Portsmouth
CITY COUNCIL

HOUSING AND SOCIAL CARE SCRUTINY PANEL

AN ASSESSMENT OF THE PROGRESS MADE FOLLOWING THE REVIEW OF HOSPITAL DISCHARGE ARRANGEMENTS IN PORTSMOUTH

Date published: 12 December 2014

Under the terms of the Council's Constitution, reports prepared by a Scrutiny Panel should be considered formally by the Cabinet or the relevant Cabinet Member within a period of eight weeks, as required by Rule 11(a) of the Policy & Review Procedure Rules.

PREFACE

When a loved one is discharged from hospital, it can put great strain on families and care services. This report looks into whether the discharge process in Portsmouth reduces or increases that strain.

It comes amid the real prospect of Portsmouth City Council being overwhelmed by the need to provide social care in the next few years. The Local Government Association says that, if nothing is done about that, spending on services like libraries and road maintenance in councils like ours may have to be cut by between 66% and 90%. That must not happen.

The service we found was a mixture. We were told that few Portsmouth people faced delays in discharge for an authority in our position. We saw improvements in co-ordination and delivery before and after we started work. These are to be welcomed.

We were told that barriers remain. Different IT systems stopping health and social care professionals accessing the same record. Care professionals not getting vital information about their patient because they are not next of kin. Patients not being told why they cannot go to the home they want. A lack of accommodation suitable for those being discharged. These have to change.

Our approach is simple: how do we get a smooth, simple, easily-understood process that involves those being discharged, their loved ones and all suitable care professionals while minimising the pain and impact on each of them?
Achieving that helps the people involved and cuts the care bill that could strangle councils like this one.

This report offers some answers. Some like a single budget and strategy covering all aspects of the discharge process, may be unpopular. Some will require short-term investment. All will, we feel, benefit those being discharged in years to come.

On behalf of panel members past and present, I would like to thank everyone who has given up their time and provided their thoughts on this matter. Without them, this report would not be here. I would also like to extend my thanks to Lucy Wingham, who has helped us navigate the many comments made.

……
Councillor Darren Sanders
Chair, Housing and Social Care Scrutiny Panel.

Date: 12 December 2014

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EXECUTIVE SUMMARY.

1. To gather evidence on the current processes for discharge care arrangements for adults leaving hospital.

The panel heard from a number of partners, who are involved in the discharge process, from the initial assessment in an 'acute bed' in hospital to assisting with the patient care and reablement to improve their confidence and independence, mood and ability in their own home.

2. To consider what leads to delays in transfers of care and the implications of this.

It was noted that the number of people who experienced a delayed discharge from hospital in Portsmouth was the second lowest among comparable authorities. There have been some significant changes to the discharge process:

- The Integrated Discharge Bureau ("IDB"), chaired by the Managing Director of Medicine for the Clinical Services Centre and involving community partners, as of December 2013 now meets on a daily basis. The IDB discuss the discharge and care package of the more complex cases.
- A new initiative is the 'Day After Discharge' worker whose role is to follow patients who have come through the social care route to see if all has gone well with the discharge, ensuring that basics i.e. milk and support are in place.
- There have been improvements to the waiting time for adaptations since the new provider has been appointed.

It was also noted that a delayed discharge is often not health related i.e. whilst admitted a patient could become homeless or if a particular nursing home cannot accommodate a discharged patient it is often the case that the family will insist on waiting on the home of their choice to become available.

3. To investigate what arrangements are put in place for patients' return to home or suitable accommodation to ensure continuation of appropriate care.

Adult Social Care ("ASC") 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 in a care home or with carers. Priority is given to give domiciliary care in their own home if possible.

There are six rehabilitation flats in the city which are supposed to be used for a maximum of 12 weeks to continue the continuity of rehabilitation whilst confirming their housing requirements following discharge. An obstacle to their effective use is the lack of wheelchair accessible accommodation for the client to move on to. Due to the economic climate the panel noted that there had been a lull in the number of new builds. However the panel were pleased to note that some were due for completion in 2014.

The panel heard that the majority of hospital discharges to sheltered accommodation do go well, but problems seem to occur with patients who had been in hospital longer. Staff could be hampered due to confidential and data protection issues if the next of kin were involved. The panel felt that good communication with sheltered housing managers was essential and hoped that this would continue.

Disabled facility grants are available to residents in any tenancy. Timescales from assessment to completion seem to vary depending on the complexity of the works required, the financial contribution and who the owner of the property is.

4. To identify ways of developing improved, well-co-ordinated and timely discharge arrangements between agencies.

During the course of this report matters have changed and various ways of improving the hospital discharge experience have been implemented. Working relationships between ASC and the hospital, and partners, are much improved.

The IDB at Queen Alexandra Hospital ("QAH") continues to meet on a daily basis to discuss the discharge and care package of the more complex cases. This has improved the flow of patients through the hospital. There is room for improvement but the healthy relationship means there is an appetite to strive for perfection.

More adapted disabled properties, preferably on the ground floor, are needed.

Conclusions.

Based on the evidence and views it received, during the review process the panel has come to the following conclusions:

1. The number of people delayed discharge affects is low. The council's Adult Social Care department told the panel that Portsmouth's discharges (84 in 2013/14) were the second lowest of our comparator authorities. The figures were less than 30% of the average for the authorities and compares to 229 in Brighton and Hove and 414 in Southampton. (Paragraph 5.3 refers)
2. Working relationships between Portsmouth Hospitals' NHS Trust and its partners are key and its relationship with Portsmouth adult social care is very positive. (Paragraph 3.5 refers)
3. There have been improvements to the process, especially since this report was started. For instance:
    - A new provider of equipment patients would need in their new home has brought down the time taken to install equipment. (Paragraph 4.7 refers)
    - The IDB, which discusses the needs of more complex cases, has, since Christmas 2013, met daily, rather than twice-weekly. This has improved the flow of patients through the hospital. (Paragraph 3.5 refers)
    - QA hospital has improved its internal processes:
    - A Day After Discharge ("DAD") worker now checks if all has gone well with the discharge, looking after 4-5 patients a day who have come through the social care route. (Paragraph 6.6 refers)
    - Social care workers are now based in the hospital until 8pm daily. (Paragraph 6.6 refers)
    - A registrar can discharge patients for three hours on both Saturday and Sunday, the days when families can often offer support. (Paragraph 6.6 refers)

