Newcastle City Council

Your Homes Newcastle

Newcastle City Council Active Inclusion Service

Hospital Discharge and Homelessness Prevention Protocol

Reviewed January 2023

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Northumberland, Tyne and Wear NHS Trust

Newcastle Primary Care Trust

January 2023

Introduction

Homelessness prevention is a major plank of the Government's new approach to homelessness, signalled by the Homelessness Act 2002 and policy report, More Than a Roof[1].

The Department of Health issued guidance in 2003 which was explicit about the role of hospital trusts in ensuring that homelessness is prevented for patients leaving hospital:

> "It is vital all hospitals consider the housing situation of patients to ensure that people are not discharged to inappropriate places, homeless or become homeless as a result of their stay in hospital"[2].
>
> "All acute hospitals should have formal admission and discharge policies which will ensure that homeless people are identified on admission and their pending discharge notified to relevant primary care services and to homeless services providers. In addition, for patients in psychiatric hospitals/units a post-discharge care plan will be drawn up well in advance of discharge and procedures put in place to ensure that appropriate accommodation and continuity of care is in place for each person discharged".

Guidance from the Office of the Deputy Prime Minister in 2005 echoed this approach:

> "It is essential that local authorities and health services work together to provide accessible and appropriate services if health inequalities and homelessness are to be tackled"[3].

A policy brief issued in 2004 had established the importance of the contribution that health agencies can make to tackling homelessness[4]:

> "By working together to achieve shared outcomes, and taking a public health approach to addressing the health needs of homeless and vulnerable people, local housing authorities and health providers can deliver:
>
> - marked improvements in the health of homeless people
> - reductions in homelessness caused by poor health
> - reductions in poor health caused by homelessness
> - reduced public expenditure on health and homelessness
> - reduced repeat homelessness and increased sustainability of tenure through relevant support"

To help local authorities and their partners in developing protocols aiming to prevent homelessness for people leaving hospital, further guidance has recently been issued on behalf of Communities and Local Government department and the Department of Health

[1] More Than a Roof: a report into tackling homelessness, DTLR, 2002
[2] Discharge from hospital: pathway, process and practice, Department of Health, 2003
[3] Homelessness and Health Information Sheet: Number 4 Hospital Discharge, ODPM, 2005
[4] Achieving positive shared outcomes in health and homelessness, ODPM, 2004

with Homeless Link[5]. This recommends a set of nine steps for developing a protocol for hospital discharge. The protocol will be fit for purpose if it:

- establishes a patient's housing status on admission
- includes procedures for obtaining patients' content to share information
- includes procedures for ensuring that existing accommodation is not lost
- identifies key external agencies to notify about a homeless person's admission
- develops the resources and training needed
- involves voluntary sector agencies, primary care providers and local authorities throughout the discharge process

This protocol has been developed in accordance with those principles.

Who is signed up to the Protocol

This Protocol has been developed between key agencies in Newcastle working with people who may be homeless and have had a stay in hospital. Newcastle's Homelessness Review and Strategy (2003) noted that homelessness may arise following a stay in hospital, and the Strategy identified the development of a protocol as an action required to prevent homelessness in the city.

The Protocol has been signed up to by all relevant agencies:

- Newcastle City Council Active Inclusion Service
- Newcastle City Council Social Services
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- Cumbria Northumberland, Tyne & Wear Mental Health NHS Trust
- Newcastle Primary Care Trust
- Your Homes Newcastle

[5] **Hospital admission and discharge: People who are homeless or living in temporary or insecure accommodation,** Communities and Local Government, Department of Health, and Homeless Link (2006)

Why this Protocol is needed in Newcastle

Most people admitted to hospital are not homeless and can return home to the address they came in from. A few people have nowhere to go on discharge, or have their stay in hospital extended, for one of the following reasons:

- They were homeless before admission to hospital - they had nowhere at all to stay, and may have been sleeping rough
- They were in an institution such as prison
- They had a temporary arrangement – a hostel or staying with friends or family – and either cannot go back, or there is no bed reserved for them on their return
- They have just arrived in Newcastle and have nowhere to stay here
- They had accommodation before they came into hospital but are refusing to go back there
- They had accommodation before they came into hospital but cannot go back there because the person who lives there will not take them back
- They have accommodation but it needs to be adapted following their treatment in hospital

A further group had accommodation but it is not considered safe for them to go back there because of poor conditions or the house being too dirty or unhygienic. This Protocol does not cover that group, but a separate Clean Homes Protocol agreement has been developed to resolve the needs of people whose home is considered too unhygienic for them to return to from hospital, including the process for seeking the views of the Environmental Health section.

