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Housing and Accommodation: maximising local opportunities and resources

Accommodation issues and approaches to support hospital discharge

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Overview

- Longstanding difficulties between hospitals and local authority housing options departments on homelessness hospital discharge for many years despite local efforts to introduce protocols, step down accommodation, and introduction of specialist discharge support e.g. pathway teams or housing options in reach officers.
- Difficulties can result in delayed discharge, discharge to the streets, discharge to accommodation which is unsuitable for recovery, or discharged patients arriving in taxis to housing options on a Friday afternoon!
- Partly a result of different priorities and legal frameworks for NHS, Housing Options and Adult Social Care, so that incentives and processes are not well aligned, and often not mutually understood.
- Also issues of appropriate accommodation for some patients with support needs not being available.

What would hospitals like?

- Simple process to refer patients to local authorities, who will accommodate homeless patients at the point of discharge, at short notice, in suitable accommodation that meets their needs

What would local authority housing options teams like?

- Not to be referred patients who don't have a local connection to their area
- For patients to be referred well in advance of discharge
- For the information they need to complete an assessment of eligibility, homelessness, priority need and local connection to be provided e.g. ID, address history, evidence of vulnerability
- For Adult Social Services to pick up responsibility where patients have support needs under the Care Act

What does the law say?

- The Homelessness Reduction Act introduced a statutory 'Duty to Refer' on hospitals in 2018 to refer patients at risk of homelessness within 56 days to a local housing authority (subject to patient consent)

- Local housing authorities have a duty to take reasonable steps to prevent or relieve homelessness to anyone who is eligible for assistance and a duty to provide interim accommodation for those who are homeless and 'may' have a priority need for assistance

- Neither of these duties depend on local connection and applicants have a choice of which local authority to approach at this stage

What does the law say?

- Hospitals must also refer patients to local authority adult social services if it is not likely to be safe to discharge the patient unless arrangements for meeting the patient's needs for care and support are in place

  (a)the local authority in whose area the patient is ordinarily resident, or

  (b)if it appears to the body that the patient is of no settled residence, the local authority in whose area the hospital is situated.

- That local authority must then conduct a needs assessment and must inform the NHS body whether the patient has eligible needs for care and support and how the authority plans to meet those needs

What goes wrong?

- Hospitals don't identify that a patient is likely to be homeless on discharge until close to the date of discharge, reducing the opportunity for the local housing authority to assess the case or try to prevent homelessness before discharge.
- In EDs there is no opportunity to refer other than very soon before discharge

- Hospitals don't consistently refer to local housing authorities under the duty to refer, e.g. because
  - they don't know which authority to refer to
  - they don't have the contact details for the authority
  - they lack the information the local housing authority wants from them
  - they have tried before and the outcome has not been successful
  - the process appears too time consuming and difficult to understand
  - there is no proper monitoring of the use of duty to refer by the NHS

- Local housing authorities don't respond quickly enough or effectively enough to D2R referrals

What goes wrong?

- Local housing authorities take too long to assess cases and/or are too demanding of evidence of local connection, eligibility, or priority need beyond what is realistic for wards to provide
- Local authorities refuse to provide interim accommodation unless local connection is established
- Adult Social Services don't do timely Care Act assessments and/or apply very high thresholds before they will provide support
- Suitable accommodation with the right support may simply not be available for some patients in some areas
- Emergency accommodation for those leaving A&E can be very difficult to access in the time available
- Most of these difficulties are made significantly worse where a patient has unclear immigration status or No Recourse to Public Funds
- Homelessness hospital discharge protocols are abandoned or fall into abeyance e.g. due to staff turnover

What goes right?

- Specialist homelessness discharge teams e.g. Pathways, St Mungos and others can help to identify homelessness risk early in a patient's stay

- Local authorities and hospitals build up close working relationships with a local authority 'in reach' officer or other named housing options lead, who can help speed up and simplify processes and support hospitals in early identification

- Local protocols are developed and work effectively, with doubts about eligibility, priority need and local connection resolved after a patient has left hospital and been accommodated temporarily rather than delaying discharge

- Specialist homelessness step up and step down accommodation with support is developed for people who need further recovery time after discharge or who need a dry environment, or as an alternative to hospital admission

- Short term low support accommodation is provided in which housing and support status can be established post discharge to free up a hospital bed

What goes right?

- Local authorities and the voluntary sector work together to provide timely move on from hospital and/or stepdown for people who are not in priority need
- Local housing options, out of hours, and commissioned rough sleeping services are geared up to provide emergency accommodation for those at risk of sleeping rough after visiting A&E or who do not have safe accommodation to return to
- Housing Options and Adult Social Services work together closely to meet support needs and accommodation needs
- Neighbouring ASS departments work closely together to enable rapid assessment of care and support needs with arguments around ordinary residence and payment settled later on, rather than presenting a barrier to needs being met in the first place
- Step down accommodation is delivered on a cross authority or whole ICS basis where this makes sense
- Homeless patents are able to access mainstream D2A services
- Out of hospital follow up care services are delivered effectively to patients in temporary accommodation and supported housing