Strategic Review of Housing for Older and Vulnerable People
Report No 2: Vulnerable Adults (Mental Health; Learning Disability; Physical Disability)

Executive Summary

Kingston currently lacks a strategy for older and vulnerable peoples' (O&VP) housing. Affordable housing within the borough is in short supply, with only 4,800 council owned homes and 6,000 households currently on the waiting list. It was agreed last year that a strategic review would be undertaken to address the needs of specific O&VP groups for whom the Council in many cases has a statutory duty.

The Older and Vulnerable Peoples' Housing Review formed part the of 'One Kingston' suite of projects (OK5, Project 2) and ran from May 2013 to January 2014, led by Housing Services. It took a cross departmental look at housing supply and demand issues for older people, plus certain groups of vulnerable adults and young people. The Project Board, chaired by Simon Pearce, Director Adult Social Care included representatives from Housing, Adults and Children's Services, Kingston Clinical Commissioning Group and third sector partners. The process included desktop research, discussions with key officers and external partners, also interviews and focus groups held with the relevant client groups. To ensure the review was meaningful and manageable the review looked at likely housing requirements through to 2020.

This report is the second in a series of three. The first focuses on Older People and Sheltered Housing and the third on Vulnerable Children. It is recommended that all three reports are read together to gain a full understanding of the review.

Key Findings

Skilful data mining by Strategic Business has established RBK population estimates for physically disabled adults, adults with a learning disability and adults with mental health needs. In all cases the numbers known to RBK's social care and housing services are smaller than the

predictions. More tends to be known about adults with a physical disability. For example it is known that one in five council homes, with tenants aged 18 to 64, contain a person with a physical disability.

Population growth projections indicate that across all three groups (physically disabled adults, adults with a learning disability and adults with mental health needs), numbers will increase between 2014 and 2020, although not significantly.

RBK's housing allocation policy gives added weight to vulnerable applicants and seeks to achieve fairness within limited resources and statutory obligations. With just 365 lettings a year and many competing priorities, the 'social services quota' of 25 cannot be criticised as unreasonable. But it results in some decisions that seem counterproductive – for example, sometimes forcing physically disabled people to stay in expensive residential care homes that they do not need, when they are ready to be rehoused in the community with resultant financial savings to RBK. Communication arrangements in RBK between Adult Social Care, Health and Housing Services are in no way 'broken' but need to be further developed to ensure RBK is making best use of its limited resources. It should be noted that Housing Services provide RBK's gateway to additional non council housing services including Private Sector Leasing, access to social housing from registered providers (housing associations) through the Common Housing Register, also new grant funded affordable housing developments using GLA and RBK capital funding. It is therefore even more important that good and effective liaison is maintained to enable Housing Services to support the needs of Adult Social Care and Health.

People in private accommodation who are permanently and substantially disabled may be eligible for a Disabled Facilities Grant (DFG) to provide major adaptations to their homes i.e. stair lift, level access showers or ramps. Council tenants in the same position and in need of adaptations are also able to request help from RBK. There seems to be agreement across departments that the efficiency and speed of current processes could be improved, delivering savings to the council.

Within the housing advice and homelessness service there is scope for more joined up working with Adult Social Care and Health to ensure that vulnerable people, especially those with mental health needs, are best helped into housing arrangements that support sustained recovery.

Work is underway within Adult Social Care to improve services for those with urgent needs, to achieve better outcomes and cost savings. Housing Services could make a more substantial contribution to support, provision and access to accommodation and disabled adaptations if they are more fully involved.

Housing Services may be able to deliver short term housing solutions for certain groups of vulnerable adults very quickly and cost effectively, by reusing sheltered housing that is in process of being decommissioned, or might in the near future be decommissioned due to low demand.

Recommendations arising from these findings are below. Most will need further in-depth exploration that is beyond the scope of this project before they can be taken forward as practical measures.

Summary of Recommendations

Recommendation VA1: *Housing Services should work jointly with Adult Social Care to develop housing strategies for all the major vulnerable adult groups that have been missed in the current review, e.g. drug and alcohol mis-users, homeless, victims of domestic violence. These might not need intensive study, if principles established in this review can be adapted across other needs groups. In line with good practice it will be important to include service users in future consultations on the redesign of services. This particularly applies to people with mental health needs, who can prove 'hard to reach' through conventional approaches (see page 24).*

Recommendation VA 2: *Adult Social Care/ Kingston Clinical Commissioning Group should review cases where individuals are unable to return to their home from hospital or nursing/care home because they cannot access their accommodation and, with Housing Services, seek mechanisms to ensure that all such cases achieve a suitable outcome within a target period to be agreed (see page 28).*

Recommendation VA3: *Occupational Therapists and Housing Services should review management arrangements for disabled adaptations including:*

- *A monthly 'adaptations panel', or similar, held between Housing Services and OTs*
- *A 'fast track' adaptations procedure whenever an adult is 'bed blocking' in a hospital or care home*
- *Measures to overcome the reluctance of private landlords to agree to disabled adaptations being carried out*

- *Measures to reduce wastage when previously adapted properties are vacated and relet (see pages 28-30).*

Recommendation VA4: *Housing Services to resume monitoring and review of equalities impacts of the Housing Advice service for (amongst others) vulnerable adults; for example footfall, user satisfaction and outcomes (see pages 30-31).*

Recommendation VA5: *Allocations to resume regularly quarterly reporting on housing outcomes for disability, as soon as possible, to minimise the risk of challenge (see page 31).*

Recommendation VA6: *Housing advisors (and possibly other relevant RBK and third sector services providing direct access to people who may suffer mental health issues) should undertake additional training in the detection and management of mental health issues, for those that present at their door. Housing advice especially should provide a safety net for those who manage to drift out of view of medical services. KCCG might consider funding additional advice and training for housing advisors. Training could be provided directly by health professionals, third sector partners and others as an investment in prevention (see pages 31-31).*

Recommendation VA7: *Adult Social Care/Kingston Clinical Commissioning Group should consider commissioning peripatetic housing advice and support services for patients moving towards discharge from hospital, as part of integrated housing, social care and health commissioning of preventative support; for example, to minimise the likelihood of expensive drug rehabilitation failing because the client had no stable home to go back to. Support services should follow the patient into the next stage accommodation, whether provided by RBK, third sector partners or private landlords (see page 33).*

Recommendation VA8: *Allocations Service should participate in peer learning and benchmarking, such as House Mark, and report periodically on comparative equalities policies, procedures and outcomes (see page 33).*

Recommendation VA9: *Housing Services should assert that it is not merely a contractor but a stakeholder in the planning and delivery of joined up support, based on a wider range of community based services and better information from the right person at the right time. This means willingness on the part of Housing Services to contribute resources and participate actively in reshaping services (see page 34).*