4. There remain, however, barriers to a smooth process. For example, some residents have been discharged even though they were not ready to make their own drinks. (Anonymised accounts refer)
5. Some professionals do not appear to have the access they need to conduct a smooth transition from hospital to home. For instance:
    6. the council and the NHS use different IT systems, which leads to problems reading case notes. (Paragraph 6.1 refers)
    7. Confidentiality and data protection issues are used to stop professionals accessing important information. The council's Sheltered Housing Manager told the panel that their staff could not have information on progress as they were not next of kin. This was despite residents being happy for them to be involved. (Paragraph 4.4 refers).
8. There are often disputes between professionals and families on the best way forward for the patient. The council's Housing Options Manager said people think there are many suitable properties lying empty and available when that is not the case. (Paragraph 4.3 refers).
9. Although the focus on the patient experience has improved, there are still occasions when the patient does not get the information they need. The Managing Director for the Clinical Services Centre at QA said nursing home staff will "often visit a patient in hospital, but not give reasons why (s)he has not been accepted at the home of their choice." (Paragraph 3.5 refers).
10. Sheltered housing want to feel more involved in the process. The manager there wanted staff to be involved in discharge planning meetings to reduce stress as they better understand the problems facing people in the aftermath of discharge. (Paragraph 4.4 refers).
11. More disabled accommodation, especially for wheelchair users, is needed to relieve 'blocking'. This means those rehabilitation flats that are available are in constant use for the maximum period. Other temporary accommodation often had non-accessible bathrooms, which limited their ability to be used. One potential way of overcoming this problem is if the council explores the possibility of keeping a whole housing market register of people that need adapted property. It is appreciated that this may need to be regularly updated, but may help towards increasing the supply of accommodation. Housing Association and private properties adaptations are often delayed as Housing Associations (HAs) and private landlords need to give permission for adaptations to occur. Sometimes HAs needed to ask the council for a disabled facilities grant to adapt the property. (Paragraph 4.7 refers)
12. The panel noted that the professional lead officer for Occupational Therapy had informed the panel that most disabled persons units were two-bedroom units and single people are no longer able to afford the tenancy. However, the council is working on building larger one-bedroom properties rather than having a spare bedroom. This will allow extra equipment to be stored and also overcome this problem. The panel also noted that Housing Benefit regulations allow for an additional bedroom within the calculation for Local Housing Allowance and Spare Room Subsidy (Paragraphs 4.7 and 4.10 refer).

Recommendations.

The panel made the following recommendations:

1. Communication between professionals be improved to deliver a smoother process. In particular:
   - The incompatibility of council and health IT systems needs to be resolved, or at least work so that there is mutual access.
   - Relevant professionals should be given 'next of kin' status to allow them to access appropriate information that will smooth the process.
   - Where appropriate, relevant sheltered housing professionals should attend discharge planning meetings to advise on suitable ways forward.
   - It should be a requirement for care agencies to feed back any relevant information to the discharge planning team.
2. Patients and families continue to be involved in the discharge planning process as early as possible to minimise the potential for disagreement.
3. There needs to be one care plan for each patient being discharged, accessible to everyone involved and with clear explanation of each step taken. It should also include named individuals and realistic dates by which actions are expected to be taken. This plan should be available to patients and families and they should be involved, as much as medically appropriate, in the devising of it.
4. The council explore the possibilities to keep a whole housing market register of people that need adapted property. It is appreciated that this may need to be regularly updated, but may help towards increasing the supply of accommodation.
5. The improving relationship between PHT and the council's ASC team should continue.
6. Continuing effort should be made to encourage weekend and evening discharges as 60% of discharges occur after 3pm. The employment of a registrar to oversee discharges at the weekend will assist. Yet staff who work in the lower support schemes of sheltered housing do not cover these periods. Employing a weekend team, perhaps working alongside the council's out of hours unit to oversee these discharges.
7. Continued effort be made to develop accommodation for people with physical disabilities as part of the council's house building programme and in any affordable part of private housing developments.

1. Purpose.

The purpose of this report is to present the Cabinet with the recommendations of the Housing and Social Care Scrutiny Panel's assessment of hospital discharge arrangements for adults in Portsmouth.

2. Background.

2.1 This review was started by the Housing and Social Care Scrutiny Panel, which comprised:

Councillors Phil Smith (Chair)
Steven Wylie
Mike Park
Lee Mason
Michael Andrewes
Margaret Adair

Standing Deputies were: Councillors Caroline Scott, Steve Wemyss, April Windebank and Matthew Winnington.

2.2 At the Council Meeting on 11 February 2014, Councillor Phil Smith replaced Councillor Sandra Stockdale, as chair on the panel.

2.3 Following the annual Council Meeting on 3 June 2014, Councillor Darren Sanders was appointed chair and the panel comprised:

Councillors Alicia Denny
Hannah Hockaday
Phil Smith
Sandra Stockdale
Alistair Thompson

Standing deputies are: Councillors Michael Andrewes, Simon Bosher, Margaret Foster, Stuart Potter and Gerald Vernon-Jackson.

2.4 At its meeting on 12 September 2013, the Housing and Social Care Scrutiny Panel (henceforth referred to in this report as the panel) agreed the following objectives for the review:

- To gather evidence on the current processes for discharge care arrangements for adults leaving hospital.
- To consider what leads to delays in transfers of care and the implications.
- To investigate what arrangements are put in place for patients' return to home or suitable accommodation to ensure continuation of appropriate care.
- To identify ways of developing improved, well-co-ordinated and timely discharge arrangements between agencies.

2.5 The panel met on 10 occasions between 12 September 2013 and 12 December 2014. A list of meetings held by the panel and details of the written evidence received can be found in *appendix one*. A glossary of terms used in this report can be found in *appendix two.* The minutes of the panel's meetings and the documentation reviewed by the panel are published on the council's website and paper copies are available from Democratic Services upon request to scrutiny@portsmouthcc.gov.uk.