The Government expects local authorities to prevent homelessness wherever possible, but it is also in the interest of the patient – saving stress and anxiety – and of both hospital and housing staff, to try to resolve the patient's problem well before they have to leave. It is not comfortable for either hospital or housing staff to know that a patient may leave a hospital with no accommodation to go to.

Without this Protocol, it is clear that some health and social care staff may spend a considerable period of time trying to identify a solution for a hospital patient. It is also more difficult and time-consuming for housing staff to find the most appropriate solution at very short notice and without access to all the information needed to resolve the problem. Hospital staff are not always familiar with housing organisations and how they work, or with the best way to resolve a housing problem, or with which housing organisation the patient should be approaching.

Any delay in discharging a patient is costly to the health and social care system in the city, it can put back the care of another patient who needs a bed, and can exhaust staff and build up bad feeling between organisations. This Protocol aims to remove those constraints and pressures wherever possible, by setting up clear procedures, providing information on who does what, and by establishing clear roles and routes of communication.

The principles underpinning the Protocol

Agencies signing up to this protocol will work towards the following aspirations:

- People leaving hospital in Newcastle will have had their housing and support needs assessed in time to make appropriate referrals in advance of a discharge date
- People should not be discharged from hospital unless they have accommodation to go to: people leaving hospital in Newcastle will have accommodation appropriate to their housing and support needs, no patient should become homeless during their hospital stay, and no patient should leave without appropriate and stable housing options being identified; and no agency will rely on a hospital bed being available in place of suitable housing
- Discharge from hospital should not be delayed because of a lack of suitable accommodation, but where this is unavoidable and all steps in the Protocol have been followed, hospitals should consider not levying a charge on Social Services
- Staff working in hospitals in Newcastle will have sufficient information and training to be able to make appropriate and timely referrals to housing and support agencies
- Staff working in all agencies will know who to contact to help to resolve any problems which arise in the process
- Agencies will work together effectively to jointly resolve housing problems, preferably without a homeless application having to be made
- Shortfalls in resources will be identified through regular meetings of the Hospital Discharge and Homelessness Prevention Working Group and this information will be passed to the Housing Services for action

Format of the Protocol

The Protocol sets out a number of steps for all agencies to take which will help to prevent homelessness:

- **Action to take to prevent a patient being homeless on discharge from hospital, including the process to be followed on admission**
- **Seeking help from other agencies in finding accommodation and arranging support**
- **Information for display in hospital wards, for patients and staff**

The Protocol includes a note on how agencies are to share information, and how the Protocol is to be monitored and reviewed.

Sharing information

An important feature of good working arrangements between agencies working with people leaving hospital who may be homeless is that information is shared so that the person's problem can be resolved as quickly as possible.

Information should always be shared with the twin aims of helping the service user to obtain the most appropriate services to meet their needs, whilst preserving their dignity and privacy.

Information can best be shared by:

- **All agencies ensuring that the patient has filled in a consent form** - making sure that the service user has given written consent to information about them being shared in order to help them secure the right services to meet their needs
- **Sharing information in a positive way** - that informs people about the needs of the service user and supports good decision-making, rather than trying to "sell" their case
- **Ensuring that any information about known risks is shared** – including to other service users, or to staff, are not hidden, even if this may lead to another agency making a decision that their services are not appropriate for the person at this point
- **Ensuring that information which is passed on to other agencies is based on known facts, professional judgements, and close involvement with the service user**
- **Basing good decision-making on documented information** - this can be informal information which is constructive and supports other evidence, but can be verified

Agencies to share information with
This should include any agency which can help the service user to obtain or keep appropriate housing and support services. Such agencies should abide by the Data Protection legislation, and should have guidelines for staff about how and what information to share, how to store information, and what will happen if data protection rules are breached. The principles of good data protection state that data must be:

1. fairly and lawfully processed
2. processed for limited purposes
3. adequate, relevant and not excessive
4. accurate
5. not kept for longer than is necessary
6. processed in line with your rights
7. secure
8. not transferred to countries without adequate protection

These principles apply to information held on computer and some paper records.

