Leicester
City Council
Housing

Guidelines for Social Care and Health staff when making referrals to Housing

Agreed in consultation with:
Hostels & Supported Housing Service Manager
Housing Community Care Service Manager
Social Care & Health Service Manager
Head of Housing Options Service
Community Homeless Practitioner Nurse
(Leicester Homeless Primary Health Care Service)

Amended December 2004

GUIDELINES FOR STAFF MAKING REFERRALS TO HOUSING:

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GUIDELINES FOR SOCIAL CARE AND HEALTH STAFF MAKING REFERRALS TO HOUSING:

Is There a Housing Issue?

Hospital Admission and Discharge – Information that may be of some assistance to Ward Staff, Social Care & Health with regard to Housing.

Many people entering hospital for treatment will live in their own homes and will have settled accommodation to return to, whilst others may be of no fixed abode or may loose their accommodation whilst in hospital. Lone occupants may also on admission have left pets in their home or may, for instance, be returning to a property that is unfit, unsafe and cold. These are just some examples but one is quickly able to recognise that housing issues need to be addressed both at admission stage and again when a discharge date is imminent. **An early response to the patient's housing problems may for instance prevent homelessness, escalating arrears, potential delay in discharge and additional stress to the patient.**

The following list of trigger questions may be useful on pre-admission or admission for Social Care and Health staff:

1. Does the patient just admitted:

- ✔ Live alone?
- ✔ Require arrangements to be made for paying rent?
- ✔ Require arrangements to be made for securing their property?
- ✔ Require arrangements to be made for safeguarding / feeding pet?
- ✔ Require arrangements for turning the heating on prior to discharge?

2. Do Housing / Social Care and Hospital Staff need to be contacted to deal with any of these problems?

3. Can the patient return to their previous home / address or do they need to move to an alternative form of accommodation? (e.g. Sheltered / Supported / Warden Assisted Accommodation). Is there any risk to the patient returning to previous accommodation?

4. Does the patient present any risk to self or others?
In considering risk consider: ***1)*** environmental risk if returning to own accommodation or temporary accommodation ***2)*** risk to others from change in health status for instance with behavioural or anti-social behaviour issues presenting on the ward or known.

5. Is the patient to be discharged likely to need:

- ✔ Aids and equipment?
- ✔ Minor adaptations?
- ✔ Housing renovation?
- ✔ Alternative housing?

6. What is the housing tenure of the patient to be discharged as you may need to contact an appropriate landlord. Always check and get confirmation that your patient can return to that accommodation. If previous accommodation was at a hostel, ensure that some assurance is given that your patient's accommodation will be kept available for that day. If hostel staff can not give that assurance discuss with the team leader in Housing Community Care Team. If homeless, a Planned Discharge with an appropriate Care Plan meeting / Care Package may be necessary.

- ✔ Owner-occupier?
- ✔ Council tenant?
- ✔ Housing association tenant?
- ✔ Private tenant?
- ✔ Homeless?
- ✔ Lodger?

7. Has the patient enough money for discharge?

8. Does the patient need to clarify their personal benefit entitlement with the Benefits Agency?

9. Does the patient need to be referred to Primary Community Health Services or to Social Care & Health?

10. Do representatives of the Housing Department / Housing Association need to be contacted?

11. Does the designated Housing Community Care Officer or Housing Options Centre Officer need to be contacted?

12. Does the patient need information? (e.g. local housing office, benefit information, …).
If the answer to any of the above is yes then direct to relevant services.

Housing Triggers

At point of admission has it been established that the patient has suitable accommodation to return to in order to aid a safe discharge?

YES / NO

If No see page 5 a), b), c) and d) and then flow charts 1 and 2 on pages 7 and 8.

Does the patient require a Housing Needs Assessment?

YES / NO

If Yes see page 5 a), b) and c).

Does the patient require any further assessment prior to discharge e.g. a basic Occupational Therapist / Physiotherapist / Risk Profile Assessment prior to discharge to establish if there are any risks or safety issues?

YES / NO

If yes contact Hospital ward.

Does the patient require any assessment by a Community Occupational Therapist in their home or a referral to relevant support agencies?