3. To gather evidence on the current processes for discharge care arrangements for adults leaving hospital.

3.1 The Senior Programme Manager for the Integrated Commissioning Unit explained that the ASC team works on 50-80 referrals at the hospital a week, with eight front line key staff working over seven days giving cover on an 8am to 8pm 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 Clinical Commissioning Groups (CCG) where there was a well-developed relationship.

3.2 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. There were 16 examples of where the process could have been better and 3 cases where there had been good practice, had been received. Some residents had been discharged when they were not yet ready to make their own drinks or when it was outside of office hours so they could not receive support.

3.3 There are currently 12.5 full time equivalent Occupational Therapists (OT) in the ASC community fieldwork teams. There is an open referral system for Portsmouth residents and referrals come from both social care help desk and Single Point access (Health). There has been no increase or decrease in staffing but processes have been reviewed and are now more streamlined. There continues to be a large demand on the services and waiting list of approximately 193 people, the length of time people are waiting for the service has reduced and at present stands at between 12 and 16 weeks for non-critical cases (figures as at August 2014).

3.4 Equipment Provision

The Professional Lead Officer for Occupational Therapy explained that standard equipment is provided by the new provider Millbrook and can be ordered by a variety of users including OTs, physiotherapists, nursing staff and trusted assessors.

http://www.millbrookhealthcare.co.uk/

CASE STUDY (2013)

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, Physiotherapist, S&LT, Clinical Psychologist, Social Worker, Housing Options officer, Housing OT, Relatives, PRRT, Stroke Association, Sheltered Housing Scheme manager, CSRT and Tenancy support.

8 July - Client was discharged to a rehabilitation 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 multi-disciplinary team.

2 September - The client moved into their new property.

3.5 The Managing Director of Medicine for the Clinical Services Centre (MD of MCSC) at QAH informed the panel:

- There are 105,000 discharges a year which are managed through the hospital; 80% of these discharges are classed as 'simple' and the remainder as 'complex'. There is a cohort in the middle which requires more focus and attention. An example of a simple discharge would be a patient who has an arranged procedure and is in hospital for a few hours for that procedure. An example of a complex discharge is when a patient is admitted following an event and has more than likely come through the emergency department.

- Prior to Christmas 2013 the IDB met twice a week; since then it has continued to meet on a daily basis. These meetings are chaired by the MD of MCSC and community partners from Hampshire and Portsmouth also attend. The IDB discusses the discharge and care package of the more complex cases which tend to have a complicated discharge planner. Often social services recommend a referral whilst on the ward. It is at the IDB that the patients other needs are often identified e.g. whilst admitted a patient could become homeless. A delayed discharge is often not health-related and these cases are discussed daily at the IDB meetings. The bed stock needs to be utilised for acute care. The hospital looks to discharge a patient once the healthcare plan is complete and it can ensure a safe discharge. The hospital does not want to leave any patient feeling vulnerable. Working with its partners is key and its relationship with Portsmouth is very positive.

The following additional information has been provided by the Service Manager for Hospital and Health Services, ASC at the request of the panel in September 2014.

- ASC meets with the PHT senior nurses. These are often very positive meetings with good outcomes. For example, the issues log information is sent to the matron of the ward and they investigate these issues and look at ways to minimise the risk of it happening again. There continues to be issues which are logged and flagged to PHT. There is a lot of work going on in PHT to resolve some of the main issues/themes and matrons put actions into place to address the issues/themes. The introduction of the 'Safer Discharge Bundles' has recently been introduced and will help to improve and standardise discharges across the trust and resolve the issues.

- When a patient is in hospital, this offers a period of respite and it is often at this point that the carer feels they cannot cope. This is not recognised prior to the patient admission and so is not planned for. Families/ carers feel that they cannot cope when the patient is discharged. The hospital would identify this as 'potentially complex' and would involve social services.

- It is important that all of the clinical groups are working towards one document plan within the patients' notes. This is managed by the Managing Discharge Team on their white board rounds, at ward level, who look at the whole care package. All patients

have a named consultant and any decision made by that consultant can be challenged as to its reasonableness.

- With regards to the times of the day or evening that patients are discharged, PHT would be very concerned if patients have been discharged unsafely. Hospital transport is available up to 9pm and the teams work with the family regarding the most appropriate time of the day for a patient discharge. 60% of discharges occur after 3pm and this is mainly due to family need.

- Some care agencies do not know how to feedback information to the hospital. Patient care providers should know how to feed information back. If agencies have a wasted visit or an agency goes out to see a patient recently discharged, the team needs to know. The Managing Director met with PHT to look at aligning these processes. There is now a much more co-ordinated approach for all.

- There is currently a big focus on patient experience and PHT has appointed a role of Corporate Nurse (CN) who will lead on this issue. Friends, family and patients are encouraged to provide feedback on the website, through the Patient Advisory Liaison Service (PALS) and PHT meets with nursing home managers on a regular basis, where patient experience feedback is encouraged. It was mentioned that the Service Manager for Hospital and Health Services, ASC at the council had met, and will continue to meet with the CN to look at sharing the issues logs and to look at any recurring themes. It was felt that there is now a real sense that things are moving forward.

- If a particular nursing home cannot accommodate a discharged patient, it was explained that options would be provided for a suitable alternative vacancy but it is often the case that the family will insist on waiting for the home of their choice to become available. The family are then encouraged to accept an interim move but again this often takes a lot of persuasion. It is appreciated that this is often a difficult decision for the family to make but there is an expectation from families, which needs to be managed. Often homes will not accept patients if they cannot accommodate their particular needs even if there is room available. Nursing Home staff will come to assess the patient whilst in hospital but quite often the patient does not receive the reasons as to why they have not been accepted at the particular home of their choice. The Managing Director of Medicine for the Clinical Services Centre at QAH added that if there are staff shortages at the nursing homes, then they are unable to attend to assess a patient. This non-assessment has a knock-on effect and means they have to stay another night in hospital when it is not necessary and the patient is ready for discharge. There are arrangements in place where groups of home care staff come out to make an assessment. The question has been raised as to why PHT cannot make assessments, particularly when the patient has been agreed ready for discharge. However the Care Quality Commission must undertake the assessment of care.

