planned expansion of the service across Hampshire is welcome news and means that Home & Well will be able to support increasing numbers of vulnerable people who might otherwise have been at risk of having additional complications with their recovery. With increasing demand on hospital beds, we need to support community solutions that enable people to stay well and avoid preventable hospital admissions."

5.2 SGN GD2 Business Plan – Stakeholder feedback

In developing our GD2 business plan, we committed to supporting over 250,000 vulnerable customers to use gas safely, affordably and efficiently over the 5-year price control period. In July 2023, following extensive engagement with strategic stakeholders, we extended our ambition to support 500,000 customers in vulnerable circumstances with an enhanced focus on supporting those impacted by living in fuel poverty.

5.3 Vulnerable Steering Group (VSG)

Throughout GD2 our dedicated Vulnerable Steering Group has helped us shape our vulnerability strategy and our priorities to ensure that we meet our Business Plan commitments to support vulnerable customers, those most in need of support to maintain a safe and warm home. It is with guidance and support from our dedicated Vulnerable Steering Group that SGN has a clear approach to delivering support to vulnerable customers, ensuring that we're targeting priority customer groups and working in geographic areas most likely to be living in cold and unhealthy homes.

The Home and Well partnership has a track record of supporting the priority customer groups – those living with critical and long-term health conditions. This scheme is co-designed with Citizens Advice Hampshire, NHS, Scottish and Southern Electricity Networks, Southern Water, South East Water and Portsmouth Water to provide tangible support from the health care setting into a safe and warm home. This approach has been endorsed by our strategic panel as it looks to provide a holistic and empowering service in partnership with other utilities.

5.4 Customer Engagement Group 2019/20

Shaping our business plan to support customers in vulnerable circumstances we have committed to, over the 5-year price control, supporting over 250,000 vulnerable customers to use gas safely, affordably and efficiently. We have a three-tiered approach and tier 1, 2 and 3 priorities include providing independent support to help vulnerable customers with access to affordable energy.

5.5 Warm Bods - warming the person not just the home

Working with South East Hampshire' ICB Home & Well was asked to support the distribution of winter warm packs (which include hat, scarf, torch etc) as well as electric blankets. The aim of the packs is to warm the person, not the home. The funding is to address health inequalities in the local system. As well as addressing inequalities, this project also seeks to promote personalised care, by linking with relevant components of the model, particularly those that promote choice and supporting people to facilitate self -management of their health and links to community-based support and social prescribing.

6 Outcomes, associated actions and success criteria

6.1 Outcomes

The Home & Well partnership will work collaboratively to support 5,000 vulnerable people return to safe and warm homes per year across Hampshire and the IOW. The partnership will be embedded within the health care setting working closely with health care workers, consumer advocates and utility company representatives to

address the barriers patients face to going home and re-admission. The Home and Well project provides the following outcomes.

More patients will:

- Be supported by their utilities Priority Services Register - providing them with the security and support they would need in the event of an unplanned outage
- Be able to manage and pay their own utility bills going forward and avoid going into debt
- Be more aware of the risks of Carbon Monoxide and how to mitigate these
- Be more healthy and warm - particularly during the winter period and/or when being discharged from hospital
- Have reduced stress, improved health and wellbeing, and therefore better life chances/quality of life
- Be more able to cope at home

The Home and Well project provides the following outcomes. The partners will:

- See a reduction in the length of hospitalisation periods
- See a reduction in the number of readmissions
- See eligible vulnerable customers represented on their respective PSR's enabling utility companies to proactively support those most vulnerable with utility matters
- See an increase in household income

6.2 Success Criteria

We aim to support on average 2,500 patients each year from the clinical environment into independent living by addressing the issues that would prevent them from returning to a safe and warm home long term. We aim to support those in need with access to practical help that improves their health and wellbeing and increases their confidence to manage their household utility costs.

