HOUSING & SOCIAL CARE SCRUTINY PANEL

MINUTES of the meeting of the Housing & Social Care Scrutiny Panel held on Thursday, 7 November 2013 at 10.00 am in the executive meeting room, floor 3 of The Guildhall, Portsmouth.

Present

Councillor Sandra Stockdale (in the Chair)

Councillors Steven Wylie
Margaret Adair
Michael Andrewes
Lee Mason
Mike Park

41. Apologies for absence (AI 1)

None.

42. Declaration of Members' Interests (AI 2)

None.

43. Previous Minutes - 11 October 2013 (AI 3)

Further evidence had been provided by Adult Social Care and the Integrated Commissioning Unit in response to the presentation by the Sheltered Housing Manager; this was circulated but members wished to have more time to give consideration to this so it would be brought back to the next meeting.

Alison Croucher, the Sheltered Housing Manager, had further information regarding case studies that could be considered in more depth at the next meeting too.

RESOLVED that the minutes of the meeting held on 11 October were agreed as a correct record.

44. Review - Hospital Discharge Arrangements (AI 4)

a) Karen Wigley and Cathryn Francis - Role of PCC's Occupational Therapists (OTs)

A paper was circulated at the meeting regarding the role of the Council's OTs in the hospital discharge process. It was reported that there are also OTs employed by Solent NHS Trust and by Hampshire Partnership Trust co-located at the hospitals.

There are currently 12.5 full time equivalent OTs in the Adult Social Care community fieldwork teams. They operate on an open referral system for Portsmouth residents. The backlog/waiting list is being addressed.

Out of City Hospital Discharges - Clients also discharge from hospitals outside Portsmouth. Salisbury and Stoke Mandeville hospitals deal with very traumatic injuries, the latter being specialists for spinal injury - requiring long stays in hospital for life-changing conditions, which may further require changes to the home accommodation.

Comprehensive multi-agency working is needed to facilitate safe and timely hospital discharge.

Possible obstacles to timely discharge from outside of the city are:

- Distance between out of city hospital and residents home
- Previous private rental accommodation is not suitable for a wheelchair user or person with impaired mobility and client is essentially homeless
- Poor communication between hospital and community team
- Major adaptations are required to property
- Bespoke specialist equipment is required for discharge
- Delay in wheelchair provision
- Changing financial circumstances
- Limited suitable wheelchair accommodation available in the city
- Appropriate psychological support unavailable on discharge

Portsmouth Discharges - Most of the above can also be applicable to discharges from Portsmouth hospitals. There are variations of OT input; medical discharges should be referred through the Portsmouth Rehabilitation and Reablement Team (PRRT) team who have a number of resources available to support discharges and provide ongoing rehabilitation such as the Grove Unit and Victory Unit. F1, surgical and orthopaedic ward based staff should refer to Hampshire Partnership Trust OTs to plan discharge, Spinnaker ward should refer to Solent NHS OTs. The key to all discharges is timely referrals and good communication.

Accommodation Resources Available

Some discharges will require major adaptions and it was reported that there is limited wheelchair specific accommodation in the city. PCC has 6 rehab flats in the city, only one of which, Arundel Street, is fully adapted for a full time wheelchair user. Clients are supposed to use the flats for a maximum of 12 weeks to continue their rehabilitation and confirm their housing requirements following discharge from hospital. All are continually used, and there are usually used for a maximum 12 week period. A major obstacle to their effective use is the lack of suitable wheelchair accommodation for the client to move on to, leading to "blocking". Due to the economic climate there has been

a lull in the number of new builds and this has impacted on the building of disabled persons units. There has been no new one bed Disabled Persons' Units (DPUs) completed this year although some are due for completion in 2014. Their colleague Karen Grose is involved in the designing of wheelchair adaptations on new build sites, such as the Dame Judith site in Cosham.

An impact from the welfare reforms ("bedroom tax") has been the increased the difficulty in PCC's ability to house single people. Most of the DPUs have previously been 2 bed units and single people are no longer able to afford the tenancy. The need for more single bedroom adapted accommodation has been reviewed. There is temporary accommodation in PCC's tower blocks but these have non-accessible bathrooms, which will impact on car and equipment requirements and this restricts the clients who can be accommodated in them.