Recommendation VA10: *Operational discussions should continue between Housing Services and Mental Health with a view to firming up and implementing short term proposals for the use of redundant sheltered schemes (see pages 34-35).*

Recommendation VA11: *Adult Services should be liaising ad hoc, but at least twice a year, with Housing Development to review long term projects and ensure that Adult Services do not miss out on opportunities to secure a share of RBK's housing development programme (see page 35).*

Recommendation VA12: *Housing Development, Allocations and Occupational Therapy to review joint working on how disabled housing is commissioned to see if 'smarter working' can be achieved, producing a more appropriate fit between the design of the home and the needs of the incoming tenants. Outcomes of this review should be reported to the relevant management teams in Housing Services and Adult Social Care and agreed recommendations taken forward (see page 36).*

Background to this Report

Origins

As indicated in the Executive Summary, this project is one element of the OK5 Strategic Housing Programme that forms part of the overarching One Kingston Programme. The review was undertaken between May 2013 and February 2014. It was originally conceived as a project to help the Council to understand the housing needs of older people and to make more informed decisions about future housing supply. At the Annual Housing conference 2012 there was a strong call to develop similar strategies for a range of other vulnerable groups in Kingston. As a result the project scope was broadened to encompass physically disabled adults, adults with a learning disability and adults with mental health needs, as well as vulnerable children**.**

Objectives

The project objectives are formally set out in the Project Initiation Document, May 2013:

"Project 2, Older & Vulnerable People's Housing (O&VP) will enable the Council to make informed decisions about supply and the projected needs of O&VP through to 2020. An effective strategy will help address the balance between future O&VP housing needs and the supply of suitable long term housing.

This strategy will consider the need for new housing supply for O&VP, both public and private, and how to make the best use of existing accommodation.

Consequences of ineffective housing strategies will fall on other RBK and public services: public health, education, adult social care (ASC), children's services (CS), crime and justice, etc. Hence the strategy aims to align with Adult Social Care, Children's' Services, NHS and Public Health strategies. The project will provide an opportunity to generate collaborative solutions across departments and to involve customers and the third sector.

The first objective of the project will be to identify the likely housing needs of O&VP through to 2020 to enable better medium-term planning. The project will include a review of current housing provision, particularly of the Council's sheltered housing, which makes up around 20% of RBK's total housing stock.

The strategy that emerges will include options for redevelopment of existing HRA land and sites, private and registered provider developments and procurement of homes through private landlords. It will, therefore, also closely link to OK5 Project 3, Affordable Housing Supply."

Project Manager and Board

A project manager, Paul Kingsley, was recruited externally. He was appointed on the basis of his longstanding experience as a provider and consultant in the field of supported and sheltered housing. A Project Board was then recruited as a 'task and finish' supervisory group, aiming to meet six-weekly until the project closed in February 2014. Project board members were tasked with:

- Shaping the project Securing better outcomes and greater buy in from key stakeholders
- Helping the project to keep on track and managing and reducing risks
- Ensuring that the Council's equalities responsibilities were being met
- Providing an effective channel for input and exchange of information between the project team and internal and external stakeholders
- Ensuring the accuracy and relevance of data and analysis.

The O&VP Project Board had formal responsibility to approve progress reports to the Housing Project Board and to communicate concerns that could not be resolved within the project. It was also responsible for agreeing the final report and recommendations.

Project Board members represented a good cross section of internal and external stakeholders. Those regularly attending meetings included:

- Simon Pearce, Executive Head of Adult Social Care and Board Chair
- Loraine Shaile, Older People's Housing Team Manager
- Justine Rego, Data Team Strategic Business
- Angela Parry, Supporting People and Commissioning Manager Adult Social Care

- Peter Hodges, Chair Kingston MENCAP
- Tom Bell, Age Concern Kingston
- Andy Redfearn, Development Manager Surrey YMCA
- Dawn Secker, Practice Lead Adult Social Care
- Mac Heath, Strategic Head of LAC, Adoption and Permanency
- Theo Harris, CEO Kingston Centre for Independent Living
- Sylvie Ford, Kingston Clinical Commissioning Group
- Jo Williams, Interim Group Manager, Strategic Housing and Project Sponsor
- Paul Kingsley, Project Manager and Secretary to the Board.

Information Gathering

The project methodology involved several processes. The project manager first sought to gather background data through interviews and meetings with over 50 council officers and external stakeholders. They helpfully pointed him to a wealth of additional data on file or in the public domain. RBK's Strategic Business Unit put together all the tables and graphs, drawing on local and national datasets, to an agreed plan under the direction of Justine Rego.

The second broad phase of work comprised interviews and focus groups held over approximately two months in September and October 2013. An external experienced social worker, Diana Kuznetsova, was recruited to undertake the bulk of the interviews. Assisting her was Andrew Bushell, a third year social work student on secondment to RBK's Resettlement Team. Debbie Hunter from Strategic Business, provided the team's 'back office' and data analysis support. In all, the team succeeded in interviewing 176 individuals and holding 9 focus groups involving a total of 76 individuals. A good selection of adults 18 to 64 participated in one to one interviews. They comprised: 20 adults with a physical disability; 10 adults with a learning disability; 17 adults with mental health needs. The team was unsuccessful in arranging focus groups with disabled adults and adults with mental health needs. In line with good practice it will be important to include service users in future consultations on the redesign of services, arising from recommendation in this report. This particularly applies to people with mental health needs, who can prove 'hard to reach' through conventional approaches.

Analysis and Challenge

Following the data gathering and analysis stages, draft conclusions and recommendations were developed and exposed to constructive challenge from board members and peers within Housing Services. Concurrently, progress reports were presented to a range of council committees: Housing Partnership Board, People's Services Committee, plus an information update to the Health and Wellbeing Board in the Director's report.

Formal Consultation

Draft conclusions and recommendations were circulated to colleagues and external stakeholders prior to finalisation of the report in February 2014.

Acknowledgements

It would be impractical to name each individual who contributed to this review by the provision of advice, challenge and practical support. It would also be unfair to pick out just a few. The Project Manager expresses gratitude to them all, without whose help this project would not have been possible. Thanks also for the good humour with which everyone responded to requests for help, quite often at unreasonably short notice!

The Demography of Adult Disability in Kingston

The following section is mostly based on information from published source. ONS data has been particularly useful, alongside various published studies that are referenced in footnotes. RBK's tenancy data has also been extensively used. However within the Housing Services Department the quality of some tenancy data is seen as problematic and requiring further work, beyond the scope of this project. Uncertainties and gaps have been pointed out in the text wherever possible.

People aged 18-64 with Physical Disabilities

The adult (18 to 64) population of Kingston, with moderate or severe physical disabilities, has been estimated at just below 10,000. This has been calculated by applying latest GLA population projections to the most recent estimates of disability contained in the 'Health Survey for England, 2001'[1]. Projections to 2020 are shown below. Small but significant increases in numbers are predicted over the period for both moderate and severe disability.