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

3.6 The Service Manager for Hospital and Health Services, ASC at the council asked the panel to note the following points:

- On one occasion, social services had recommended that a patient be discharged to the Grove Unit as an interim arrangement but the family were adamant that the best

place for the patient was in hospital. A whole care package was available for the patient at the Grove Unit but the family was blocking the discharge. The acute care had finished and the family wanted the patient to go home but not via another route. The family were advised that this is a step down opportunity to give the family more time to look at the next care step.

- In these situations, families do not see that they are 'bed blocking' and feel that it is their right to say no to a discharge. Managing expectation is essential, firstly at ward level by nurses and doctors, and then this being reinforced by other partners of the MDT.

The following additional information was provided by the Service Manager for Hospital and Health Services, ASC at the request of the panel in September 2014:

- Families do not have to pay for interim care and no financial process causes any delay. If someone needs interim care for a period of assessment and/or rehabilitation then the patient does not have to pay as this is normally termed as 'intermediate care'. Should someone have on-going care needs, they will be discharged before financial assessment, but made fully aware prior to discharge that they will be subject to a financial assessment and likely client contribution.
- The patient does have the right to say no to an interim discharge if they have the capacity to do so. If the patient does not have the capacity then a 'best interest' multi-disciplinary decision is made on the patient's behalf. If they have a Power of Attorney they make the best interest decisions but should someone not have a Power of Attorney, ASC would seek Court of Protection in these cases.

3.7 The Senior Programme Manager for the Integrated Commissioning Unit explained that there are virtual ward meetings close to the discharge dates and there are community reviews within three months to ensure ongoing monitoring.

4.0 To consider what leads to delays in transfers of care and the implications of this.

4.1 The Senior Programme Manager for the Integrated Commissioning Unit explained that there was 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.

4.2 The Sheltered Housing Manager informed the panel that 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. (Category 1 - unfurnished accommodation often in blocks ranging from 2-25 floors high. Close to shops, bus stops etc. Some but not all residents will have support needs. Some properties have a communal lounge and there is one manager per block on site Monday-Friday 9-5. Category 2 - unfurnished accommodation for older persons with support needs. Pull cord alarm is in place, all have communal lounge, there is one manager on site Monday-Friday 9-5 supported by one or more assistants and not all properties have private bath and shower. Category 2.5 - specifically for older persons with higher support needs. All have communal facilities and private bathrooms and there is a manager and support staff on site 24hours daily.)

4.3 The Housing Options Manager informed the panel that the allocations team look at all demands throughout the city and that hospital discharges is just one element in the allocations scheme. The team would usually be a part of the hospital discharge discussions for elderly and disabled persons. Homeless persons are looked at through the Homeless Persons legislation. The council would usually find them accommodation. Street drinkers are a major concern but they will usually go back to a hostel.

- One big problem is the commonly held view that there are housing properties lying empty and available. This is not the case. In the interim, it is often difficult to provide suitable accommodation. The OTs work with the housing options team who would draw up a care package, which is best for that person at that time.

- There are rehabilitation flats which can be reviewed at any time but there is a lack of accessible properties in the city. The benefits issue for a single person living in a two-bedroomed property is a challenge because of the 'under occupying' implications. This is something which needs to be resolved.

- The council's Housing Department is building and whenever a new development is proposed housing options request an 'adapted' unit in all council builds, and specify ground floor level access. There is a housing OT, which is a jointly funded role, which sits with housing and social care. Housing options are also involved in extra care housing for elderly persons which is working well. There are no major problems with allocations. Housing options do try to get an officer to attend all discharge meetings although the timings of these meetings can sometimes be an issue.

- The council has temporary accommodation for homeless persons which is used in a crisis. However it is usually high in a tower block but it would still be suitable for a wheelchair.

4.4 The Sheltered Housing Manager informed the panel that the sheltered housing scheme staff get involved where residents require hospital care either in emergencies, after an accident, or if they were just unwell, and in the discharge process. The involvement of the staff should be seen to be crucial 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 individual's lifestyle and personal circumstances and could liaise with the hospital staff where able to do so. Their staff build up a relationship with residents and there is a level of trust. However the lower support schemes (Category 1 and 2) are not staffed after 5pm on a Friday until the Monday morning so it would be unsuitable for more vulnerable residents to be discharged at this time. The Sheltered Housing Manager 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.

4.5 The Sheltered Housing Manager (SHM) presented the anonymised accounts provided by sheltered housing residents and explained that some hospital discharges go really well but the accounts provide a fair snapshot of cases. Problems are more likely to occur with patients who had been in hospital longer. Staff can be hampered due to confidentiality and data protection issues if the next of kin are not involved.

- It is vital for there to be good communication with the sheltered housing scheme managers to ensure their involvement. The SHM felt that it was disappointing to see that there was a lack of knowledge of their service, as their involvement would help reduce the need for readmissions. The SHM would ideally like their staff to be involved in the discharge planning meetings with ASC and the PHT. Their involvement would allow for safer transition, reduce a 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 including health and social care.

- Perhaps the wrong areas were being measured regarding the hospital discharge process as the measures appear to stop upon discharge. In their opinion, there appears to be few measures in place 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 and how they feel they are managing with the services/support put in place by the hospital discharge team.

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

4.6 Out of City Hospital Discharges

The Professional Lead Officer for Occupational Therapy informed the panel that patients are also discharged 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.

- There are variations of OT input; medical discharges should be referred through the PRRT who have a number of resources available to support discharges and provide ongoing rehabilitation such as the Grove Unit and Victory Unit.

- The 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.

4.7 Accommodation Resources Available

The Professional Lead Officer for Occupational Therapy explained that:

- some discharges will require major adaptations and it was reported that there is limited wheelchair specific accommodation in the city. The council has six rehabilitation 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 for the 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 in 2013 although some are due for completion in 2014. One of the occupational therapists 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 ("under occupancy penalty") has been the increased difficulty in the council's ability to house single people. Most of the DPUs have previously been two 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 the council's tower blocks but these have non-accessible bathrooms, which will impact on care and equipment requirements, and this restricts the clients who can be accommodated in them.