Disabled Facilities Grants (DFG)
Disabled facilities grants are available to residents in any tenancy or owner occupier accommodation, and the most common examples are for stair-lifts and ramps. Timescales from assessment to completion can vary enormously depending on the complexity of the work required, financial contributions and who the owner of the property is varying from 3 months to 12 months.
If a client is in hospital and currently open to an ASC OT, then the DFG application can be made as soon as the clients' needs are known. If the client is not open to an ASC OT, the request for an assessment will be prioritised and if non critical will be place on the OT waiting list.

Waiting times vary; they have been as long as 6 months. Currently there are 198 people on the waiting list with the longest waiting time being 67 days. An OT review has recently been undertaken with a view to reducing the OT waiting list through streamlining processes. This has seen an immediate effect in reducing waiting times. Safe discharges will be the responsibility of the hospital OTs, including PRRT, and this may require arrangements being made for downstairs living or temporarily living with a relative whilst waiting for adaptations to be completed.

DFGs are dependent upon the level of income and some delays are contributed to by waiting for the evidence to be provided. Housing Associations and private landlords need to give permission for adaptations to their properties. PCC's Housing Management department is quicker to give permission and secures the contractor to do the work.

Equipment Provision
Standard equipment is provided by the new jointly commissioned provider Millbrook and can be ordered by a variety of users including OTs, physiotherapists, nursing staff and trusted assessors.

Providing equipment is in stock, it should be available for same hour or same day delivery if urgently required. As costs are greatly increased as delivery

times are shortened, 7 day delivery is the usual option. Examples of equipment required for discharge are raised toilet seats, kitchen trolleys, profiling beds, hoists etc.

Minor adaptations, include, stair rails, grab rails door entry intercom systems, chair and bed raises etc. They cost under £1000 and are non-chargeable to the client. They are provided, on the recommendation of the OT, by Millbrook for clients living in their own or privately rented properties, by the appropriate housing association for HA tenants and by PCC contractors for council tenants. Housing Associations vary in their response times and a request for a stair rail takes on average 4 weeks.

Millbrook technicians inherited a historical backlog when they took over the service from PCC in July. At one time clients were waiting up to 6 months for minor adaptations. This has now been largely cleared and in theory timescales are supposed to be the same as for equipment.

Council minor adaptations are timelier and urgent requests can be done within a week. Minor adaptations are not achieved the same day.

Special Equipment
Clients need to be stabilised in hospital before special equipment can be measured for and quotes obtained. If the client is in an out of area hospital, the OT in hospital will be asked to arrange quotes on the ward. These are then forwarded to the PCC community OT who is allocated the case. Examples are bespoke shower/commode chairs up to £1200 and specialist seating £2000+.

If the client is dependent on this equipment for discharge, non-provision can cause delays in the discharge process. If equipment is in stores, provision can be within 7 days, bespoke equipment can take up to 10 weeks, which can be common for spinal injuries.

Case study with a positive outcome
Karen stressed that the are a high number of professionals working towards discharge including consultants, ward nurses, OTs, housing options, social care, the patient and their family - therefore good communication is essential to ensure that discharges are planned, all equipment, support and adaptations are in place and to ensure that the client can be discharged to a safe environment with successful outcomes. She gave the following example of a patient's history and interaction with agencies.

CASE STUDY - of a client under 40 admitted to Queen Alexandra Hospital with a stroke.

10 June - Hospital OT completed rehousing report- Unable to return home as living in an upper floor flat with no lift

24 June - hospital planning meeting on ward took place.
Those involved with the planning of the hospital discharge:

Consultant, ward nurse, OT, Physio, S&LT, Clinical Psychologist, SW, Housing Options officer, Housing OT, Relatives, PRRT, Stroke Association, Sheltered Housing Scheme manager, CSRT and Tenancy support.

8 July - Client was discharged to a rehab flat where they were given an opportunity for further rehabilitation and was able to demonstrate that they could return to independent living and hold a tenancy again.

25 July - A flat was subsequently offered to the client via the housing register. OT ensured that adaptation and equipment needs were met., and support continued by other members of the MDT team.