People aged 18-64 predicted to have a moderate physical disability, by age, projected to 2020 in RBK

People aged 18-64 predicted to have a moderate physical disability, by age, projected to 2020 in Kingston	2012	2014	2016	2018	2020
18-24	739	752	757	753	742
25-34	1,072	1,064	1,060	1,063	1,066
35-44	1,430	1,417	1,416	1,404	1,406
45-54	2,044	2,098	2,139	2,175	2,180

[1] *'Health Survey for England, 2001' edited by Madhavi Bajekal, Paola Primatesta and Gillian Prior.*

55-64	2,337	2,318	2,363	2,454	2,552
Total population aged 18-64 predicted to have a moderate physical disability	**7,624**	**7,648**	**7,736**	**7,849**	**7,946**

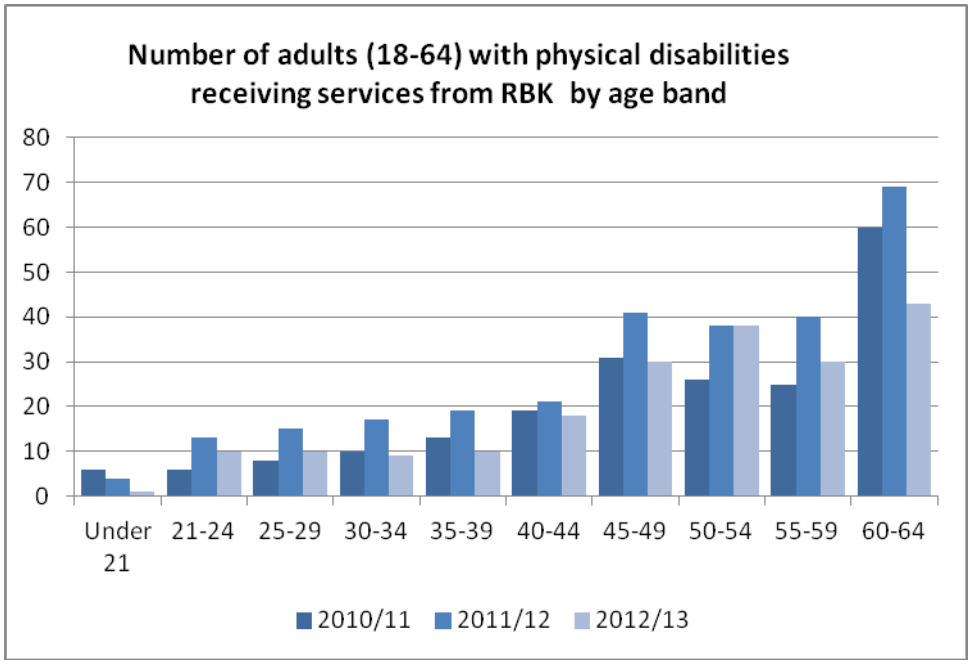
People aged 18-64 predicted to have a serious physical disability, by age, projected to 2020 in RBK

People aged 18-64 predicted to have a serious physical disability, by age, projected to 2020 in Kingston	2012	2014	2016	2018	2020
18-24	144	147	148	147	145
25-34	102	101	101	101	102
35-44	434	430	430	426	427
45-54	569	584	595	605	607
55-64	910	902	920	955	993
Total population aged 18-64 predicted to have a serious physical disability	**2,159**	**2,164**	**2,194**	**2,235**	**2,273**

People aged 18-64 with physical disability and in receipt of Adult Social Care

Out of an estimated population of nearly 10,000 physically disabled people in Kingston, there were just 199 adults aged 18 to 64, who received services from adult social care in 2013. The number has varied by a small amount from year to year but variances do not seem to follow a predictable trend.

Age distribution is indicated below, which shows that numbers rise slowly with increasing age, with step increases from age 45 and again from age 65.



Physical Disability and Tenure

Most people with a physical disability manage to live out the majority of their lives without a call on RBK's housing resources. There is no data currently available on the tenure distribution of Kingston households with a physically disabled member and it would be dangerous to assume that it faithfully reflects the wider population, where 40,762 out of 63,639 households (63%) comprise owner occupiers.

Within general needs council housing, some data is available. The number of households with a family member with a disability is recorded, but this information does not identify who within the household. Thus, these figures may include families with disabled children or family members over the age of 65. Subject to that caveat, tenancy records show 758 households out of 4,802; nearly one in five, include a person with a disability. RBK records show that this number includes:

- 44 with a sensory impairment
- 145 with a physical impairment
- 376 with unspecified or multiple disabilities.

People aged 18-64 with a Learning Disability

The adult (18 to 64) population of Kingston with moderate or severe learning disabilities has been estimated as just over 2,500[2]**.** Projections to 2020 are shown below. A small but significant annual increase in numbers is predicted.

People aged 18-64 predicted to have a learning disability, by age, projected to 2020 in Kingston	2012	2014	2016	2018	2020
18-24	485	494	497	494	487
25-34	636	631	628	630	632
35-44	626	620	620	614	615
45-54	481	493	503	511	512
55-64	345	342	349	362	377

[2] Source : Prevalence rates for people with a complex or severe learning disability established as a proportion of those known via learning disability registers (the administrative rate as established by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004).

Total people aged 18-64 predicted to have a learning disability, by age predicted to 2020	**2572**	**2579**	**2597**	**2612**	**2623**

Estimates are available, using the same methodology as before, to show people with:

- Learning disability (includes moderate and severe) – 587
- Severe learning disability – 173
- Downs syndrome – 72
- Autistic spectrum disorder, males – 1,092
- Autistic spectrum disorder, females – 116.

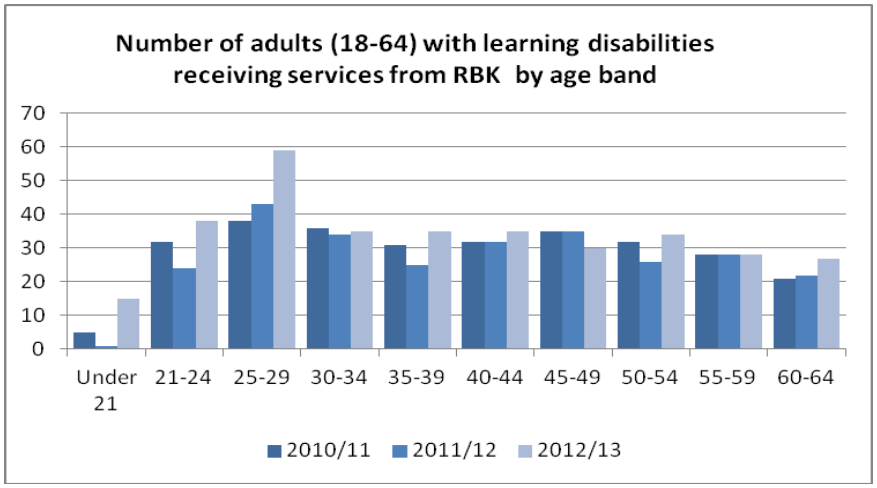
People aged 18-64 with Learning Disabilities and in receipt of Adult Social Care

People with a learning disability are more likely to access a council service than those with a physical disability. For learning disability the ratio of people with a disability in receipt of a council service to all people with a disability is 13%, compared with 2% for physical disability.

