HOUSING & SOCIAL CARE SCRUTINY PANEL

MINUTES OF THE MEETING of the Housing & Social Care Scrutiny Panel held on Friday, 11 October 2013 at 2.00 pm at the Conference Room A - Civic Offices

Present

Councillor Sandra Stockdale (in the chair)

Councillor Margaret Adair
Councillor Michael Andrewes
Councillor Mike Park

36. Apologies for Absence (AI 1)

These had been received from Councillor Steve Wylie who was unwell.

37. Declaration of Members Interests (AI 2)

There were no declarations of members' interests.

38. Previous Minutes - 12 September 2013 (AI 3)

(TAKE IN MINUTES OF 12 SEPTEMBER 2013)

The minutes of the meeting held on 12 September 2013 were approved as a correct record.

RESOLVED that the minutes of 24 June 2013 be agreed as a correct record.

39. Review - Hospital Discharge Arrangements (AI 4)

a) Claire Budden, the Senior Programme Manager for the Integrated Commissioning Unit and Tim Hodgetts, Service Manager for Adult Social Care (ASC) had produced a joint report which was circulated, outlining hospital discharge arrangements in Portsmouth. The report set out statistics from the National Adult Social Care Intelligence Service illustrating measures from the ASC Outcomes Framework (ASCOF) for Portsmouth in the context of both national statistics and the 15 comparable councils.

Figure 1 showed that the local authority was the lowest of the comparative group at 2.8 regarding delayed transfers of care from hospital per 100,000 population in 2012/13 whereas for the comparator group the average was 10.2 and for England it was 9.5. On page 2 the chart showed the delayed transfers of care from hospital attributable to Adult Social Care per 100,000 population which was very low for Portsmouth being 0.7, for England 3.3 and comparator group also 3.3. Members congratulated the officers on the ASC department being the best in the country. It was noted that there was an impact caused by Hampshire CC with bed blocking of Portsmouth residents.

Discharge Duty: Claire explained the monthly delayed transfers (SITREPS) as the Community Care (Delayed Discharges) Act 2003 introduced responsibilities for the NHS to notify social services of the patient's likely need for community care service on discharge and to give 24 hours' notice of actual discharge. The Act also requires local authorities to reimburse the NHS Trust for each day an acute patient's discharge is delayed where the sole reason for the delay is the responsibility of social services. It was later explained that PCC's Adult Social Care had not been charged as the delays had not been their responsibility and further information would be sought regarding the level of charges that could be incurred. Adult Social Care attend each weekly SITREP forum and feed the completed data through the ASC information team which provides evidence for the ASC outcomes framework comparator report.

Joint Accommodation Strategy - This set out the availability of accommodation for older people published in 2007 for a ten year period. The aim was to ensure that the right amount and quality of accommodation available for older people which supports their rights to independence and choice irrespective of who is funding their care. During the first five years of the strategy the number of residential beds PCC need has reduced over time as reflected in the closures of PCC residential homes and the development of extra care accommodation. (Table 1 on page 3 of the report outlined the bed usage according to the type of provision split between dementia and non-dementia.) Officers were continuing to engage with all housing providers regarding the need for enough provision to meet demand and to be of the highest quality. The ICU and ASC staff take a proactive approach in working to ensure that any future developments link to the city and population needs. PCC officers were also working to provide **free dementia training** to care home staff even where dementia was not the specialism of the homes.

PCC's equipment and adaptations service
A new service had come into effect in July 2013, to help facilitate a smooth discharge process. The few initial problems with orders which had now been solved and the service was now doing well. There was flexibility for prescribers in the service and high risk patients could have equipment ordered as a priority and the service was receiving good feedback from Queen Alexandra Hospital.

Commissioning

Paragraph 6 of the report explained how the council and Portsmouth Clinical Commissioning Group are pooling their residential nursing and domiciliary care budgets with the council leading the commissioning and procurement of all residential and nursing care. A long term plan would be developed to facilitate choice and control for individuals needing care and support. One of the aims of this was:

- No delayed transfers of care from acute hospital: this will mean using residential and nursing beds in a much more flexible way, for assessment, and as step up or step down beds to prevent or facilitate discharge from hospital.