2 September - Client moved into their new property

Members Questions

It was noted that there were variations in the times taken for adaptions between Housing Associations; both Karen Wigley and Nigel Baldwin worked closely with PCC's Development Liaison Officer for Housing Associations.

It was asked if a simpler approach could be achieved: the number of different specialists involved for each discharge meant that this would be hard to deliver although the previous system of early interventions had advantages. Changes in personnel and distances travelled by staff could be disruptive but were generally unavoidable. Written procedures being in place were necessary to help with changes in staff.

The PRRT is a large, joint health and social care team - their processes may be reviewed by the City Council's Transformation Team.

The use of designated contractors by PCC had led to improvements and the OTs worked with all the PCC Housing offices so there should be a uniform service provided to all PCC tenants.

It was reported that PCC Housing Management is working on building 1 bedroom properties with extra space rather than a spare bedroom to help address the problems caused by welfare reform for residents requiring extra equipment storage. There was also close liaison with the Housing Associations to discuss their developments at a planning stage to make best use of the space, and for PCC to demonstrate the need for this type of accommodation. Lifetime homes standards are now required on new builds, whereas a lot of older Portsmouth properties were hard to adapt for accessibility. There is a significant waiting list of mobility units and it can be the children of the family who are disabled requiring such a property. A national consultation exercise is taking place on housing standards.

PCC ask the Housing Associations to accept direct referrals. They should be undertaking minor adaptations themselves. It was reported that First Wessex HA, one of the largest local housing associations, usually undertake major adaptations but it could depend on the timing within the financial year and they may need PCC to pursue a DFG.

The role of the discharge planner was explained - they used to have the responsibility to liaise with everyone. The OTs like to be invited to the discharge planning meetings, but sometimes the hospital based OT attends and it can depend also upon whether the patient is returning to their own home - if they are not, the OT may not be involved.

The panel would be interested in hearing more about discharge and re-admittance figures.

It was reported that the DFG budget had not been fully spent the previous year, which was unusual, but this could be partly due to the waiting list. With regard to patients waiting for adaptations to property leading to delays it was reported that minor adaptations are about safety and can delay discharge. Some major adaptations not being in place would not necessarily prevent discharge e.g. installations of showers.

The panel were interested in the case study of a good outcome but asked about examples of poor outcomes - reference was made to a case in Arundel Street rehabilitation flats where a move out had taken 6 months rather than the target of 6 weeks. In another case a patient had stayed at Salisbury hospital for 4 months due to the wait for proof of finances, which is out of the control of the local authority.

The age of clients for the OTs was 70% older persons. Many of the spinal injuries patients were young.

With regard to resources and issues beyond PCC's control it was reported that PCC and health use different IT systems, which leads to problems with reading case notes.

Their waiting list was currently 190; 200 had been allocated the previous month and improvements to duty systems had improved efficiency. Some Adult Social Care OT posts had been cut in the previous budget cycle.

Work was also taking place on 'virtual wards' as a Health and Social Care partnership to support people in their own homes, with 3 teams working in the city. There are weekly multi-disciplinary team meetings. The patients are living at home but being supported and are successful in dealing with those who are frequently in and out of hospital. There is also a link here to Telecare facilities (which were later explained by Nigel Baldwin).
An element of self-assessment and telephone call assessments where appropriate helped in addressing and prioritising the waiting list for OT assessments. Short term equipment can be put in place where necessary, such as commodes before toilets could be adapted.

Councillor Stockdale on behalf of the panel thanked Karen and Katherine for their very informative presentation and some of the information would be expanded on by Elaine Bastable at the next meeting.

b) Nigel Baldwin, Accommodation and Enabling Manager, explained PCC's private sector housing involvement in the hospital discharge process. There are various activities in Private Sector Housing which assist people to settle back into their home in the longer term after hospital or prevent them being admitted. Whilst the most immediate activity in relation to hospital discharge is *Telecare*, other activities include:

- Improving the warmth of properties - Green Deal assessments can be carried out - insulation - efficient boilers - draught proofing - loan of heaters temporarily to provide warmth.

