EAST AYRSHIRE COUNCIL

HOUSING COMMITTEE – 5 NOVEMBER 2003

JOINT PROTOCOL FOR ACCOMMODATING SERVICE USERS WITH COMMUNITY CARE NEEDS AND SERVICE USERS DISCHARGED FROM ACUTE HEALTH CARE SERVICES

Joint Report by the Director of Homes and Technical Services and the Director of Educational and Social Services

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to seek Committee approval for the introduction of a joint protocol for accommodating service users with community care needs and service users discharged from acute health care services.

2.0 INTRODUCTION

2.1 As key Partners in the Joint Future Planning Process, and the Community Care Agenda, both departments are keen to ensure their continued contribution to the delivery of services for individuals requiring support in order to live independently within the community.

2.2 The joint protocol (Appendix 1) has been developed to ensure that community care clients are able to move into council accommodation with the minimum of disruption.

2.3 The document has also been designed to fulfil the commitment to homelessness prevention which shapes the recently produced homelessness strategy, and details arrangements for ensuring individuals with no permanent address are not discharged from acute health care units without accessing advice and assistance (where appropriate) from homeless services.

2.4 The responsibilities of agencies involved in the transition process are currently set out in a range of documents. However it was felt that in order to streamline and clarify the process for the service users, and those involved in their care and support, a single protocol should be drawn together.

2.5 The Council's Housing Allocation Policy recommended by this Committee on 3rd September 2003 and approved by full Council on 23rd October 2003 specifically includes Community Care Service Users within the Miscellaneous Category thus ensuring that community care applicants are given more opportunities to be considered for vacant properties

3.0 JOINT PROTOCOL OBJECTIVES

The protocol has been designed to:

a) Improve the experience of individuals with community care needs seeking council accommodation.

b) Fulfil the Joint Future commitment to ensuring better results for people, quicker and better decision making, greater emphasis on care at home and ensuring that agencies working more closely together.

c) Ensure individuals with no permanent address are not discharged from hospital without contact with the homeless team.

d) Clarify the responsibilities of the department of Homes and Technical Services, Social Work and the Health Authority in this area;

e) Provide contact details to assist staff from other agencies when contacting the housing department;

f) Develop a more flexible allocation process for individuals with community care needs.

4.0 INTRODUCING THE SCHEME

4.1 It is proposed that East Ayrshire introduce the joint protocol with immediate effect in the light of the retraction of services for individuals with learning disabilities at Strathlea and Arrol Park Resource Centres.

4.2 Details of the joint protocol will be disseminated to service users, carers and staff in all agencies.

5.0 POLICY IMPLICATIONS

The joint protocol supports and complements the Joint Future Agenda, and its introduction would strengthen the continued success of joint working arrangements that currently assist individuals to maximise the opportunities provided by accessing care and support in the community.

6.0 FINANCIAL IMPLICATIONS

Nil.

7.0 LEGAL IMPLICATIONS

Nil.

8.0 RECOMMENDATIONS

Committee is asked to:

i) Approve the recommendations to introduce the joint protocol with immediate effect; and

ii) Otherwise note the contents of the Report.

James Lavery
Director of Homes and Technical Services
October 2003

John Mulgrew
Director of Educational and Social Services

LIST OF BACKGROUND PAPERS

1. East Ayrshire Council, Housing Advice Service to Crosshouse Hospital, Operational Procedure.

2. In-Patient Discharge and Aftercare Protocol for Mental Health Services in Ayrshire and Arran

3. Local Planning Agreement for Hospital Discharge with Ayrshire and Arran NHS Trusts. Local Authorities and Ayrshire and Arran Health Board.

4. East Ayrshire Council Joint Community Care Accommodation Strategy 2001-2004.

5. Joint Future Full Partnership Agreement, Older People's Services, April 2003.

6. Social Work Committee of 11 September 2003 (Hospital Retraction Development)

For further information please contact Joseph Cassidy, Policy Manager, on 01563 576617

Implementation Officer: Christopher McAleavey, Head of Homes and Jackie Donnelly, Head of Social Work

Department of Homes and Technical Services

Protocol for Accommodating Service Users with Community Care Needs and Service Users Discharged from Acute Health Care Services

Sept 2003

1. Procedure for Discharge from Hospital / Residential Accommodation

The process for dealing with individuals who are being discharged from hospital and other types of residential accommodation within East Ayrshire is set out in the Local Planning Agreement for Hospital Discharge and the In-patient Discharge and aftercare protocol for Mental Health Services in Ayrshire and Arran.
These documents were developed by The Ayrshire and Arran NHS Trust, the Three Ayrshire Authorities and Ayrshire and Arran Health Board, and set out the responsibilities of all agencies involved in the discharge process throughout Ayrshire and Arran.