YES / NO

The check list below may trigger both Hospital Staff and Social Care and Health Staff to consider Housing issues as follows:

- ✔ Do you know the main housing agencies in your area (local housing office, homelessness unit, housing associations, voluntary run hostels)?
- ✔ Do you have a contact name/s and number of each of these?
- ✔ Do you have brief information about such services?
- ✔ Do you know how to access such agencies?
- ✔ Do you know what each agency requires on health / medical conditions of the applicants?
- ✔ Do you know how to contact a Neighbourhood Housing Office if your patient is a tenant with Leicester City council or other social landlord?
- ✔ Do you know the number of agencies in your area, which are able to assist vulnerable homeowners carry out repairs or adaptations to their homes?

If your Team would welcome more information on Housing, the services provided by the Community Care Team, or other Housing Services please ask by contacting Housing Community Care - tel: 252 8721.

Useful Telephone Numbers:

Before completing please photocopy this form for your use.

Blaby District Council ..... tel: (0116) 275 0555
Charnwood Borough Council ..... tel: (01509) 263 151
Harborough District Council ..... tel: (01858) 821 100
Hinckley & Bosworth Borough Council ..... tel: (01455) 238 141
North West Leicestershire District Council ..... tel: (01530) 833 333
Leicester City Council ..... tel: (0116) 254 9922
Oadby & Wigston Borough Council ..... tel: (0116) 288 8961
Rutland County Council ..... tel: (01572) 722 577

The following information is required if the client is screened under the **Care Plan Approach:**

How are the Housing Needs of the patient addressed in the care plan?

.....

.....

.....

.....

Who is the named key co-ordinator for the Care Plan?

Has Housing been consulted to assist in the Housing Needs Assessment? **YES / NO**

If **NO** and the patient lives in Leicester City, please liaise with the Community Care Team on 252 8721 who will arrange for a Community Care Officer to contact you urgently.

Contact relevant local council if in the County.

Do you require any further general housing advice? **YES / NO**

If **YES** contact the Housing Options Centre (New Walk) – tel: 252 8707

Notes for Social Care & Health Staff:

Planning a Discharge - How to Refer to Housing

On admission or as soon as it has been established

a) If the patient has **no accommodation to return to and previously resided in Leicester (or has connections with Leicester),** you can refer the case to the **Community Care Team in Housing – tel: 252 8721** who will take a referral by phone, assess the case, and as appropriate, engage with other services. In many instances if the client has no community care needs you will be signposted to the Housing Options Centre in order to make an appointment for your patient. Appropriate housing advice together with housing options will be discussed. It may also be requested that a pre-discharge care planning meeting is held in order to assess complex needs or if the patient has a record of difficulty to place in a hostel due to health / social care needs. In some instances a Care Plan will be appropriate.

b) The patient can also complete the necessary housing application forms and return them to the **Housing Options Centre (Bishop Street)** for urgent registration.
Note: If the patient is of No Fixed Abode and has no prior local connection with Leicester, advice and assistance can be sought from the **Housing Options Centre (New Walk Centre tel: 252 8707).**

c) If the patient has no accommodation and has no previous connection with Leicester but wishes to reside in Leicester, you can contact Leicester City Council Housing Advice Line on 252 8707 (mornings only) for advice and assistance. If the patient normally resides in another local authority area you should contact the relevant housing department for that area, as under Part VII of the Housing Act the responsibility for rehousing may lie with that authority. A list of local housing departments can be found on page 4. Your patient can also contact independent housing associations and private landlords.

d) If a patient is to be discharged to a hostel, in some cases a hospital O.T. / Physio Assessment will be requested in order to establish if the patient can manage stairs, make a drink and sandwich. It is always helpful if this can be done in such cases prior to discharge, as individual hostels may be self catering and accommodation could be on higher than ground floor.

A Planned Discharge is always more appropriate and less stressful for the client and services. If however refering under a Section 5 Discharge Notice from a UHL Acute Bed, refer to Flow Chart 2 as regards to accessing Housing Services.

For use by Social Care and Health Staff:

Before completing please photocopy this form for your use.

As soon as it is identified that a patient has no accommodation to be discharged to and your patient has a Leicester connection. Contact the Housing Community Care Team by telephone on 252 8721 to make an urgent referral and to assist in a planned approach to discharge if your patient has community care needs as well as a housing need.

NOTE: If a patient is occupying an Acute Bed within UHL (University Hospitals Leicester) and discharge is imminent under a Section 5, refer direct to the Housing Options Centre - tel: 252 8707 in normal working hours or out of hours tel: 255 5152. This is clearly shown in the flowchart attached to this guide on page 8.