- The council's Housing Management Team is working on building one 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 HA to discuss their developments at a planning stage to make best use of the space, and for the council 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 for 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.

- The council request that HAs accept direct referrals and undertake minor adaptations themselves. It was reported that First Wessex HA, which is one of the largest locally usually undertakes major adaptations but this depends on the timing within the financial year and they may need the council to pursue a Disabled Facilities Grant.

<u>Disabled Facilities Grants (DFG)</u>

- DFGs 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 three months to 12 months.

- If a client is in hospital the case is open to an ASC OT, then the DFG application can be made as soon as the client's needs are known. If the client is unknown or on the waiting list they are not open to an ASC OT, the request for an assessment will be prioritised and if non critical will be placed on the OT waiting list.

- Waiting times vary and have been as long as six months. 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. The Professional Lead Officer for OT explained that providing equipment is in stock, it should be available for same hour or same day delivery if urgently required. As costs greatly increase as delivery times are shortened, seven day delivery is the usual option. Examples of equipment required for discharge are raised toilet seats, kitchen trolleys, profiling beds, hoists etc.

- OTs recommend minor adaptations which could include stair rails, grab rails, door entry intercom systems, chair and bed raises. These cost under £1,000 and are non-chargeable to the client. Millbrook provides them for clients living in their own or privately rented properties. HAs and the council provide them for their own tenants. HAs vary in their response times and a request for a stair rail takes on average four weeks.

- Millbrook technicians inherited a historical backlog when they took over the service from the council in July 2013. At one time clients were waiting up to six 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 provided more quickly 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 hospital OT will be asked to arrange quotes on the ward. These are then forwarded to the council community OT who is allocated the case. Examples are bespoke shower/commode chairs which cost up to £1,200 and specialist seating which costs up to £2,000 or more.

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

4.8 The Service Manager for ASC explained that there are often pressures from discharge from PHT, when the patient is deemed medically fit for discharge by the consultant. It is at this point ASC become involved. The OT then visits the patient on the ward and agrees what equipment is required. Often this means that the patient cannot go home to their own property (if for example the equipment cannot fit in the property). This then becomes ASC's responsibility and at this stage the housing allocations team is called in.

4.9 The council's Housing Options Manager explained that the allocations team has much involvement with Portsmouth HA. It was noted that council flats are managed by the Roberts Centre, with daily visits etc. The Housing Options Team needs to be involved at the first stage, to ensure this works. For others who have more complex needs, rather than move them from a two-bedroom to a one-bedroom property, there are means to 'top up' their benefits.

4.10 The following additional information has been provided by the Head of Revenues and Benefits at the request of the panel;
Housing Benefit regulations already allow for an additional bedroom within the calculation for Local Housing Allowance (private sector rents) and Spare Room subsidy (Social Sector rents) if the customer has a need for:

- A carer (or team of carers) who do not live with the customer but provides them or their partner with overnight care (if an extra bedroom is available).

The Spare Room subsidy rules would not be applied in the following circumstances:

- Temporary accommodation - if the customer has been accepted as homeless under homelessness legislation of the Housing Act 1996 and placed in temporary accommodation by the local authority.
- Supported exempt accommodation - if the customer is placed in a property provided by a housing association or a registered charity where the landlord or a third party on their behalf provide care/support or supervision.
- State pension credit age - if the customer is over state pension credit age or they have a partner over state pension credit age.

For those who are entitled to Housing Benefit and cannot have the additional bedroom under the legislation, there may be additional help available via a Discretionary Housing Payment.

The policy does allow for medical needs, however there is also an income/expenditure assessment to establish whether or not the customer could afford the 'top up of rent'.

4.11 The Housing Options Manager explained that there is a waiting list for all council properties. There is often a delay but not in the interim, it is much more of a long term delay. Not so much from the hospital but in terms of their rehabilitation. The rehabilitation flats are very busy (one in one out). The flat is cleaned after the departure and the next person is in the next day with continuous occupancy. The rehabilitation flats are within sheltered accommodation so patients come out with a support package. There is a wealth of retirement homes in the city.

- The wait for an OT depends on the level of need, which team picks it up and the risk to the patient waiting for assessment. There could be a wait for equipment and adaptations, depending on the cost and work needing to be undertaken. Communication is the key, as long as housing options are kept informed and all departments are sharing information then discharges are fairly smooth. It is not uncommon for homeless persons to be in and out of hospital with injuries due to their drink problems.

4.12 <u>Joint Accommodation Strategy</u>

- The Senior Programme Manager for the Integrated Commissioning Unit explained that: the Joint Accommodation Strategy 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 is available for older people which support 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 the council needs has reduced over time as reflected in the closures of council residential homes and the development of extra care accommodation. (Table 1 on page 3 of the strategy 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 Integrated Commissioning Unit and ASC staff take a proactive approach in working to ensure that any future developments link to the city and population needs. Council officers also work to provide free dementia training to care home staff even where dementia is not the specialism of the homes.

- Paragraph 6 of the strategy outlined how the council and Portsmouth CCG 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 was to have 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 Joint Accommodation Strategy report outlines the initial review of the hospital discharge team in early 2013 which had considered the role of the council's ASC team in facilitating the 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.

- Regarding the involvement of families there was much 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. The contracts Team Manager for ASC is involved in dealing with the payments for these arrangements. It was noted that the provision of Telecare was incorporated within the assessment forms used by ASC at the hospitals.

4.13 The Lead Professional Officer for Occupational Therapy 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 essential for safety and can delay discharge. Some major adaptations not being in place would not necessarily prevent discharge e.g. installations of showers.

- Reference was made to a case in Arundel Street rehabilitation flats where a move out had taken six months rather than the target of six weeks. In this instance there was no appropriate adapted housing available that would meet the client's needs. Rehabilitation flats are sometimes blocked for this reason as are the temporary accommodation flats. There is a long list of people on the re-housing list waiting for specialist or adapted properties. This is obviously dependent on people moving or vacating properties and limited construction of new builds. In another case a patient had stayed at Salisbury hospital for four months whilst proof of finances was obtained. This is out of the control of the local authority.