Confidentiality
All parties to the Protocol will agree to ensure that information is not disclosed without the consent of the service user, and that it is not disclosed to people who are not entitled to have such information or do not intend to use it in the best interests of the service user. All parties will also agree to deal with any breaches of confidentiality by their staff or organisation.

Agencies following this Protocol will also be made aware of the Northumberland, and Tyne & Wear Strategic Health Authority Information Sharing Protocol Strategic Agreement, which health and social care agencies in Newcastle are asked to sign up to.

Duty to Refer

We have two process that work alongside each other in terms of hospital discharge and homelessness prevention, we have this protocol and the national Duty to Refer process which was introduced by Homelessness Reduction Act 2018. Duty to refer was a new requirement on specified public authorities in England to notify councils of service users they think may be homeless or threatened with becoming homeless. Hospitals (both acute and mental health) are one of those specified public bodies. In Newcastle the duty to refer supplements, rather than replaces, our existing Active Inclusion Newcastle partnerships and protocols, like the Hospital Discharge and Homelessness Prevention Protocol.

To support this process an Active Inclusion Officer liaises with the discharge facilitators within CNTW and a Discharge Nurse Specialist at the RVI to confirm cases of potential delayed discharge due to homelessness and allows opportunity for early identification of issues and to confirm that they have had no patients at risk of homelessness who have been missed. A fortnightly meeting is also held with CNTW and accommodation providers as an opportunity raise queries, discuss referrals and manage ongoing cases.

1. Preventing homelessness – the process on admission to hospital

The most important step to preventing homelessness is to identify what accommodation they have on admission. This will enable action to prevent or tackle homelessness to be started straightaway.

Patients are usually asked for their address on admission to a ward in hospital. The exception is where the person has been admitted previously or has been admitted after being in Accident and Emergency, when the address might already be on the notes but not have been checked on admission to the ward.

Under this Protocol, as part of the admissions process, hospital staff will check the address for all patients, regardless of how they came to be admitted to the ward.

Some patients become homeless whilst staying in hospital, either because they decide not to go back to the home they were in before, or because the person they were staying with decides not to allow them to return there. In a few cases, patients do not reveal that they have nowhere to go until discharge is imminent.

Preventing homelessness – key actions

- **On longer stay wards, hospital staff will check that the patient can return to suitable accommodation** - **as soon as possible after admission** (and no less than a week before discharge)
- **On short stay wards, hospital staff will check that the patient can return to suitable accommodation -** ideally at least a day before discharge (but preferably two days - a longer period of notice for housing agencies allows enough time to arrange supported temporary accommodation)

- **If there is no accommodation identified for them to return to,** either the hospital staff or a social worker will contact the Lead Practitioner- Housing Services at the Housing Advice Centre, at least a day before the discharge is due
- **Patients may need to be advised that their welfare benefits (including Housing Benefit) may be reduced after four or six weeks in hospital**. It is very important that action is taken to make sure that the patient is aware of this reduction so that rent arrears do not build up

a) General wards

Step 1 Check the patient's housing situation

On admission to the ward, ask <u>every</u> patient for their address, and whether this is the address they expect to return to.

Ward staff are asked to be particularly careful to ask this question where:

- The patient was noted by A&E as being **homeless** (No Fixed Abode - NFA) (the Bed Bureau notes this information and passes it on to the Hospital Discharge Liaison Nurse)
- The patient is known to be staying at a **hostel or other temporary accommodation** or
- The patient has been admitted following an **overdose** and referral from the Psychiatric Liaison Team

Step 2 Check if the patient comes from Newcastle and why they may be homeless

If the patient has no accommodation, or is not confident that they can return to that address, ask the following questions before deciding what to do next:

- **Does the patient come from Newcastle or wish to be in Newcastle?**
- **If they had a home before coming into hospital, why are they not able to go back there?**

People from outside Newcastle
For people who do not come from Newcastle, and do not wish to stay in the city, contact the homelessness office for the relevant council area.