The following gives an indication as to what information Housing will request from you in order to take the referral.

If you wish to forward this information in writing please mark it 'Private and Confidential' to the relevent team (see page 7 & 8 - flowcharts)

Patients Details:

Name .....

Home Address .....

.....

Postcode .....

Housing Tenure – owner / occupier, private tenant, council tenant, housing association, homeless

.....

Telephone Number .....

Main Carer's name & number .....

Current Ward .....

Hospital .....

Key Nurse .....

Social Worker .....

Consultant's Name .....

GP's Name & Address .....

.....

Date of admission .....

Anticipated Date of Discharge .....

Any risk issues (risk to self or others) .....

Name & Signature of Referrer .....

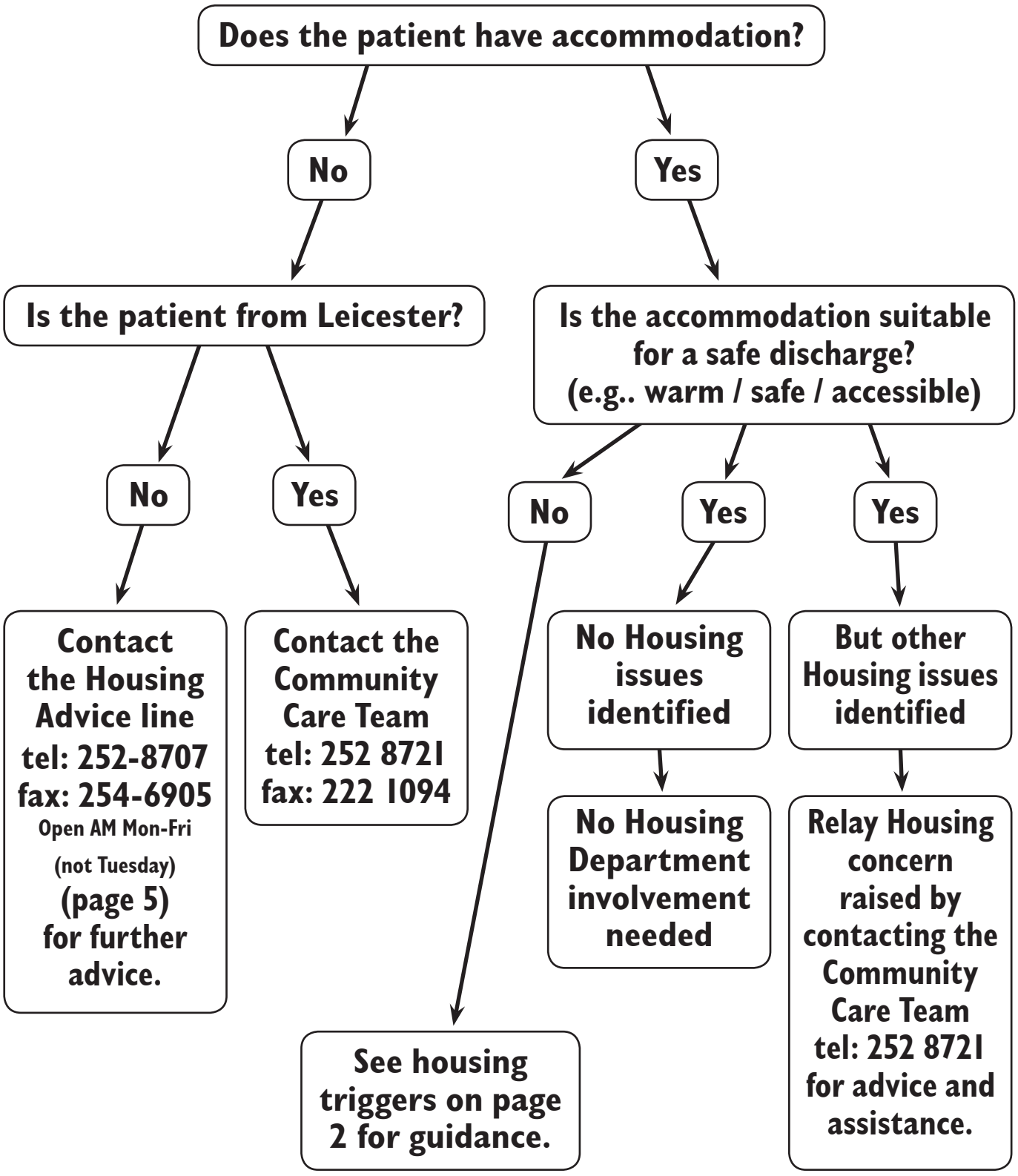
Date .....