However the take-up of council services by people with a learning disability is substantially lower than predicted by the Emerson and Hatton study referred to above. Their predicted figure for 2014 is 587 or 23% of the population with a learning disability, against 336, or 13%, actually receiving services in 2013 from adult social care[3].

The distribution by age of service users shows that whilst childhood numbers are low, they rise but then level off in adulthood. However there is a spike in the 25 to 29 age group. As this cohort ages, the spike will presumably progress through the age bands.

[3] *Source : Referrals, Assessments and Packages of Care returns 2010/11, 2011/12 and 2012/13*



Learning Disability and Tenure

There is no published data on tenure of people with a learning disability in Kingston, a population numbering some 2,500. However, information has been collected on the accommodation status of the 336 learning disabled social care clients. According to this, just over two in three live in the community.

Type of Service	2010/11	2011/12	2012/13
Community	186	178	238
Nursing	2	1	3
Residential	102	91	95
Grand Total	**290**	**270**	**336**

Within general needs council housing, tenancy records show only nine households showing with a learning disability although there are 758 council households that record a person with a disability. Nine is therefore likely to be a gross under-recording. Another data source, the Adult Social Care Combined Activity Return (ASC-CAR) to Health & Social Care Information Centre, 2012/13 indicates that only three people with a learning disability in Kingston are council tenants (there is no ALMO in Kingston). But 127 are recorded as living with family or friends, i.e. living in households where another person, such as a parent, is the main tenant or homeowner. This probably explains why under-recording of learning disability takes place relating to council homes. Of the remainder, 168 are living in supported accommodation (only four of which are directly provided by RBK in Kingston) and 95 are in residential care.

Accommodation	2012/13
Supported accommodation	168
Adult Placement	2
Registered care home	95
Registered nursing home	3
Acute/long stay healthcare	2
Owner occupier	1
Tenant LA/ALMO	3
Tenant private landlord	5
Family/friends	127
Total	**406**

Source : ASC-CAR Return to HSCIC

Note: ASC-CAR total does not tally with previous table as it includes people 65 and over.

Living with Parents

It is important to understand the phenomenon of learning disabled people living with parents and how, from age 45, some start to encounter problems as parents grow older and become unable to support their adult children. By age 55 it has become a cliff edge: Hardly any are still living with parents beyond 54. This has implications for housing, care and support planning.

People aged 18-64 predicted to have a moderate or severe learning disability and be living with a parent, by age, projected to 2020 in Kingston	2012	2014	2016	2018	2020
18-24	78	85	87	87	86
25-34	68	75	81	86	91
35-44	63	65	68	71	74
45-54	26	27	28	30	30
55-64	7	7	8	8	9
Total people aged 18-64 predicted to have a moderate or severe learning disability and be living with a parent, by age, projected to 2020	242	259	272	282	290

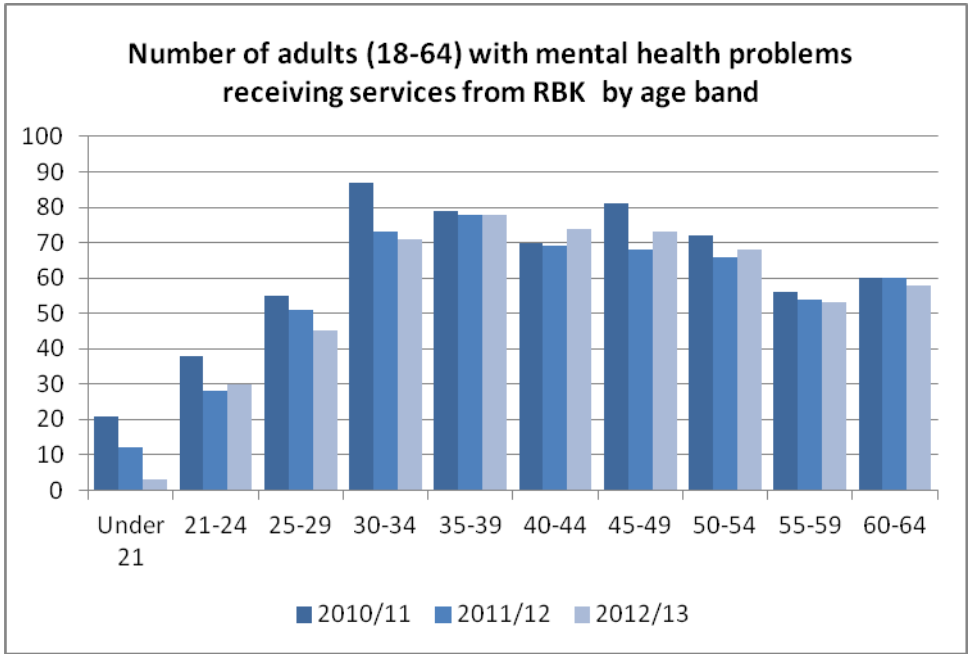
People aged 18-64 with Mental Health Needs

The adult (18 to 64) population of Kingston with a mental health need had to be extrapolated from national data. The tables below show estimated male and female populations between 2012 and 2020. Population projections through to 2020 show rising numbers year on year. There are significant gender differences. Disorders cannot be totalled due to possible double counting, however it is estimated nationally that just under a quarter of adults (23.0%) meet the criteria or have screened positive for at least one of the psychiatric conditions below. Of those, 68.7% meet the criteria for only one condition, 19.1% meet the criteria for two conditions and 12.2% meet the criteria for three or more conditions.

Males aged 18-64 predicted to have a mental health problem, projected to 2020	2012	2014	2016	2018	2020
Common mental disorder	6,555	6,611	6,670	6,718	6,757
Borderline personality disorder	157	159	160	161	162
Antisocial personality disorder	315	317	320	322	324
Psychotic disorder	157	159	160	161	162
Two or more psychiatric disorders	3,618	3,650	3,682	3,708	3,730

Females aged 18-64 predicted to have a mental health problem, projected to 2020	2012	2014	2016	2018	2020
Common mental disorder	10,525	10,494	10,550	10,617	10,665
Borderline personality disorder	321	320	321	323	325
Antisocial personality disorder	53	53	54	54	54
Psychotic disorder	267	266	268	269	271
Two or more psychiatric disorders	4,007	3,995	4,017	4,042	4,060

There were 553 people with mental health needs receiving a service from RBK in 2012/13. Age bands are shown in the Table below. It will be seen that service user numbers grow through to the 35-39 age band and then decline slowly till age 60-64, when numbers rise again mainly due to increasing onset of dementia.