Updates on progress with this work are regularly reported through the Joint Integrated Commissioning Board (which is a joint structure between PCC and the CCG).

Hospital Discharge Team

Section 7 of the report outlined the initial review of the hospital discharge team in early 2013 which had considered the role of this PCC Adult Social Care team in facilitating time of discharge of patients from hospital where there is a need for social care input. A more detailed review was ongoing. The team has a vital role in working with health colleagues to ensure that as well as being medically fit, clients have the support they need to return home safely or where necessary to be accommodated elsewhere such as with carers or in a care home. The hospital team is managed by a team manager with two assistant team managers, one higher grade social worker, six main grade social workers, four independent support assistants, three administration staff and a referral co-ordinator.

The following additional information was given in response to members' questions:

- Whilst reference had been made to a 24 hour discharge notice the ASC team being placed at Queen Alexandra Hospital also worked on hospital admissions and could pre-empt and challenge predicted discharge dates (and work on admission avoidance where care could be delivered at home).

- The ASC team were working on 50-80 referrals at the hospital on a weekly basis with eight front line key staff working over seven days giving cover on an 8.00 am to 8.00 pm basis and there was liaison with a similar team for Hampshire County Council. The success of the team was due to close work with partner organisations such as the CCG where there was a well-developed relationship.

- Regarding the **involvement of families** there was a lot of liaison with them in the majority of cases, if the client gives their consent to this, or if they do not have the capacity to deal with matters themselves. There is a need to discuss the options with the patient and the family to find solutions.

- The high number of **external placements** to nursing and residential care could reflect specialist conditions where there may not be a suitable home in the city and there is an element of choice with some people wanting to move to be near their families. The priority would be to give domiciliary support in their own home if possible rather than in a nursing home where appropriate. Simon Nightingale who was present at the meeting is involved in in dealing with the payments for these arrangements.

- There was also use of **transitional beds** at units such as Longdean Lodge and The Grove where assessment of needs could take place between hospital and this placement. The "step down" units were not seen as part of the hospital treatment but are an option for discharge - these units do not have the fixed timeframes for placements as the focus needs to be on each individual's progress; block timeframes have been used in the past but have proved unhelpful at times.

- The **equipment service** had historically been provided by Solent NHS but had not been flexible around change and so the service was retendered. As with any major change in service provision there has been some initial disruption. Previously the adaptations service was run in-house but this has now been combined with the equipment service - there have been improvements to prevent the backlog with the two services now linking up which was more effective.

- The proposed **dementia training** would be scoped once the questionnaires to all the care providers in the city had been analysed to look at the level of competency of staff and would be offered over and above the current registration requirements.

- It was asked how discharge was seen to have been successful; there are virtual ward meetings close to the discharge dates and there are community reviews within three months to ensure ongoing **monitoring**.

- It was noted that the provision of Telecare was incorporated within the assessment forms used by ASC at the hospitals.

- With regard to demographic data there was close work with colleagues at Public Health and reliance on the Joint Strategic Needs Assessment (JSNA) documentation and monitoring of data and it was noted that two thirds of patients at the

Portsmouth hospitals were from Hampshire which would affect statistics.

- It was noted that dementia was an increasing pressure for the city and a CCG priority.

- The reimbursement levels for the PHT where ASC were at fault in the discharge delay would be brought back to the panel members as this had not been paid by the authority due to the successful outcomes. (**Action: CB/TH/SN**)

Councillor Stockdale, the chair thanked Claire, Tim and Simon for attending and for their very interesting presentation and answering the questions and invited them to leave the meeting should they wish to at this point.

(b) Alison Croucher, Sheltered Housing Manager

The city council's housing department is responsible for 1,174 residents within sheltered accommodation. The breakdown of this was as follows: 698 in Category 1, 115 in Category 2 (schemes in Leigh Park, Wecock Farm and Crookhorn) and 281 in Category 2.5 which had higher housing and care needs with 24 hour support.