The above information will be useful if shared when referring a patient's case for housing. The trigger question overleaf may assist you in identifying whom you may need to speak to if approaching Leicester City Council Housing.

Flowchart 1

Leicester City Council Housing

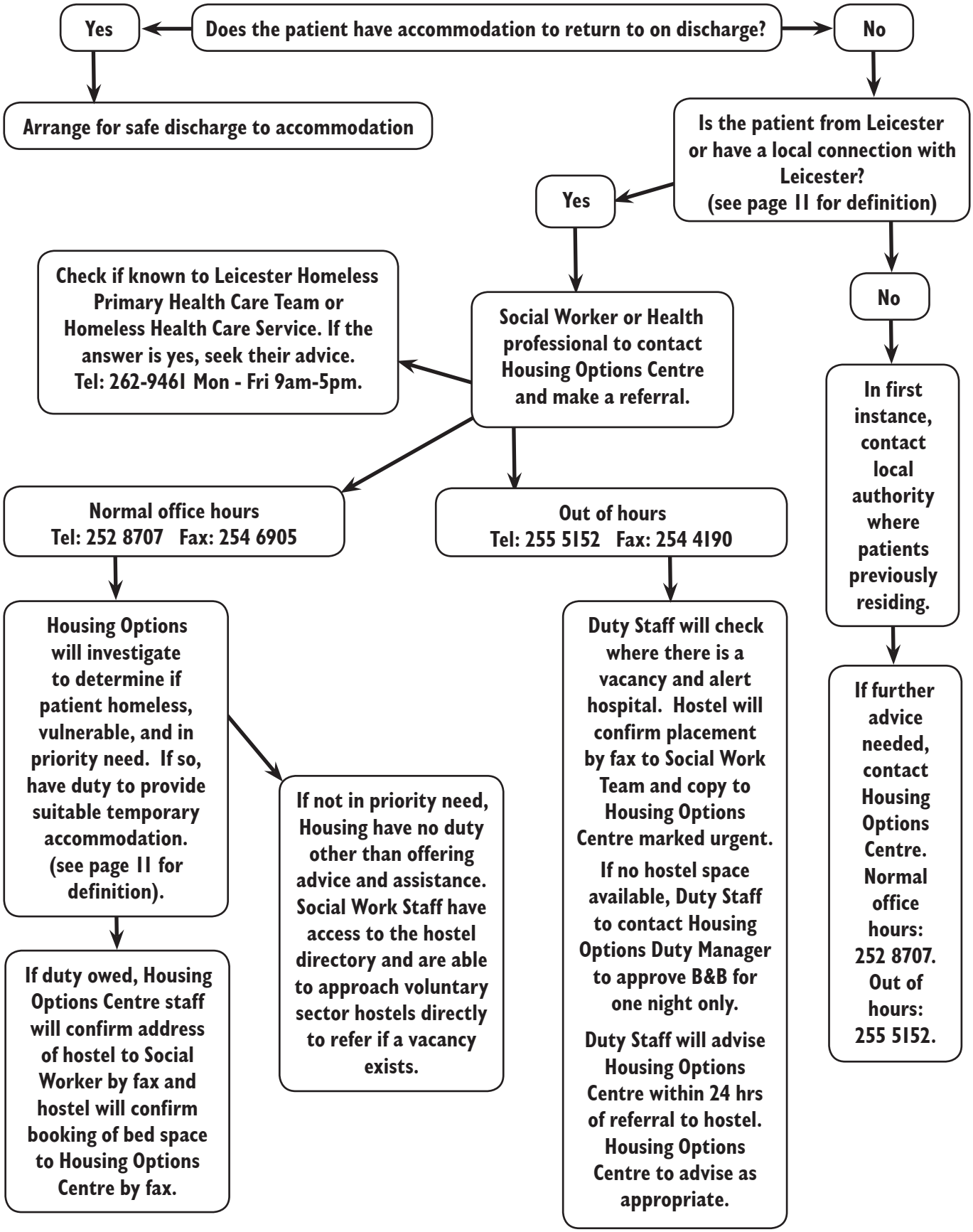
Guidelines for staff making referrals to Housing for a planned hospital discharge where the patient has a housing need and community care needs.