You can ring the Housing Advice Centre for this information (Tel: 0800 1707 008 or email housingadvicecentre@newcastle.gov.uk)

Step 3a During office hours (8.30am – 12 noon, 1pm - 4.30pm)

If the patient is homeless and needs help to find somewhere in Newcastle**, contact the Housing Advice Centre (HAC): 0800 1707 008**

The **Housing Advice Centre** (HAC) provides Newcastle's homelessness prevention service, makes decisions about where the Council has a legal duty to accommodate someone, and provides housing advice.

Referrals to HAC may be made by nursing or medical staff, or social workers. There is no need to contact hostels directly. HAC has information each day about where there are beds available in temporary accommodation in Newcastle. **Priority is given to placing people for whom the council has responsibility, and people leaving hospital,** as well as those who are sleeping on the streets, or leaving prison, and others who cannot live independently.

The Homelessness Prevention Officer may interview the patient over the phone, or arrange to visit if there are complex needs, and a longer interview is needed. This will take place within 48 hours on working days (or sooner if this is possible), and particularly if it is known that the person was admitted for a stay of less than 24 hours).

Information which will be needed by the Homelessness Prevention Officer (HPO):

- Full name and date of birth
- Previous address, and type of housing (e.g. council tenancy, or hostel)
- Names and ages of any dependants
- How long the person has been in Newcastle
- Any other agencies involved with the patient
- Details of any risks posed by the patient or linked to their health
- Any particular needs which should be taken into account

The Housing Advice Centre will have time to make their decisions, and to help to find accommodation for the patient, if they receive clear information well before the patient is going to be discharged.

If the decision to discharge is made late on a working day, it is unlikely that accommodation will be found that night. In that case, hospital staff will try to ensure that a bed remains available for the patient until the next day.

Step 3b Out of office hours

If the patient is homeless and needs help to find somewhere in Newcastle**, contact the Emergency Homeless Service**
5.30pm - 8.00am

0800 1707 008 (select option 2)

The **Emergency Homeless Service** is provided by Housing Advice Centre staff who are on call outside office hours. They use information provided to them at the end of each working day about where there are beds available in temporary accommodation in Newcastle.

Support and Progression Workers (YHN)

A team of support and progression workers work with the Homelessness Prevention Officers at the Housing Advice Centre. They will help homeless people through the process of applying for housing, finding temporary accommodation, dealing with any debts, and getting benefits and furniture sorted out. They will also assess whether the person will need support to manage their home or needs supported housing.

b) Accident & Emergency

Step 1 Check the patient's housing situation

Ask <u>every</u> patient for their address

Step 2 Check if the patient comes from Newcastle and why they may be homeless

If the patient has no accommodation, or it is not clear that they can return to the address they gave, ask the following questions before deciding what to do next:

- **Does the patient come from Newcastle or wish to be in Newcastle?**
- **If they had a home before coming into hospital, why are they not able to go back there?**

Nursing staff should take every opportunity to check whether the person can go back to the address they have given. If the patient is homeless, the next step is for A&E staff to:

Step 3a During office hours (8.30am – 4.30pm)

If the patient is homeless and needs help to find somewhere in Newcastle**, contact the Housing Advice Centre (HAC): 0800 1707 008**

Step 3b Out of office hours

If the patient is homeless and needs help to find somewhere in Newcastle**, contact the Emergency Homeless Service:**
(or advise the patient to contact them)

0800 1707 008 (select option 2)

People with mental health needs

If a patient is likely to be discharged with nowhere to go, and none of these visits are due within a short period of time (i.e., within the next day for a short stay, or within the next week for a longer stay), ward staff should:

- Contact the Psychiatric Nurse or the Social Worker for Homelessness to arrange for them to visit the patient, and give advice on the best options for them

- All details will be noted and this will be passed to the Homelessness Prevention Officer (hospital discharge)

- The Homelessness Prevention Officer will take a homeless application and arrange temporary accommodation, and may also visit the patient if necessary

- The Psychiatric Nurse or Social Worker will then discuss the next move, into supported or other accommodation with support

Every patient with a mental health problem should have a Care Co-ordinator. Care Co-ordinators are closely involved throughout the process in assessing housing and support needs and identifying the most appropriate accommodation and support. The Care Co-ordinator will work with the YCH Mental Health Adviser, Psychiatric Nurse or Social Worker to do a risk assessment and risk management plan, and work out a housing and support package, with the aim of securing the best option without the patient having to go into temporary accommodation.

The patient may have made an Advance Statement about how they want to be treated, and what arrangements should be made about their home and other personal matters, if they need to go into hospital. If they have written this down, the Statement will be held by the person's Care Co-ordinator.

Actions for hospital staff, working alongside housing advisers, for people with mental health problems:

Step 1 Check the patient's housing situation

On admission to the ward, ask <u>every</u> patient for their address, and whether this is the address they expect to return to

Step 2 Check if the patient comes from Newcastle and why they may be homeless

If the patient has no accommodation, or it is not clear that they can return to the address they gave, ask the following questions before deciding what to do next:

- **Does the patient come from Newcastle or wish to be in Newcastle?**
- **If they had a home before coming into hospital, why are they not able to go back there?**

Step 3a During office hours (8.30am – 4.30pm)

If the patient is homeless and needs help to find somewhere in Newcastle, and a ward session is not due

contact the Housing Advice Centre (HAC): 0800 1707 008

Step 3b Out of office hours

If the patient is homeless and needs help to find somewhere in Newcastle**, contact the Emergency Homeless Service 0800 1707 008 (select option 2)**

1. Other action to prevent homelessness

a) Resolving problems for patients who cannot return home because their accommodation is thought to be unsuitable

There are several possible reasons for a patient's home being considered to be not available or unsuitable for them to return to. These fall into three groups:

i. The home is not in a fit state to live in

- Home is too dirty, unhygienic, or too full of rubbish to live in healthily
- House is unfit or unsafe to live in
- Home is not suitable as area is unsafe

website www.newcastle.gov.uk/housingadvicecentre.

ii. The home is unsuitable to meet the person's current needs

- Patient has drug or alcohol problems, or other problems, which lead to the view that they cannot manage their home at the moment
- The patient is no longer able to look after themselves and requires residential or nursing care
- Sheltered housing could be more suitable for them
- Home is no longer suitable as patient needs aids and adaptations to be in place before they can return
- House needs physical adaptations but this is not possible or cannot be done at reasonable cost

Where the home needs some physical adaptation, the Hospital Social Worker will contact the Housing Occupational Therapist. The Housing Occupational Therapist will assess whether people would be eligible for medical priority on the grounds of physical health or help the patient to plan a move to a more suitable home, and organise adaptations to that home. Where there are adaptations needed to an existing home, this will be organised by the Hospital Occupational Therapist.

Where a temporary move might be needed before a patient could return home, or community safety measures need to be installed, or the patient needs housing-related support or home care to be able to remain in their home, or they need help to apply for and move to more suitable housing (for example, supported or sheltered housing), a referral should be made to the YHN Support and Progression Workers. They will make referrals to other agencies if needed, and possibly may refer the person ultimately to one of the YHN Support and Progression Workers based at housing offices.

iii. The person (or the people they were living with) has decided that this is not where they should live in future

- Patient does not want to return as it is not where they want to live
- Partner or family refuse to allow person to come back

If a patient is likely to become homeless because the person they previously lived with does not want them to come back, contact the Housing Advice Centre as described in the earlier parts of this Protocol.

b) Helping people to obtain settled housing

Patients in hospital may be able to obtain settled housing without having to go into temporary accommodation first, and without having to make a homeless application first.