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

4.14 The Senior Programme Manager for ICU explained that work was taking place on virtual wards as a Health and Social Care partnership to support people in their own homes, with three teams working in the city. There are weekly multi-disciplinary team meetings. The patients are living at home but being supported and this is proving to be an efficient way of dealing with those who are frequently in and out of hospital. There is also a link here to Telecare facilities. 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 could be put in place where necessary, such as commodes before toilets could be adapted.

4.15 Telecare, the Housing Enabling Manager explained that:

- <u>The council's private sector housing involvement in the hospital discharge process.</u> 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 in the first place. 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 for insulation, efficient boilers, draught proofing and the temporary loan of heaters.
- 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 to identify hazards to prevent tripping).
- Homecheck security checks for people over 60, those with children under 5 and some disabled people.
- Community based OTs refer clients for adaptations and changes (via the statutory DFGs) 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, for example they first go to live in a rehabilitation flat for a few weeks.
- In some circumstances hospital based OTs can request palliative adaptations. In these circumstances a reconditioned stair lift may be utilised for a short period of time and is given priority for installation.

<u>Telecare & Hospital Discharge</u>

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

<u>Referrals for Telecare Equipment</u>

- A variable number of referrals from professionals tend to be received on a weekly basis and usually the telecare equipment can be installed within two - three days subject to a technician's availability. Some professionals mistakenly believe that installation will occur within 24 hours. It would be quite unusual for this to happen

particularly at the weekend or on Bank Holidays. 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 an ongoing requirement for referring hospital professionals to become familiar with the technology so that they understand that this is 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. They have often 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 are the result of patients finding out about the service between January and September 2013.

- OT involvement - from autumn of 2013 the Private Sector Housing Telecare team has been joined by an OT 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 are not completed properly. The council's Telecare service is for Portsmouth residents and 40 PCC tenants in the Borough of Havant who have a historical link to Portsmouth.

4.16 The Senior Programme Manager for Integrated Commissioning Unit informed the panel that:

- The sheltered housing 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 comes under Hampshire County Council Social Services.

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

4.17 The Chief Executive Officer and the Project Co-ordinator, from AgeUK Portsmouth circulated copies of a powerpoint presentation which had been presented to the Board of Trustees in September 2013 together with the latest Reablement Pilot Project report concerning outcomes of the first year's work recently completed. It was explained that the project was initially for one year but a second year's funding had been approved from the Portsmouth CCG for the End of Life Champions work which AgeUK Portsmouth is about to engage in. The project has meant AgeUK Portsmouth has been working alongside partners in the first year, all of whom have the same target to improve readmission rates into hospital acute care 30 and 91 days after discharge. The Red Cross is now based within QAH and look after the patient for the first month and any additional on-going care which is needed. AgeUK takes over the care after this period where the client is beyond being poorly but are often agoraphobic and feel they are 'not worthy'. AgeUK need to ensure they are loved and protected and help move them forward. AgeUK Portsmouth provides emotional and physical care, based around cleanliness, food and trying to encourage independence, not medical or personal care. It was also explained that clients are offered help but they are often in hospital at the time and taking medication, so will not necessarily realise or remember that help has been offered.

4.18 The Project Co-ordinator explained that the Red Cross assist people with their shopping. AgeUK Portsmouth works alongside them. The project can provide two hours of care a week, over eight weeks. There is a degree of flexibility in the hours provided as some clients may need a slightly longer period to support their independence.

4.19 The Senior Manager, Hospital & Health Services, Adult Social Care explained that:

- It was usual practice for a private care provider to be the care post hospital if the client has had a needs assessment and are eligible. AgeUK Portsmouth would come in alongside that package as a whole system approach. The Reablement provided by AgeUK Portsmouth is critical as part of the support and in building the patient back up in strength.

- If a person had a fall, with no serious injuries, but do not have a care or support package they can often end up in hospital. Therefore it is imperative that everyone knows what support is out there. GPs do not always know the full range of services social care and community services can provide to help avoid hospital admissions. Preventative projects are underway with the ambulance service and GPs to stop people from going into hospital.

4.20 The Hampshire Domiciliary Care Association (HDCA) is trying to stop the initial admission to hospital. If the client is not in need of critical care then they should not be sent to hospital; there are other options available. All HDCA clients have a documentation folder in their property which lists the care package they are receiving and there are forms within this folder for other care providers to complete their details so there is an awareness of who and what type of care is being provided.

5. To investigate what arrangements are put in place for patients' return to home or suitable accommodation to ensure continuation of appropriate care.

5.1 The Lead Professional Officer for Occupational Therapy informed the panel that some possible obstacles to timely discharge from outside of the city are listed below and it was noted most of these could also be applicable to discharges from Portsmouth hospitals:

- Distance between out of city hospital and residents home.

- Previous private rental accommodation that is not suitable for a wheelchair user or person with impaired mobility meaning that the 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 being unavailable on discharge.

5.2 The Professional Lead Officer for OT explained that DFGs are dependent upon the patient's income. Some delays are exacerbated by the wait for evidence. Has and private landlords need to give permission for adaptations to their properties. The council's Housing Management department gives permission quickly and secures the contractor to do the work.

5.3 The Senior Programme Manager for the ICU for Adult Social Care informed the panel that:

- They had produced a report outlining hospital discharge arrangements in Portsmouth. The report set out statistics from the National ASC Intelligence Service illustrating measures from the ASC Outcomes Framework for Portsmouth in the context of both national statistics and the 15 comparable councils. The report showed that the local authority was the lowest of the comparative group with 2.8 delayed transfers of care from hospital per 100,000 population in 2012/13. For the comparator group the average was 10.2 and for England it was 9.5. It also showed the delayed transfers of care from hospital attributable to ASC in Portsmouth at 0.7, in England and the comparator group both at 3.3. It was noted that there was an impact caused by Hampshire County Council with bed blocking by Portsmouth residents.