Flowchart 2

Leicester City Council Housing

Guidelines for staff making referrals to Housing where Section 2 and Section 5 Discharge Notice apply, re discharge from Acute Beds with University Hospitals Leicester.



Further guidance to assist in the day to day practices used by Health and Social Care and Housing in planning discharge from a hospital.

NOTE The original Guidance was agreed in 2000, amended in 2003 and updated again in February 2004 in light of the Leicester City Social Care and Health Department procedure for the Community Care and Health Delay Discharge Act 2003, and further updated in September 2004. This slightly amended version has been drawn up in partnership with Social Care & Health Housing Community Care and colleagues in the Housing Options Service and Hostels and the Community Homeless Team.

The aim of this joint protocol and guidance is to promote good joint working between Social Care and Health and Leicester City Council Housing Services. The procedure followed will depend on whether the persons has social care needs as well as unmet housing needs, whether the patient is vulnerable in some way or whether there are other identified needs. Wherever possible a **planned** approach to a safe discharge should be undertaken and the Flowcharts 1 and 2 within the guidance should assist staff in accessing the appropriate service.
NOTE Refer to flow chart 2 only when making a referral under a Section 5 Discharge Notice after an assessment under Section 2, and in accordance with the agreed protocol around delayed discharge from Acute Beds, UHL.

Examples below indicate different situations that may assist in the guidance: -

Situation One:

When a patient in the hospital or someone on their behalf enquires about housing needs but there are no identified social care needs or issues of vulnerability (see later section on meaning of vulnerability) they can be directed to appropriate sources for advice. This can be in the form of a leaflet detailing statutory and voluntary agencies. A patient may be in an Acute Bed but may not have a Section 2 or Section 5. Therefore no Social Care involvement and same as above.

Situation Two:

A social worker may be carrying out an assessment of need in which a housing issue is identified.
If it is not essential that the need is met before discharging the person, their family / friends can be directed to appropriate sources of advice as in situation one. When the social worker feels that the person is not able to initiate contact with a housing agency and there is no-one who can do this on their behalf, the social worker can refer on to the Housing Community Care Team for follow up action after discharge.
If it is essential that the housing need is met before discharge then the social worker should make a referral to the Housing Community Care Team and work with them to facilitate safe discharge.

Situation Three:

A social worker may become aware of a patient on a ward who has a housing need and a planned discharge becomes appropriate as there are issues of vulnerability and / or potential social / health care needs. However, it is too early to take a social work referral as the person needs further medical

treatment, investigations, therapy or health assessments before it is appropriate for a social work assessment to take place. The social worker attached to the ward or duty social worker should take the following courses of action:-

Ask the health worker who has brought this matter to the social worker's attention to refer directly to the Housing Community Care Team as soon as possible (see flow chart 1 attached to these guidance notes). Stress that this does not preclude social work involvement if needed at a later date (also if referring under Section 5 Discharge Notice see flow chart 2 and follow procedure).

Situation Four:

When someone has presented directly to Accident and Emergency and is not admitted / or only admitted for a very short period for investigation but there are clear housing issues and concerns of client vulnerability, please ring the Housing Community Care Team on: 252 8721. Advise the Team of the name of the client giving some brief details in order that the officer that you speak to can offer the appropriate advice. In an emergency outside normal office hours, if the client is homeless the contact number is 221 1407 if it is a family seeking accommodation, or 255 5152 if a single person. In such cases if there are any ongoing medical treatment issues at the time of referring, Hospital staff should give as much detail as is appropriate regarding the ongoing treatment / medication required, together with details of the client's G.P. If the person has been identified as having no fixed abode it is the responsibility of Health to refer and give details of the person to the Homeless Health Care service. Contact (0116) 262-9461. The homeless Health care Service at this stage will check if the person is known to them, assess and identify need and refer as appropriate to Housing and other related services.

Good Practice

A planned admission to hospital for Detox is to take place and the patient will be absent from his/her temporary hostel placement for ten days. In promoting a more positive approach to accept the detox if some assurance to the service user or to Health can be given that a spare bed will be available on discharge the service user may feel more positive about going in for treatment.