Provide a dedicated Home and Well Citizens Advice team who offer the following support services to patients in need of additional help to be discharged from the clinical environment to a safe and warm home;

- Patients offered the support to assess eligibility and sign-up to the PSR with an expectation of 60% registration
- Patients offered energy advice including information about who to call in an emergency, smart meters, Winter Fuel Payments, Warm Homes Discount, information on tariffs and energy / water efficiency
- Patients assessed as to whether they need crisis support to manage energy or water debt, and where eligible provided with access to emergency fuel vouchers, and heated blankets where suitable and onward support for food and wellness services (2,000 £25 fuel vouchers / 500 blankets)
- Patients offered information on gas safety including access to a free Locking Cooker Valve or a carbon monoxide alarm (250 CO Alarms)
- Patients will be offered support to access affordable warmth schemes where appropriate with an onward referral to assess for energy efficiency scheme eligibility including the FPNES
- Patients assessed for income related benefits, and supported where eligible for debt support in increase household financial resilience
- Health service outcomes, with reduced readmissions, faster discharge rates

To monitor our impact in line with the above, we will:

- Monitor patient outcomes against services provided, patient demographics, vulnerabilities and needs
- Build in targeted, concise questions to our post service patient survey
- Work closely with our partners to ensure that we all understand the issues faced by patients enabling us to continue to develop our services by need
- Monitor the impact on hospitalisation times, re-admissions and the number of GP visits

7 Project partners and third parties involved

- Citizens Advice Hampshire – programme lead and lead delivery partner providing the advisory teams in the clinical environment and the support services to patients.
- Hampshire and Isle of Wight Integrated Care Board (ICB) – lead NHS representative and co-founder of the partnership, identifying and referring patients who would benefit from the support services team.
- SGN – lead gas network providing funding and support to the delivery team, including training, access to broader referral partners, and direct services for customers including but not limited to Locking Cooker Valves, CO alarms and access to the Fuel Poor Network Extension Scheme.
- SSEN – lead electricity network providing funding and support to the delivery team, including training, access to broader services, and access to the energy Priority Services Register.
- Portsmouth Water & Southern Water – regional water network providing funding and support through the water sure teams on social tariffs and the water PSR.
- Broader referral partners include Fire and Rescue Services, Age UK, NHS England Social Prescribers, Gosport Health and Strategic Wellbeing Partnership, Gosport Food Partnership, British Red Cross, Royal Voluntary Service, Stroke Association, Mind Charity and others.

8 Potential for new learning

Monitoring and evaluation

The following activities will be in place to monitor and evaluate project progress and impacts:

- Quantitative and qualitative service user outcomes and demographics/vulnerabilities recorded/monitored
- Service user before-and-after-support surveys and follow-up calls
- In-bound and out-bound referrals from/to partners and other services recorded/monitored
- Feedback, indicators, outputs and outcomes reported on quarterly
- Project progress monitored: these include monthly and quarterly partner meetings to share ideas and challenges through individual and organisational partnership case studies.

Learning

We are keen to learn from this project and for successes to be incorporated into future delivery as well as promoted to others both in the Citizens Advice network and to broader stakeholders. Good practice is shared between advisors and regular monthly newsletters are shared with all stakeholders including case studies of clients and how they have been helped. We intend to share an annual report across electricity, gas and water networks and the ICB's in addition to sharing project impacts and case studies during a showcase event. In addition to networking, the project offers learning opportunities across stakeholder organisations which result in an improved understanding of clients' needs. It also enables stakeholders to hone interaction with clients giving a better client experience.

9 Scale of VCMA Project and SROI Calculations, including NPV

We worked with leading social impact research consultancy SIA Partners to carry out an assessment of the financial and wellbeing outcomes applicable to our services for vulnerable customers incorporated in this partnership. Carrying out an in-depth assessment of the predicted outcomes we forecast a positive net social return on investment (SROI) of £3.45.

Total cost	£537,735.99
Total gross present value	£2,395,006.08
Net Present Value (NPV)	£1,857,270.09
SROI	£3.45

10 VCMA Project start and end date

The project will run from 1st October 2023 – 31st March 2026

11 Geographic area

The service will support customers in Hampshire and the Isle of Wight with a key focus on Isle of Wight, Gosport, Havant, Portsmouth, East Hampshire, Basingstoke, Winchester and Southampton where there is the greatest need in the NHS services.

12 Internal governance and project management evidence

SGN has worked alongside the partners to co-design this partnership and ensure that its ambition contributes to the delivery of our Vulnerability Strategy, the guidance from our Vulnerable Customer Steering Group and adheres to the updated VCMA governance criteria.

The SROI has been externally assessed by SIA Partners using the DNO / GDN common methodology, this includes a review of the last three years of delivery of the Home and Well partnership.

To support the partnership to deliver the success criteria outcomes as detailed, the partners already meet weekly to review partner challenges, and monthly and quarterly to review outcomes, learn, share best practices, and address any delivery issues.

The PEA has been reviewed and approved by the business lead Kerry Potter and the Director of Customer Services Maureen McIntosh.