Mental Health Needs and Tenure

Again there is no published data on tenure in Kingston for the overall population with mental health needs; estimated to be 7,645 (2014). The accommodation status of the 553 social care clients is shown below. It is noteworthy that, at any given time, the overwhelming majority are living in the community. But probably a higher number go into hospital from time to time, with a relatively short stay.

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Type of Service	2010/11	2011/12	2012/13
Community	589	530	525
Nursing	4	4	5
Residential	26	25	23
Grand Total	**619**	**559**	**553**

Within general needs council housing, tenancy records show 135 households where mental health has been logged as a disability category. This is out of 758 council households that record a person with a disability.

Consultation with Vulnerable Adults

One-to-one Interviews

The consultation team carried out 39 one-to-one interviews in total, with a range of vulnerable adults including 13 people with physical disabilities, nine with learning disabilities and 17 with people with mental health needs. General needs housing tenancy records provided some contact details. Names and introductions were also provided through Housing Resettlement Team, Kaleidoscope Project, MIND in Kingston (interviews were held at the MIND Café), Kingston Mencap, Kingston Centre for Independent Living, the Learning Disability Parliament, Kingston YMCA and others. All of the people who agreed to participate preferred to be interviewed one to one.

The samples were ethnically mixed: one black African, five Asian, one Arabian, nine white British. Ages ranged from 27 to 63. Gender was 23 male to 16 female. Tenure included five hostel residents (Kaleidoscope), 19 RBK tenants, six housing association tenants, ten private tenants, one owner occupier. Over 40 questions were asked, using a standard template and a mix of closed and open ended questions. Key findings are set out below.

Adults with Mental Health Needs

- Respondents were mostly single people and lived on their own.
- Most common conditions amongst the respondents were depression and anxiety.
- Most of the respondents had a combination of mental health conditions and physical health problems.
- Around half of the respondents were drug addicts or recovered drug addicts. They also believed that their mental health problems were triggered by taking drugs. People also acknowledged that their physical health suffered from using drugs and caused conditions such as liver cirrhosis and cardiac conditions.
- Common reasons for moving to present addresses were facing homelessness, after being discharged from hospital and due to health reasons.
- Those seeking to move and those content to stay were about evenly divided; the same applied to hostel residents as a group.
- Most of the interviewees from the Kaleidoscope hostel were happy with the support from their key workers and other professionals.

- Some clients of the Kaleidoscope project felt that they could not socialise there, due to fear of being influenced to take drugs by other drug using residents.
- Interviewees emphasised the importance of emotional support. Nearly all respondents were getting some form of professional support. One respondent (the Mind Café) felt that there was not enough support provided for people with mental health needs in Kingston, apart from the Mind Café.

Adults with Learning Disabilities

- Most of the respondents with learning disabilities were satisfied with their homes and the support they received, though six households were in temporary accommodation and would therefore require a move in due course.
- All bar one of the six private tenants were looking to move. Common reasons for wanting to move were 'bad landlords' who did not provide any repairs or had a bad attitude towards the tenant, dislike of neighbourhood (students, noise), wanting to move to the country.
- In five out of six (non-temporary) cases where people wanted to move, problems with inadequate space and mobility issues were cited.
- Respondents generally thought that they would benefit from more social opportunities and having someone to help them with practical things.
- Respondents did not need have a need for adaptations in their homes, now or in the future.

Adults with Physical Disabilities

- Six out of 13 respondents lived alone.
- Medical conditions amongst the respondents varied; five considered their disability to be 'moderate', and seven 'severe'[4].
- Ten households were council tenants. Reasons for moving to present addresses often included being unable to cope physically in the previous home. Five household were rehoused from a potential homeless situation, or from temporary accommodation.

[4] *Moderate would mean that you need help with some needs such as getting in and out of bed, getting in and out of a chair, dressing, washing, feeding, and use of the toilet. Moderate means you could perform these tasks yourself with some difficulty. Severe means that the tasks above always require someone else to help.*

- Five households thought their present home was ‘fine as it is’; the others were either seeking a home with more space, wanted repairs to be done or needed adaptations.

Housing Issues and Recommendations

Housing and Vulnerable Adults

Housing Services' contribution to the recovery and wellbeing of vulnerable adults ('safe, happy, healthy') currently consists of:

- Providing suitable housing advice
- Providing access to council housing, or other suitable accommodation, for those with a priority need for accommodation
- Providing access to disabled adaptations (Disabled Facilities Grant- DFG)
- Providing access to housing-related support (e.g. resettlement, floating support).

The scope of this report excludes some categories of adult vulnerability, notably domestic violence, drug and alcohol misuse and homelessness. Although it is important that all vulnerabilities are considered in relation to housing, it is beyond the scope of this report to address them all.

Recommendation VA1: *Housing Services should work jointly with Adult Social Care to develop housing strategies for all the major vulnerable adult groups that have been missed in the current review, e.g. drug and alcohol misusers, homeless, victims of domestic violence. These might not need intensive study, if principles established in this review can be adapted across other needs groups. In line with good practice it will be important to include service users in future consultations on the redesign of services. This particularly applies to people with mental health needs, who can prove 'hard to reach' through conventional approaches.*

Fair Access to Housing Resources

Only a small section of the population of vulnerable adults is known to RBK's housing service. Data in this report shows the extent to which vulnerable groups are not in contact with RBK about housing or support. Most physically disabled adults are not in contact with RBK about housing or support, as indicated by the gap between the estimated population of 9,812 and the 199 receiving adult social care and the 758 council tenants. There are proportionately more adults with a learning disability, who access housing or a social service: from the estimated population of 2,579, those receiving adult social care number 336 and those holding a council tenancy number just nine. With regard to

people with mental health issues, the estimated population is 7,645, whilst those receiving adult social care is 533 and those holding a council tenancy is 135. Concerns about the accuracy of RBK housing data have already been noted.

Where only a small minority within certain groups, such as learning/physically disabled adults present to RBK for a service, it is difficult to assess whether that group's housing and support needs are being adequately addressed. But it is possible to ask:

- Are housing related services compliant with the main Equalities Act and Housing Act duties towards vulnerable adults?
- Does RBK procure suitable accommodation for people who are vulnerable because of disability and have a priority need for accommodation?
- Within constraints of resources, does RBK provide access to disabled adaptations, including Disabled Facilities Grant?
- Does RBK provide access to housing-related support (e.g. resettlement, floating support)?
- Are RBK's housing services well promoted and taken up?
- Are they effective and efficient and do they compare well with peer authorities?