Essential for Discharge

A distinction needs to be made between housing issues which affect safe discharge and those which can be resolved on a longer term time scale. Issues affecting safe discharge would include lack of accommodation, access issues including essential facilities within the home, risk of violence and other immediate health and safety risks. Some of these issues can be resolved without rehousing, albeit sometimes on a temporary basis.

Procedure for the Community Care (Delayed Discharge) Act 2003

Social Care and Health workers need to adhere to the above policy, a copy of which is attached (p13-17). Equally Social Care and Health need to work with partner agencies such as Housing to aid the procedure.

Explanatory Notes

Vulnerability

A person may be considered to be vulnerable for example, if they are affected by disability, old age, mental illness, learning disability, substance misuse, or are living with HIV / AIDS. People who are vulnerable may require a community care assessment. Whether a vulnerable person requires a community care assessment before discharge from hospital will depend on whether at the point of discharge, they have unmet social care needs which need to be met to enable safe discharge.

It must also be noted that under Part VII of current Housing Legislation there is a test of homelessness, and the appropriate Housing Services will undertake the necessary investigations to identify if the client meets this test.

Community Care Assessment (Hospital Discharge)

An assessment may be requested when one or more of the following needs have been identified: -
- difficulty in managing essential personal care tasks, difficulty in preparing meals and getting access to adequate nutrition, difficulty in safely managing the home environment and a need for ongoing supervision and / or reassurance to ensure safety and well being. If existing services are already in place, a new assessment may not be needed if these services will continue to meet the person's needs on discharge. If it is apparent that new needs can be met by informal help (i.e. family or friends) then an assessment may not be needed.

When a community care assessment takes place, attention will be paid to issues of accommodation. However, not all people with accommodation problems will require a community care assessment.

Local Connection

Where a person's most obvious connection is not with Leicester and the social worker needs to involve Housing Services they should seek the advice of the local authority where the person does have a local connection in the first instance. However, staff should be mindful of the fact that a person has a right to make a declaration of homelessness to any local authority, and it is for that authority to investigate and issue a decision in writing as to the outcome.

Definition of Section 2/5 Discharge

See guidance procedure notes given on Pages 13-17.

Definition of Risk

Risk to self or to others that may cause physical or mental harm.

Leicester
City Council
Housing

Leicester City Council

Social Care & Health Department

Procedure for the Community Care (Delayed Discharge) Act 2003

Agreed in conjunction with the University Hospitals of Leicester

Peter Reading
Chief Executive
University Hospitals of Leicester

Andrew Cozens
Corporate Director
Social Care & Health

Leicester City Social Care and Health Department

Procedure for the Community Care (Delayed Discharge) Act 2003

1. Introduction

This procedure identifies the process to be followed in minimising delayed transfers of care from the acute setting in accordance with the above Act.

This applies to people in acute beds only within UHL and not those identified as undergoing rehabilitation. The current standard continues to apply within those areas.

2. Principles

This procedure is to enhance the existing positive joint working relationships and assumes that:

- Staying in an acute hospital bed longer than is necessary causes delays for the admission of other patients.
- Patients must be deemed medically fit and safe to transfer by a multi-disciplinary team (minimum of a health worker and social care worker) to receive a section 5 discharge notification.
- Patients will be treated with respect and dignity and be involved in the process.
- Agencies will work together to ensure that the assessment processes and discharges are co-ordinated.

Process

3. Notification of assessment (Section 2)

3.1. At the most appropriate and earliest opportunity ward staff will notify social care staff of the potential need for an assessment.

This does not necessarily need to be a formal notification under Section 2 and could be a telephone discussion with the central referral team to establish the needs of the individuals and appropriateness.

For example:

An elderly person with complex health and social care needs, where it is apparent that the individual will need multi-disciplinary assessment and there is a lack of stability in their condition, may be informally notified to social care and at the most appropriate point i.e. days later a Section 2 notice submitted.

3.2 A formal notification of assessment is required under the new legislation from the Trust (Section 2) and ward staff will have:

- Determined that the patient is a qualifying patient

- Consulted with the patient / carer

Wherever possible the Section 2 notification will give an indicative date of discharge and should include the following information:

- The name of the patient
- If given prior to admission (maximum of 8 days), the expected date of admission and the name and ward of the hospital in which the patient is expected to be accommodated
- Whether the patient or carer has objected to the notification
- A named health worker who will be responsible for liaising with social care staff in relation to the individuals discharge
- The status of the patient as set out in appendix 3.