The scheme staff got involved where residents required hospital care either in emergencies, there being an accident or if they were just unwell and in the discharge process. Alison explained the role of the staff as many residents do not have the support of family or friends, a social worker or other advocate and may not have the ability or capacity to advise hospital staff of their home circumstances. The sheltered housing staff are aware of their lifestyle and their personal circumstances and could liaise with the hospital staff where able to do so. Their staff build up a relationship with their residents and there is a level of trust however the lower support schemes (Category 1 and 2) are not staffed after 5.00 pm on a Friday to the Monday morning so it would be unsuitable for more vulnerable residents to be discharged at this time. Alison would like the hospital discharge team to rely more on the knowledge of the scheme managers who were helpful in making arrangements for their residents such as the need to get emergency food in, charging up the key meters for their return.

The Sheltered Housing Manager had asked the scheme managers to provide examples of what happened at discharge for their residents, where there had been longer stays in hospital over the last year. She received feedback from the managers giving 16 examples of where the process could have been better and three cases where there had been good practice. Some residents had been discharged when they not yet ready to make their own drinks or when it was outside of office hours so they could not receive support in the schemes.

Alison felt it was vital for there to be good communication with the scheme managers to ensure their involvement and she was disappointed that there was a lack of knowledge of their service as their involvement would help reduce the need for readmissions. She would like their staff to be involved in the discharge planning meetings with Adult Social Care and Health.

Alison suggested that perhaps the wrong areas were being measured regarding the hospital discharge process as the measures appear to stop upon discharge. There appears to be little measured to establish whether the hospital discharge has actually been successful i.e. establishing with the person/their advocate what actually happened when they returned home and the few days after being discharged, how they feel they are managing with the services/support put in place by the hospital discharge team.

It was agreed that anonymised versions of the responses be circulated to members after the meeting. An example of the questionnaire would also be provided (**Action: AC**). Their service had been proactive in promoting their role and had given a list of their scheme managers to the hospital. Their involvement would allow for safer transition and reducing stress to the residents and their families and reduce the need for re-admittance in the early days of recovery. It may also help reduce the fear of going into hospital and ultimately reduce costs to all partner organisations (health, social care).

Further information was given in response to panel members' questions:

- A barrier to the involvement by the sheltered housing staff was when they phoned the hospital they were told that they were not able to be given information on progress as they were not next of kin although residents were usually happy for them to be involved as arrangements could be put in place for their return.

- The panel would find it useful to hear first-hand from a resident of their experience of discharge and it was suggested that a resident at Arthur Dann Court could meet with panel members in Cosham, and the opportunity could be taken to speak to the scheme manager.

- With regard to the differences in discharge between public and private sector care, Nigel Baldwin reported that the information attached to the agenda was a nationally produced **checklist** by the Chartered Institute of Housing and Alison Croucher reported that they also had their own **guidelines** for sheltered care which they followed but they were still suffering from a lack of communication with the scheme managers.

- The scheme managers were also involved in the admissions process as they were well placed to know of this but found difficulties in getting information when they phoned the hospital to enquire of progress. They also liaised with social workers on behalf of residents in all three categories of sheltered housing, however it is often harder to resolve issues relating to residents in Category 2 schemes as the properties are in Havant Borough Council which come under Hampshire County Council Social Services.

- Quarterly meetings between staff involved in discharge arrangements could be useful and it was suggested that a **consent form** be considered to allow the hospital team to contact the sheltered scheme housing staff without breaching Data Protection rules.

Councillor Stockdale as chair thanked Alison Croucher for her enlightening presentation and would welcome the further information on the feedback from staff and residents on their experiences of discharges.

40. Dates for Future Meetings (AI 5)

The next meeting was set for Thursday 7 November at 10am, and Nigel Baldwin and Elaine Bastable would be invited to give evidence.

Future witnesses: The panel members wished to hear from other sheltered housing providers during the review and also asked that Age UK be invited. Healthwatch would also be asked to contribute evidence. Private care providers could be contacted via Portsmouth Association of Residential Care (via Simon Nightingale).

The meeting concluded at 3.55 pm.

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Councillor Sandra Stockdale
Chair