Statutory Duties and Provision of Suitable Accommodation

The Equality Act 2010 (successor to the Disability Discrimination Act and other equalities legislation) places a duty ('the general equality duty') on public authorities to have due regard to the need to:

- Eliminating discrimination, harassment and victimisation and any other conduct that is prohibited by, or under, the Act.
- Advancing equality of opportunity between people who share a relevant protected characteristic (such as a physical disability) and people who do not share it.
- Fostering good relations between people who share a relevant protected characteristic and those who do not share it.

The Equality Act explains that advancing equality includes:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people with protected characteristics, where these are different from the needs of other people.

In relation to housing services, both these duties should come into play.

In addition, under The Housing Act 2006 homeless criteria, households that include someone who is vulnerable because of physical or mental disability have, a "priority need for accommodation". The Act states that housing authorities must ensure that suitable accommodation is available for people who have a priority need, although the housing authority can provide accommodation in their own stock, or arrange for it to be provided by another landlord, such as a housing association or a landlord in the private rented sector.

It is clear that RBK does strive to comply with Equalities and Housing Act duties. For vulnerable households in housing need, Kingston's housing allocation policy gives preference to housing applicants (or members of their household) who have a medical condition or disability that is affected by their housing circumstances. RBK offers three categories of medical priority:

1. "Over-riding Medical Priority", which covers life-threatening conditions which are seriously affected by the current home, also situations where an individual is unable to return to their home from hospital because they cannot access the accommodation. Applications awarded over-riding medical priority will usually be placed in Band A, which is likely to result in a successful bid under the Choice Based Lettings (CBL) system. It is estimated that 95% of band A applicants who bid 'realistically' and actively should be successful within three months.
2. "High Medical Priority" covers housing conditions with a 'major adverse effect' on the health of the applicant or a member of their household. Any application awarded high medical priority will usually be placed in Band B. Most applicants in this situation will be re-housed within 12-18 months if they bid realistically, though it could be longer than this under certain circumstances.
3. "Medical Priority" covers housing conditions that have an 'adverse effect' on the health of the applicant or a member of their household. Any application awarded medical priority will usually be placed in Band C, which for practical purposes is unlikely to result in a successful bid at all unless the applicant is registered for sheltered/older persons housing.

In addition to the award of medical priorities as outlined, RBK also seeks to ensure that households with a mobility need are offered first choice of properties with suitable level access and adaptations. When such vacancies come up, these properties are effectively "ring-fenced" and offered to those bidders who have been assessed as needing them the most.

RBK's housing allocation policy gives an additional access route to social housing for vulnerable applicants as shown in the table below. The 'social services quota' provides enhanced access to choice based lettings. 'Social Services' (adults and children combined) has an annual quota of 25 lettings, which is just over one in fifteen of the annual projected lettings of 365 for the year 2013/14.

Quota Group		**Annual Quota**	**Housed since April 2013**	**Current nominations**
MH	Mental Health	12	2	14
YPLC	Young Person Leaving Care	8	12	17
CHA	Children Act 1989	2	3	5
DIS	Physical Disability	1	1	4
CDIS	Children with Disabilities	1	0	0
LDIS	Learning Disability	1	0	10
		25	**18**	**50**

By the end of July 2013, more than half of social services' annual quota had already been used up; households housed represented slightly over one third of applicants on the list of nominations. But at the half year, the housing of people with mental health needs had notably fallen short of quota; in five cases this seemed to be due to lack of recent contact from the nominee, which may in turn have something to do with unsettled lifestyles of some in this group.

Whilst only over-riding and high priority disability cases have a reasonable chance of obtaining a suitable social housing tenancy, the allocations policy is an attempt to distribute an almost impossibly scarce resource fairly between competing needs. Whether or not the social service quota represents a fair distribution of a scarce housing resource can (and possibly will be) argued over forever. In the event of challenge, it is important that the basis of reaching decisions is clearly recorded and can be defended as reasonable and legally compliant. An equalities impact assessment was undertaken prior to the 2012 review of allocations, leading to the present 2013 allocations policy. Records are available to the public via the council's website concerning the basis on which the decision to adopt the current allocations policy and quotas was taken.

This project heard of one wheelchair user, with a long term disability, who needs adapted housing suitable for his needs. He has been in a nursing home for more than a year, apparently because the social services quota will require him to wait for four or five years before being offered alternative accommodation. He does not require nursing home care, so remains in inappropriate accommodation when he could, apparently, be supported to live in the community. At face value this suggests some malfunction within the medical priority system or an inadequate quota for physical disability. Either way, the cost to RBK of keeping this person needlessly in a nursing home is likely to be more that £700 per week; enough to support a mortgage on a family home.

Recommendation VA 2: *Adult Social Care/ Kingston Clinical Commissioning Group should review cases where individuals are unable to return to their home from hospital or nursing/care home because they cannot access their accommodation and, with Housing Services, seek mechanisms to ensure that all such cases achieve a suitable outcome within a target period to be agreed.*

Disabled Adaptations

RBK should look again at the way disabled adaptations are managed. The outcome should be the speedy identification of a household's needs, leading to a quick decision, followed by quick and cost effective implementation.

Adults in privately owned or rented accommodation who are permanently and substantially disabled may be eligible for a Disabled Facilities Grant (DFG) to provide major adaptations to their homes, e.g. stair lift, level access shower or ramps. Council tenants in the same position and in need of adaptations are also able to request help from RBK. An occupational therapist's (OT's) assessment is required for this, though control of adaptations lies within Housing Services.

Liaison arrangements are in place to ensure where possible that OT recommendations to Housing Services for major adaptations (or if necessary a housing transfer) are made before the point of need, with the aim of ensuring that the work can be completed in time to avoid a breakdown in the home care management situation, due to lack of suitable accommodation or care facilities.

This is a complex operational area involving a range of stakeholders. These may include residents, private landlords, Housing Services, Occupational Therapists, third sector organisations who provide advice and practical assistance, hospitals, Adult Social Care. Each has a different perspective and set of financial constraints. For example, in the case of privately rented housing, it is usually difficult to secure major

adaptations that affect the structure or appearance of a property, but would enable a disabled resident continue living safely and comfortably. Private landlords mostly do not welcome adaptations that might reduce the appeal of the property to a future incoming tenant, even if paid for by someone else. It is also hard for RBK to justify an expensive adaptation when there is no guarantee that it will be retained for future use if the existing tenant eventually moves on. HRA and DFG funds are currently rationed and may need to reduce in the coming years, so it is essential that investments are not squandered as a result of being removed after a short period.