For example:

Admission to surgical ward for routine operation with an average length of stay of 7 days, Section 2 notification given on date of admission with expected discharge 7 days later.

3.3. The local authority will acknowledge receipt of the notification and undertake its assessment process within the minimum 2 day period. If an acknowledgement has not been received by ward staff a follow-up call should be made to ensure the technology is working.

3.4 The notice shall have effect until the patient is discharged unless withdrawn as set out by the Act. This should be in writing wherever possible. The ward staff will inform social care at the earliest opportunity of this and liaise with them regarding any changes in location of patient or change in circumstances.

3.5 Ward staff are responsible for communicating any change in status to social care staff.

4. Notification of discharge (Section 5)

As soon as a patient is determined by the multi-disciplinary team to be medically stable and safe to transfer and assessments have been completed the Trust should issue a Notification of Discharge (Section 5.)

This should be in written form at least one day in advance of the proposed discharge date.

4.1 If after the Section 5 notification is issued and the discharge period exceeds the time allowed in the Act and the reason is the sole responsibility of City Social Care & Health Department a charge will be incurred.

4.2. The Social Care & Health Department must be in receipt of both a Section 2 and 5 notification and the minimum interval (three days) have elapsed for charging to staff.

4.3. If the local authority has made appropriate community care services available for the discharge of the patient and these are refused the Section 5 notification will cease for charging to apply, however the Trust and Local Authority will work together to try to resolve the situation and ensure discharge takes place.

5. Withdrawal of notices

5.1. The regulations require the Trust to inform the Local Authority where there is a change in circumstances affecting the discharge in medical deterioration and they should withdraw the notification in writing.

5.2. The process for reissuing notifications is the same as set out earlier and the Trust are required to give advanced warning.

For example:

Section 2 and 5 received with discharge date of Friday and on day of discharge patient becomes unwell on that day earliest discharge notification for Monday discharge would be Saturday before 2 pm with liability commencing Tuesday.

6. Disputes resolution

6.1. Where a dispute occurs local management will work together to try to resolve and reach agreement.

6.2. Where this is not possible the Strategic Health Authority will establish a process to which disputes can be referred. Until the outcome is known no payment will be made.