- The weekly A&E situation report shows the total number of attendees at A&E, Minor Injuries Units and Walk-In Centres and the number discharged, admitted or transferred within four hours of arrival. 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. This act also requires local authorities to reimburse the NHS Trust for each day an acute patient's discharge is delayed due solely to social services. ASC attends the weekly situation report forum and feeds the completed data through the ASC information team which provides evidence for the ASC outcomes framework comparator report.

- The equipment service was provided by Solent NHS but it had not been flexible around change, 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 has been more effective.

6. To identify ways of developing improved, well-co-ordinated and timely discharge arrangements between agencies

6.1 Portsmouth City Council's equipment and adaptations service.

The Senior Programme Manager for the Integrated Commissioning Unit explained that:

- A new service had come into effect in July 2013 to help facilitate a smooth discharge process. The few initial problems with orders had now been resolved and the service was 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 QA.

- The ASC team placed at QA also works on hospital admissions and could pre-empt and challenge predicted discharge dates and work on admission avoidance where care could be delivered at home.

- With regard to demographic data there was close work with colleagues at Public Health and reliance on the Joint Strategic Needs Assessment 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.

- Quarterly meetings for 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.

- The discharge planner used to have the responsibility for liaising with everyone. The OTs like to be invited to the discharge planning meetings, but sometimes the hospital based OT attends, depending on whether the patient is returning to their own home. If they are not, the OT may not be involved. Hospital OTs are employed by an NHS Trust and work predominantly in hospitals as opposed to community OTs who are employed either by the NHS or social care. There are no social care OTs working in Portsmouth local hospitals. Given the lack of access to client record systems due to the different IT systems, information is not commonly shared. If a community OT is working with a client who is admitted to hospital and may require a complex discharge it is helpful if the community OT is invited to the discharge planning meeting.

6.2 The Managing Director of Medicine for the Clinical Services Centre at QA explained that:

- The weekly IDB meetings, has improved the flow of patients through the hospital and the relationship between Portsmouth ASC and PHT has hugely improved. There is room for improvement but the healthy relationship means there is an appetite for improving, to iron out the niggles and to strive for perfection.

- An example was given of a patient who lived in a raised apartment, was admitted to hospital and following treatment needed a wheelchair. He was assessed as physically fit to leave the hospital but needed ground floor accommodation. During the patient's stay in hospital, his accommodation had been let out by his father and he was therefore was deemed to be homeless. Eventually the patient took himself to Portsmouth housing office.

6.3 The Service Manager for Hospital and Health Services, ASC explained that:

- The council needs to have a couple of adapted disabled properties, preferably on the ground floor, available. Portsmouth does have Grove House and Longdean Lodge for interim care but more independent interim accommodation is required.

- PHT can discharge or transfer patients to St James' Hospital directly or to a rehabilitation clinic. However, there are often patients at QA with mental health issues who need to be assessed. The hospital often has to provide security as they are unpredictable. Medically they have been addressed but mentally they are not fit to be discharged.

6.4 The Service Manager for Hospital and Health Service, ASC explained that

- A patient is discharged to a Portsmouth owned home when PHT is satisfied that the appropriate care package is in place.

- The PRRT works well and that the community nurses do attend the daily meetings.

- The CN team then assess the number of visits required.

6.5 The Managing Director of MCSC at QA explained that:

- Patient needs are identified as early as possible and consideration is given to what equipment would be of benefit to the patient on discharge. PHT discharges patients to Longdean House and the Grove if they are waiting for equipment or adaptations.

- When patients are discharged to a local authority sheltered home at the weekend it is never assumed that they will have support.

- PHT tries to manage quality and successful discharges to ensure that the patient receives on-going support and care. PHT is deemed to have failed if the patient is re-admitted within 28 days and does not receive any payment for a re-admittance.

- The Red Cross is situated within the hospital and supplis equipment.

6.6 The Service Manager for Hospital and Health Services, Adult Social Care explained that:

- A Day after Discharge Worker follows patients who have come through the social care route to see if all has gone well with the discharge, checking milk and that support is in place. They support between four and five patients a day.

- Social care workers are now based in the hospital until 8pm each day. The hospital now has a supply of tracksuits for patients admitted during the night in their nightwear and who are then ready for discharge the following day. PHT is working towards 24-7, seven day working.

- The hospital employs a registrar for three hours on a Saturday and Sunday who is able to discharge patients. Weekends are often the ideal time for patient discharge as the family are more likely to be able to offer support.

- The day after discharge workers have had some success by ensuring that all is well with patients after discharge. There are still some patients who are readmitted, but this is understandable given that patients are now discharged much sooner than ever due to pressures for acute beds and much better community services such as virtual wards, intermediate services, PRRT and having named social workers to ensure that

everyone has sight of the patient when returned to the community to support the transition from hospital to home. Due to the ever increasing pressure from PHT, ASC has to use the home from hospital worker to actively pull people out of the acute trust so this can often impact on the role to solely concentrate on day after discharge work.

- The day after discharge scheme is being evaluated as it would be better to use a voluntary agency such as Red Cross to do this role.

7.0 Equalities Impact Assessment

7.1 A preliminary equalities impact assessment has been completed.

8.0 Legal Comments

8.1 There are no legal implications arising at this time.

9.0 Finance Comments

9.1 As local health and care budgets come under increased pressure as a result of savings requirements, the need for closer integration between organisations becomes even stronger.

9.2 The Better Care Fund (BCF), a national programme was announced by the Government in June 2013. Its aim is to transform local services so that people are provided with better integrated care and support.

9.3 Building on the integrated approach that already exists within Portsmouth, the local BCF plan was jointly agreed by Portsmouth City Council and the CCG during 2014. It has been signed off by the Health and Wellbeing Board and has been approved by the Department of Health. Work is currently ongoing with the key stakeholders (Hospitals, GP's and the voluntary sector) on delivering Portsmouth's 15/16 BCF implementation plan.

9.4 The Government's intention for the BCF is that health and care services will change from a ‘sickness service’ which treats people as a one-off and then sends them away to another part of the system to a joined-up health and care service which helps people to manage their own health and wellbeing and live independently for as long as possible. The ambition is that people will need to go to hospital as little as possible; and that when they do, they are admitted quickly, treated well, and discharged as quickly and safely as possible to enable them to get on with their lives.