There is also recognised wastage where the council has invested in adaptations for a particular tenant, who subsequently moves out. Under pressure of time to get the property relet, it is not usually possible to find a disabled applicant with matching needs. This means expensive equipment, such as a stairlift, is removed rather than re-utilised for someone else.

A further inherent difficulty with the management of disabled adaptations is that budgets are fixed while demand is hugely unpredictable. Most adaptations are relatively inexpensive and can be budgeted for annually. Occasionally, however, the demand will come along for, say, a tracked hoist or through-floor lift that is hugely expensive.

There seems to be agreement across departments that the efficiency and speed of current processes could be improved, along with better liaison arrangements. Hopefully more effective joint working between Adult Social Care (OT department) and Housing Services on this would deliver savings to the council.

One suggestion is to introduce a ‘fast track’ procedure whenever an adult is ‘bed blocking’ in a hospital or care home but could, with suitable adaptations, return to a home in the community. The cost of a residential care bed in the private and voluntary sector is over £500 per week. Considering the weekly cost of delay, there is insufficient urgency in the current process. Part of the adaptations budget could be placed under direct Adult Social Care control for urgent cases, subject to appropriate controls. If homecare costs are racking up at more than £500 per week, there is no point spending two additional weeks deciding whether £1,000 investment in an adaptation that would get someone back home is justified – it is self evidently an investment with a two week payback and should be progressed.

Protecting the council’s DFG investment in privately rented accommodation might be resolved through a special agreement with the landlord to ensure the retention of the property for letting to a disabled person for a certain number of years. This could include, for example, offering a form of income guarantee or compensation where a landlord agrees to an alteration which makes the property hard to let, should the

current disabled tenant vacate within a certain period. This would help allay landlords' understandable concern at the prospect of being unable to re-let a highly adapted property. The cost of such a measure should be weighed against the cost of having to move the tenant into the social sector and undertaking adaptation works there instead.

RBK should also consider possible measures to reduce wastage when adapted properties become void, through earlier and more accurate matching of waiting list data with information held on property adaptations. Joint work on a more accessible database of property features (responsibility of Housing Services) including adaptations in place, and suitability for various forms of further adaptation, together with a more accessible database of disability requirements of applicants (responsibility of Occupational Therapists), could make it possible to match disabled applicants more often and more accurately with pre-adapted homes.

Occupational Therapists, Housing Services and other agencies need to work more closely together to achieve these aims. For example a monthly adaptations panel, which has worked well in other local authorities, could contribute towards a solution. This would ensure effective communication and challenge between the key players and that informed decisions are made relatively quickly.

Recommendation VA3: *Occupational Therapists and Housing Services should review management arrangements for disabled adaptations including:*

- *A monthly 'adaptations panel', or similar, held between Housing Services and OTs*
- *A 'fast track' adaptations procedure whenever an adult is 'bed blocking' in a hospital or care home*
- *Measures to overcome the reluctance of private landlords to agree to disabled adaptations being carried out*
- *Measures to reduce wastage when previously adapted properties are vacated and relet.*

Promotion and Take Up

Kingston is committed to developing online services, in preference to face to face and telephone, wherever possible and has recently launched its new-look website. As this is relatively new, it is too soon to report on its effectiveness in delivering housing advice and access to the housing register for vulnerable households, but hopefully equalities monitoring and reporting will become part of normal business in due course, if it is not so already. Throughout this project, concerns have been heard about 'digital exclusion' of the old and economically disadvantaged who

may lack access to the internet. Clearly some vulnerabilities, such as visual impairment or mental ill health, may also result in disadvantage (as defined in the Equalities Act) in accessing internet services.

Kingston's web policy seeks to follow best-practice accessibility guidelines such as the Web Content Accessibility Guidelines (WCAG 2.0, Level AA), and is seeking to improve compliance to AAA. It is beyond this project's scope to make detailed recommendations, in terms of future monitoring and reporting and it must be taken on trust that this agenda is in hand.

Housing Advice is still available in person at Kingston's Advice Centre in Guildhall 2. The IT allocations system, Universal Housing, gathers data that advisors input as part of every consultation, which should enable further reporting and monitoring. However, it appears that no regular monitoring or review currently takes place. This may be because of some of the issues encountered in switching from Orchard, the previous housing management system, to the new, Universal Housing.

Recommendation VA4: *Housing Services to resume monitoring and review of equalities impacts of the Housing Advice service for (amongst others) vulnerable adults; for example footfall, user satisfaction and outcomes.*

The allocations team is required, by the current allocations policy, to produce quarterly monitoring of equalities impacts. Regular reporting on disability and mental health outcomes should confirm that disabled families and those with mental health needs are receiving no less favourable treatment; in fact the opposite is likely to be the case if Equalities Act principles are being followed. Technical issues with the implementation of the new Universal Housing case management system has put quarterly reporting on hold for the time being and this issue needs to be resolved.

Recommendation VA5: *Allocations to resume regularly quarterly reporting on housing outcomes for disability, as soon as possible, to minimise the risk of challenge*.

Homelessness and Mental Health

The categorisation of vulnerability by the local authorities has some inevitable arbitrariness about it and can depend on which service is being approached and under what circumstances. For example, a single person presenting to the housing advice service as homeless might also be a

person with a physical disability, a mental health need, a learning disability, a history of drug/alcohol misuse, a history of domestic violence, or any combination. These needs might be previously known or unknown to RBK services and may not be disclosed when approaching RBK for help with housing.

In the case of a single person presenting to the housing advice service as homeless, but not revealing a mental health or drug history, it would depend on the advisor's skill and experience whether that suspicion was picked up from the applicant's story or behaviour. This might make the difference between being helped with an offer of housing or being refused. In the event of suspecting a mental health dimension to an applicant's housing problem, procedures would kick in to ensure contact with the community mental health team and/or GP to obtain a fuller background, but housing advisors do not receive training in the detection of mental health issues.

It will always be possible that certain vulnerabilities are missed, as in the example above. However, effort should be made to minimise this possibility through continuing 'on the job' training. RBK has access to health professionals who have an interest in sharing their expertise and reducing the incidence of hospitalisation and other unwanted outcomes that place a burden on RBK resources elsewhere. More sharing of knowledge within and across departments should be encouraged.

An assessment of potential harm to the applicant or to others is a major determinant of who gets help under homelessness procedures. Even someone who is street homeless would not automatically be considered for an offer of suitable housing, such as a hostel placement, if it was considered that they had networks that would keep them out of harm. Mental ill health is known to be both a cause and a consequence of homelessness. It can trigger, or be part of, a series of events that can lead to homelessness. For example, one study showed that 42% of clients of homelessness services in England had mental health needs and 18% had a personality disorder.[5] Another study found that the homeless population had twice the levels of common mental health problems when compared to the general population. Psychosis was 4 to 15 times more prevalent in the homeless population[6].