- Referral to the ASC financial assessment team to ensure full income entitlement is received and there is involvement in the DFG process.

- "Homecheck" safety checks for people over 60, those with children under 5 and some disabled people (this can include help in identifying hazards to prevent tripping)

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- Occupational Therapists (Community based) refer for adaptations and changes (via the statutory Disabled Facilities Grants) to properties to allow independent living.

- Individual clients can ask for an assessment via the Housing Health & Safety Rating System (HHSRS). If high level hazards are identified the individual will be assisted to remove the hazard. The client will be assisted to do everything possible to remove the hazard in their home.

- If adaptations can be completed quickly then these may be completed to allow an individual to live in their home after hospital discharge if, e.g. they first go to live in a rehabilitation flat for a few weeks.

- In some circumstances Occupational Therapists (Hospital based) can request palliative adaptations - in these circumstances e.g. a reconditioned stair lift may be utilised for a short period of time and is given priority for installation.

Telecare & Hospital Discharge

The previous Scrutiny Panel review considered assistive technology and so in terms of the hospital discharge arrangements the Telecare equipment can provide means of raising an emergency response; it can provide reassurance to the individual and their wider support group and can increase the confidence of individuals following hospital discharge.

The number of customers utilising Telecare (as at 6.11.13) (non-sheltered) = 1059.

Referral system - The arrangement to use the alarm is with the individual service user, although referrals from professionals are welcome (the referral form was attached to the briefing note as Appendix A).

A variable number of referrals from professionals tend to be received on a weekly basis and usually the equipment can be installed within 2 - 3 days subject to a technician's availability. Especially for weekends and Bank Holidays some professionals think (mistakenly) that installation will occur within 24 hours. It would be quite unusual for this to happen and delays can occur for some of the following reasons:

- The need for responders has not been made clear to potential service users
- Referrals not having the appropriate access information or the form not being fully completed.
- Referrals being inappropriate where responders live too far way
- Referrals for people who do not live in Portsmouth
- The wider family for the individual may not share the same time scales as the hospital professional teams. The Telecare installation requires the co-operation of the wider family in most cases and an installation could not occur without someone appropriate being in attendance.

There are also issues of communications with members of the wider family e.g. on knowledge about the Telecare provision; whether it is a short term or long term solution etc.

There is a constant requirement for referring hospital professionals to become familiar with the technology that they are discussing with people so that everyone understands what can happen and that this is a long term support not just a short term solution for discharge purposes. Increasingly the Telecare team is contacted by individuals and their families who are interested in Telecare, who have first heard about the technology from a hospital professional. The OTs also publicise and explain the role of Telecare to the health professionals, Telecare's promotional DVD is used.

Referrals are received from a wide variety of sources; approximately 24% of referrals during 2013 to the end of September have come from hospital information of various types, such as leaflets placed in wards.

OT involvement - from the autumn of 2013 the Private Sector Housing Telecare team has been joined by an Occupational Therapist on secondment, whose role is to promote Telecare particularly amongst social care clients and also to ensure that people`s personal circumstances are assessed in terms of Telecare.

Delays could be caused if people do not have appropriate responders, or if forms were not completed properly. The PCC Telecare service is for

Portsmouth residents (and 40 PCC tenants in the Borough of Havant who have a historical link to Portsmouth), whereas the Portsmouth hospitals serve a wider community.

Accommodation Strategy - this helps identify housing need in the City. New housing accounts for approximately 1% of local housing each year. The Private Sector Housing Team negotiate with developers regarding affordable housing quotas and the delivery of extra care provision. An example of specialist new provision is Caroline Lodge in Portsea which includes disabled units.

Councillor Stockdale, as Chair, thanked Nigel for his interesting presentation.

45. Date of Next meeting (Al 5)

A provisional date of 12th December at 10am was raised but was dependent upon the availability of the main witness for the meeting, Elaine Bastable to talk about Housing Allocations. Subsequently this date was changed to 11th December at 1.30pm to enable the witness to attend. The extra evidence circulated, as referred to in minute 43, would also be considered at that meeting.

The meeting concluded at 11.45 am.

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Councillor Sandra Stockdale
Chair of the Housing and Social Care Scrutiny Panel