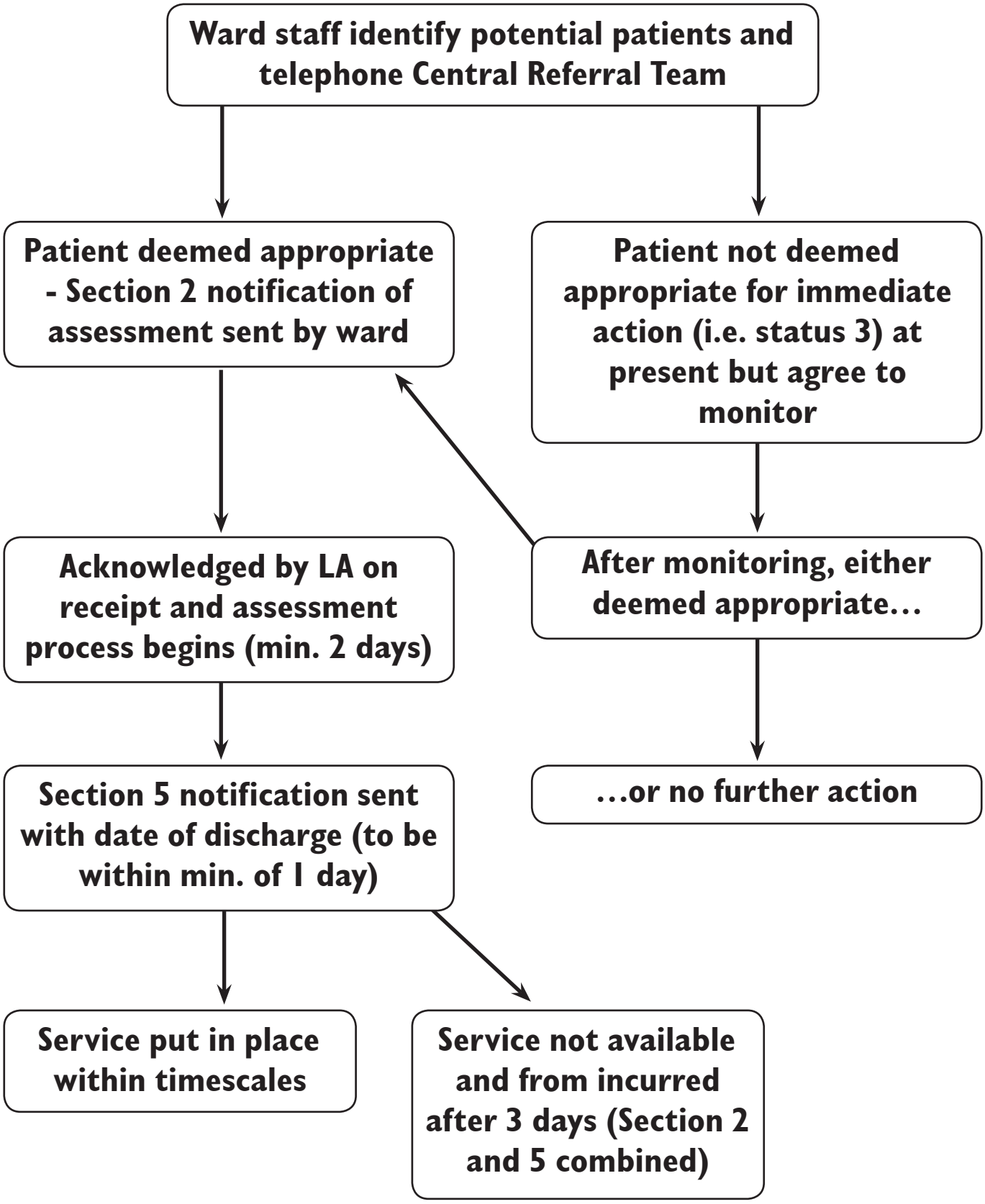

Ward staff identify potential patients and telephone Central Referral Team
Patient deemed appropriate - Section 2 notification of assessment sent by ward
Patient not deemed appropriate for immediate action (i.e. status 3) at present but agree to monitor
Acknowledged by LA on receipt and assessment process begins (min. 2 days)
After monitoring, either deemed appropriate…
…or no further action
Section 5 notification sent with date of discharge (to be within min. of 1 day)
Service put in place within timescales
Service not available and from incurred after 3 days (Section 2 and 5 combined)

Table showing the minimum interval for patient / carer assessment. This gives the earliest time for charging to start when an assessment notification is issued on any given day, *assuming that the discharge notification has been issued with the required day's advance warning and the proposed discharge date falls inside the minimum interval.* In the majority of cases, patients will remain in acute care for longer than the few days given in the examples below and assessment can take place throughout the hospital stay. The discharge notification would then trigger reimbursement if community care services are not in place by 11 am of the day after discharge date.

Assessment notification issued	**Minimum interval**	**To avoid reimbursement, services to be in place by**	**Comments**
Monday before 2 pm	Tuesday Wednesday	11 am Thursday	
Monday after 2 pm Tuesday before 2 pm	Wednesday Thursday	11 am Friday	Notice issued after 2 pm count as if issued on following day, so assessment notification counts as being issued on Tuesday.
Tuesday after 2 pm Wednesday before 2 pm	Thursday Friday	11 am Saturday	
Wednesday after 2 pm Thursday before 2 pm	Friday Saturday	11 am Monday	
Thursday after 2 pm Friday before 2 pm	Saturday Monday	11 am Tuesday	Sunday disregarded, so Monday becomes second day of minimum interval.
Friday after 2 pm Saturday before 2 pm	Monday Tuesday	11 am Wednesday	Sunday disregarded, so Monday becomes first day of minimum interval.
Saturday after 2 pm Sunday any time	Tuesday Wednesday	11 am Thursday	Sunday disregarded, so assessment notification counts as being issued on Monday.
Bank holiday weekend: Saturday after 2 pm Sunday any time	Wednesday Thursday	11 am Friday	Sunday and bank holiday Monday disregarded, so assessment notification counts as being issued on Tuesday.
Monday Thursday before 2 pm	Saturday Tuesday	11 am Wednesday	Good Friday, Sunday and Easter Monday disregarded, so Saturday and Tuesday count as two day minimum interval.
Monday Thursday after 2 pm	Tuesday Wednesday	11 am Thursday	Good Friday disregarded, so assessment notification counts as being issued on Saturday. Sunday and Easter Monday disregarded, so Tuesday and Wednesday count as two day minimum interval.

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