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[5] *Homeless Link (2011) Survey of Needs and Provision (SNAP)*

[6] *Crisis (2009) Mental Ill Health in the Adult Single Homeless Population: a review of the literature*

It seems likely that greater awareness of the mental health impacts of street homelessness and more housing and support resources devoted to street homeless people would reduce the strain on other RBK resources and ultimately result in savings.

Recommendation VA6: *Housing Advisors (and possibly other relevant RBK and third sector services providing direct access to people who may suffer mental health issues) should undertake additional training in the detection and management of mental health issues, for those that present at their door. Housing advice especially should provide a safety net for those who manage to drift out of view of medical services. KCCG might consider funding additional advice and training for housing advisors. Training could be provided directly by health professionals, third sector partners and others as an investment in prevention.*

Homelessness can also be prevented by ensuring assistance is available at known risk points, such as discharge from hospital. Statutory guidance to local authorities concerning Housing Act 2006, prevention of homelessness functions, recommends early planning for discharge between institutional staff and local housing providers including, prior to discharge, provision of advice by the local housing authority on housing options.

Recommendation VA7: *Adult Social Care/Kingston Clinical Commissioning Group should consider commissioning peripatetic housing advice and support services for patients moving towards discharge from hospital, as part of integrated housing, social care and health commissioning of preventative support; for example, to minimise the likelihood of expensive drug rehabilitation failing because the client had no stable home to go back to. Support services should follow the patient into the next stage accommodation, whether provided by RBK, third sector partners or private landlords.*

Quality Assurance

Through the One Kingston programme, Kingston's performance culture is being steadily improved. Peer group learning and benchmarking is becoming a driver for performance improvement. Evidence that RBK undertakes peer group learning and benchmarking also provides a further defence against challenge concerning equalities outcomes, if best practice can be demonstrated.

Recommendation VA8: *Allocations Service should participate in peer learning and benchmarking, such as House Mark, and report periodically on comparative equalities policies, procedures and outcomes.*

The housing waiting list is a further indicator of equality of access. If institutional barriers exist that disadvantage households with a disabled member, they should show up in the numbers. Anomalies will appear due to the nature of the housing stock and its effect on various needs groups, but these will serve as 'can openers', forcing a search for answers, or if none exist, remedial action. The allocations team produces such a report annually.

Housing Related Support

Adult Social Care (ASC) intends to re-commission all its Supporting People support services in 2014. The Housing Service is currently a major support provider to ASC, through the sheltered scheme managers and the resettlement service. The possibility of the sheltered support service growing into a floating support model will, hopefully, be discussed shortly and could result in additional floating support being available for vulnerable adults in the community. In addition, the sheltered management team is developing proposals for a cost effective community alarm service that deserve further consideration. ASC, in partnership with the Public Health Team and NHS Kingston, is also looking at how information, advice and preventative support can help adults to stay independent, safe and well for as long as possible. Maximising individual choice and control will be one focus of the commissioning programme.

Recommendation VA9: *Housing Services should assert that it is not merely a contractor but a stakeholder in the planning and delivery of joined up support, based on a wider range of community based services and better information from the right person at the right time. This means willingness on the part of Housing Services to contribute resources and participate actively in reshaping services.*

Re-purposing Surplus Sheltered Housing Accommodation

RBK is very constrained in the supply of additional social, or 'affordable', housing. Land and finance are limited and OK5 Project 3 is seeking to deliver as much as possible within those limitations. Timescales from identifying a vacant site to handing over keys to new tenants could be anything up to three years, and perhaps five for a building that is part tenanted.

However, there is another potential housing resource that could deliver short term housing solutions for vulnerable adults very quickly. Sheltered housing, that is in process of being decommissioned or might in the near future be decommissioned, due to low demand could be re-utilised for this purpose.

For example, Adult Social Care has advised that there are a number of younger (22 – 35 years) mental health and substance misuse service users who would benefit from a period of time in shared accommodation because they do not have sufficient skills to live independently. In some cases they cannot remain at home because of family relationship difficulties or more often, simply because it is time for them to move into a more independent setting. A pilot scheme using a four bedroom private landlord property is now being established. A specialist provider of mental health and substance misuse care will deliver support to the four individuals, in terms of working with them on their independent living skills, re-entering education, vocational or paid employment and supporting them if they are on medication. On current estimates, costs will be a quarter of the cost of conventional placements. This model is proposed to be extended to a sheltered scheme where further equivalent savings might be made, while bringing a partially empty sheltered scheme back into full use. A business case is under development with Adult Social care to enable Housing Services to consider how to progress this. It appears that savings in the order of £1 million over threee years are possible.

Recommendation VA10: *Operational discussions should continue between Housing Services and Mental Health with a view to firming up and implementing short term proposals for the use of redundant sheltered schemes.*

New Housing Development

Families with a disabled child as well as disabled adults with a family have particular housing needs which in many cases can only be met by an adapted family sized home with a garden and full wheelchair access. Social rented homes of this type are in short supply, whether RBK or registered provider (housing association) owned. The RBK brief for affordable homes includes the Lifetime Homes Standard throughout and new affordable housing strategies will look to include the building of some specialised 'disabled persons units' (DPUs) to full Mobility Standards.

Recommendation VA11: *Adult Social Care should be liaising ad hoc, but at least twice a year, with Housing Development to review long term projects and ensure that Adult Services do not miss out on opportunities to secure a share of RBK's housing development programme.*

Getting individual designs right for a disabled family is not straightforward and needs a blend of building and occupational therapy (OT) knowledge and skills. These should ideally be based on a detailed understanding of a particular family's needs where it is known who the tenant will be will. The allocations process needs to be part of the solution here, with a home pre-allocated at a point in time when it can still

be customised. At one time there was an OT 'Access Officer' post based within Housing Services that helped ensure designs of new schemes best met individual disability needs. Current design scrutiny is arguably less bespoke and the following examples are from recently built disabled housing where there was no OT input:

- Front doors built to 850mm width (enough for a standard wheelchair to get through), with all internal doors at 750mm width (marooning any wheelchair user in the hallway)
- Underground car parks with marked disabled parking bays that lacked sufficient headroom and rear clearance for an adapted wheelchair-carrying vehicle to be accessed.

It is recognised that within current budget constraints, ways must be found to 'work smarter' within existing resources if the best possible outcomes are to be gained in future. Modern housing is less adaptable 'after the event', especially when modular timber framed construction makes it very difficult to later remove walls or widen doorways.

Recommendation VA12: *Housing Development, Allocations and Occupational Therapy to review joint working on how disabled housing is commissioned to see if 'smarter working' can be achieved, producing a more appropriate fit between the design of the home and the needs of the incoming tenants. Outcomes of this review should be reported to the relevant management teams in Housing Services and Adult Social Care and agreed recommendations taken forward.*