9.5 Additionally via the BCF, the Government expects to reduce the total number of emergency admissions to hospital by 3.5%. A Payment for Performance element linked to emergency admissions has therefore been included within the BCF procedures and plans. The BCF also has national conditions around 7-day services to support patients being discharged and better data sharing between health and social care. Consequently IT solutions are being considered on how to achieve this data sharing aim.

9.6 Nationally, the BCF also includes the funding for the Disabled Facilities Grant (DFG). It has been included so that the provision of adaptions can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users.

9.7 However, the BCF is not a source of new, uncommitted funding. The majority of the BCF money is already being spent locally on existing health and social care activities.

10.0 Budget and policy implications of the recommendations

The following table highlights the budgetary and policy implications of the recommendations being presented by the panel:

Recommendation	Action By	Budget & Policy Framework	Resource Implications
Communication between professionals needs to continue to improve to enable delivery of a smoother process. In particular; a. the incompatibility of council and health IT systems needs to be resolved, or at least work so that there is mutual access. (Pt 6 refers)	Relevant teams from the council and the PHT	Within policy framework.	Not known at this stage.
b. Relevant professionals should be given 'next of kin' status to allow them to access appropriate information that will smooth the process. (Pt 5.5 refers)	Relevant sheltered housing staff	Legislative framework.	Operational.
c. Where appropriate, relevant sheltered housing professionals should attend discharge planning meetings to advise on suitable ways forward for their service users. (Pt 5.5 refers)	Relevant sheltered housing staff	Within policy framework.	Scheme manager time.
d. It should be a requirement for care agencies to feed back all any relevant	Domiciliary Care Agencies	Within policy framework.	None.

Recommendation	Action By	Budget & Policy Framework	Resource Implications
information to the discharge planning team.			
e. Patients and families continue to be involved in the discharge planning process as early as possible to minimise the potential for disagreement.	PHT and Adult Social Care	Within policy framework.	Already in place.
f. There needs to be one care plan for each patient being discharged, accessible to everyone involved and with clear reasons why each step is being taken. It should also include named individuals and realistic dates by which actions are expected to be taken. This plan should be available to patients and families and they should be involved, as much as medically appropriate, in the devising of it.	PHT	Ongoing work. Care Plan live and available for GP's and ambulance service.	Already in place.
g. The Council explore the possibilities to keep a whole housing market register of people that need adapted property. It is appreciated that this may need to be regularly updated, but may help towards increasing the supply of accommodation.	Head of Corporate Assets, Business and Standards	Within policy framework.	Officer time and effort.
h. The improving relationship between	PHT and Adult	Within policy framework.	None.

Recommendation	Action By	Budget & Policy Framework	Resource Implications
PHT and PCC's ASC team should continue.	Social Care		
i. Continuing effort should be made to encourage weekend and evening discharges. 60% of discharges occur after 3pm and the QA employing a registrar to oversee discharges at the weekend suggest this will help. Yet those in sheltered housing do not cover these periods. Employing a weekend team, perhaps working alongside the Council's out of hours unit to oversee these discharges.	PHT	Safer Discharge Bundles have been brought in. Increasing discharges over weekends and early mornings. A lot of ongoing work.	
j. Effort should be continued to develop accommodation for people with physical disabilities as part of the council's house building programme and in any affordable part of private housing developments.	Head of Corporate Assets, Business and Standards	Within budget and policy framework.	Within existing.

APPENDIX ONE

Meeting Date	Witnesses	Documents Received.
11 October 2013	Claire Budden, Senior Programme Manager for the Integrated Commissioning Unit Tim Hodgetts, Service Manager for Adult Social Care Alison Croucher, Sheltered Housing Manager	Summary of resources/reports held by ASC and ICU. Hospital Discharge Information - Portsmouth City Council Sheltered Housing Service
7 November 2013	Karen Wigley and Cathryn Francis, Occupational Therapists, ASC Nigel Baldwin, Housing Enabling Manager	Paper regarding the role of the Council's OTs in the hospital discharge process.
11 December 2013	Elaine Bastable, Housing Options Manager	
3 February 2014	Due to unforeseen circumstances the Managing Director of Medicine for the Clinical Services Centre at Queen Alexandra Hospital submitted his apologies at short notice.	
18 February 2014	Due to unforeseen circumstances the Managing Director of Medicine for the Clinical Services Centre at Queen Alexandra Hospital submitted his apologies at short notice.	
24 February 2014	Chief Executive Officer of Age UK Portsmouth, Dianne Sherlock Project Co-ordinator, Age UK Portsmouth, Cindy Lillington	A powerpoint presentation which had been presented to the Board of Trustees together with the latest Reablement Pilot Project report. 'Help Around The Home' and 'Just Left Hospital? Need Some Help?' leaflets

	Sarah Adams and Andrea Fernhead from Hampshire Domiciliary Care Association Marie Edwards, Senior Manager, Hospital and Health Services, Adult Social Care	
28 March 2014 Held at Queen Alexandra Hospital	Mike Quinn, the Managing Director of Medicine for the Clinical Services Centre at Queen Alexandra Hospital	
22 July 2014	An update/review of all information received from the various witnesses was given and an update on the progress of the report was provided.	
12 December 2014	The report was signed off by the panel.	

APPENDIX TWO

GLOSSARY

ASC	Adult Social Care
CCG	Clinical Commissioning Group
CN	Corporate Nurse
DAD	Day After Discharge
DFG	Disabled Facilities Grant
DPU	Disabled Persons' Units
HA	Housing Association
HDCA	Hampshire Domiciliary Care Association
HHSRS	Housing Health & Safety Rating System
ICB	Integrated Commissioning Bureau
IDU	Integrated Discharge Unit
MDT	Managing Discharge Team
OT	Occupational Therapist
PALS	Portsmouth Advisory Liaison Service
PHT	Portsmouth Hospitals' NHS Health Trust
PRRT	Portsmouth Rehabilitation and Re-ablement Team.
QA	Queen Alexandra Hospital