There are three routes into settled housing:

- applying to join Tyne and Wear Homes (people can bid through this system for housing from Your Homes Newcastle, and some Housing Association and private rented homes)
- applying directly to Housing Associations
- applying directly to private landlords or their agents by contacting the Private Rented Service and accessing the rent guarantee scheme

Both the Housing Advice Centre (0800 1707 008) and the YHN Support and Progression Support Worker can give people advice on how to apply for housing through any of these routes.

If you need housing advice or are homeless:
People leaving hospital

Most people admitted to hospital in Newcastle are not homeless and they can, and do, return to the address that they came into hospital from. However, we know that there are some people for whom this is not possible, either because their home is no longer suitable or appropriate for them to return to, or they were homeless before they came into hospital. We know that a delay in being discharged from hospital can be distressing and we want to support people to be discharged as soon as they are well enough.

Some patients become homeless whilst staying in hospital, either because:

- they decide not to go back to the home they were in before
- the person they were staying with decides not to allow them to return there
- they are at risk of losing of the accommodation they were living in prior to hospital

The most important step to preventing delayed discharges from hospital and homelessness is to identify the accommodation needs you have as soon as possible. Letting a professional know early on about concerns you have helps them to make early referrals to relevant advice and support, increasing the likelihood of finding suitable and sustainable accommodation for you when it's time to be discharged.

Who should I contact?
If you were homeless when you went into hospital or you were living in a hostel or with friends and family and you can't return to that accommodation, you should contact the Housing Advice Centre as soon as possible.

The Housing Advice Centre is part of Newcastle City Council and offers a free, confidential advice service to anyone that has housing problems. We aim to help people to keep their home or help them to find one that meets their needs. We can help you to understand the different options that are available in Newcastle to solve your housing problems.

Staff at the Housing Advice Centre can:

- prevent a homelessness situation from occurring, wherever possible
- explain the processes of homelessness prevention
- assist in locating alternative accommodation, such as a housing association, local authority or privately rented property
- provide you with information and advice on your options

There is a wide range of advice and support available in Newcastle. The Housing Advice Centre can help you, or the person you're working with, to understand the different options available to solve housing problems. The earlier you get in touch, the more likely it is that you can get help.

Phone: 0800 1707 008 (Monday to Friday, 8.30am to 12 noon and 1pm to 4.30pm)
Email: housingadvicecentre@newcastle.gov.uk
Website: www.newcastle.gov.uk/homeless

If you have nowhere to go that night you can contact the emergency out of hours number (after 5.30pm or any time at a weekend): 0800 1707 008 (select option 2)

Staff at the Housing Advice Centre can arrange a time to speak to you over the phone or, in some cases, they may be able to visit you in hospital. You can also ask a relative, friend or member of hospital staff to contact us on your behalf.

We will look into your circumstances and what assistance we can offer. We can give you advice and support to help you find somewhere to live that is suitable for you following your discharge from hospital.

Other support available

Your Homes Newcastle Pathways Team
This team can help you if you are unable to return to your existing home from hospital because it will no longer be suitable for you, or if you are worried about losing your existing home for some reason. The team can help if you:

- Are in hospital and will need alternative accommodation when you come out of hospital
- Have enduring mental health issues and are in hospital or need some housing support whilst living in a tenancy

You don't need to have been living in a Your Homes Newcastle (YHN) property for this team to help you. If you have an existing tenancy, don't terminate it without speaking to the YHN Pathways Team or the Housing Advice Centre.

Phone: 0191 277 1144

Newcastle Homeless Service
Northumberland, Tyne and Wear NHS Foundation Trust provide this service for adults who are homeless or living in insecure accommodation and are experiencing difficulties with their mental health and require assessment and treatment.

If you are receiving mental health treatment as a hospital inpatient and don't have a care co-ordinator you can contact either of the following Community Mental Health Teams for advice, or the ward you are on may do this for you.

Newcastle West
Silverdale
Grainger Park Road
Newcastle upon Tyne
NE4 8PR

Phone: 0191 287 5060

Newcastle East
Molineux Centre
Byker
Newcastle upon Tyne
NE6 1SG

Phone: 0191 287 5300