This guidance is aimed at providing specific information about the role of East Ayrshire Council's Housing Service in the discharge of Individuals seeking to be rehoused within this Authority.

Our Responsibilities

In terms of the current discharge protocols, the Housing Service has the following responsibilities in respect of the discharge planning process:

- Upon request by colleagues in Social Work or Health a member of housing staff will be nominated to attend discharge planning meetings and participate in the formulation of the discharge arrangements.

- A member of housing staff will attend regular Care Package Operational Group meetings to discuss accommodation issues of particular individuals.

- The nominated member of housing staff will provide information and advice on housing issues for individuals currently resident in hospital or other residential units upon request.

- A member of housing staff will be involved in a review of individual's ability to enjoy and sustain their home after discharge and decisions made on the provision of support and/or need for reassessment.

The discharge planning process is, in the main, aimed at patients of continuing care wards, or those admitted to hospital for a period of rehabilitation.

However, discharge from acute services also requires appropriate planning where there are matters concerning accommodation provision.

1.1 Discharge from Acute Services

- *Short Admissions into Acute Services*
- *Self Discharge*
- *Discharge on grounds of conduct*

- Homeless Services are responsible for dealing with applications for requests or accommodation from individuals in acute services who may be being discharged with little or no notice and have no home to go to. Or where staff are concerned about them returning to their previous address without adequate support.

- Where an individual is admitted into Acute Health Services and hospital staff have concerns about their accommodation upon discharge then they should make contact with the Homeless Services team.

- A Homeless interview will take place, and the application will be processed according to current homelessness procedures.[1]

- Where the patient has identified health or social care needs, Homeless Services should be made aware of any support services that are required by the patient and will be made available upon discharge.

- Where sufficient time is available to hold a discharge planning meeting a Homeless Persons Officer should be invited to attend.

- Where a patient with NFA is asked to leave the hospital as a result of mis-conduct, or where a patient chooses to leave hospital against medical advice, they should be provided with contact details for homeless services and hospital staff should contact Homeless services to inform them of a likely presentation.

[1] Copy is available from Homeless Services (01563 576663)

1.2 Discharge from Continuing Care Wards / Rehabilitation Services

In cases where individuals are being discharged from a continuing care ward, or after a period of rehabilitation, it is assumed that the discharge planning process will be sufficiently long enough to eliminate the need for the homeless team to become involved.

- Upon admission, information on a patient's housing circumstances should be collected as part of the preliminary assessment.

- Where accommodation needs are identified the Housing Service should be contacted as soon as possible.
  It is recognised that due to the nature of their illness it may not be appropriate for the patient to complete an application form at this point

- Once a discharge plan is drawn up and the patient is able to make a meaningful application, hospital staff (medical staff or social work staff) should make further contact with the Housing Service.

- The "special circumstances" section of the application form should be completed to indicate that details of the support package are attached / or will follow accordingly.

- The Assistant Area Manager responsible for the Service's Central Housing Team[2], will attend discharge-planning meetings and forward collected information to the Assistant Area Manager responsible for the area team processing the application.

- The Area Team Manager is responsible for following the case through to conclusion and they, or someone nominated by them, would be involved any other necessary meetings after discharge.

- Over the course of the assessment process, the member of the housing team responsible the case should be kept informed of the patient's progress, and provided with details of the provisional discharge date once identified.

- The Housing Service will endeavour to find appropriate accommodation in the applicant's area(s) of choice by the agreed discharge date, however where delays in allocation can not be avoided and the patient is ready for and wishing discharge, alternative temporary accommodation opportunities should be explored with the housing service where appropriate.[3]

- After Discharge, the Housing Service (*member of area team in which applicant is housed*) should be involved in reviewing the individual's progress, especially where problems in sustaining the tenancy have been identified. Where appropriate, a referral may be made to the Service's Tenancy Support Team to provide extra support for individuals requiring assistance to maintain their tenancy.

[2] Janette Nightingale (01563 576627)
[3] See Section 3 – Flexible Allocations

2. Procedure for Accommodating Applicants not currently in a Hospital or Residential Unit within Ayrshire & Arran Health Authority.

Where a Social Worker is looking to secure accommodation for:

- ❖ An individual currently in a residential unit or hospital outwith Ayrshire and Arran but wishing to return to East Ayrshire or

- ❖ An individual currently living at home (either alone or with friends or family) where the situation has become untenable and the individual has to leave, and would be admitted to a hospital or residential unit if they were not allocated accommodation, then

- Initial contact should be made with The Assistant Area Manager responsible for the Central Area Housing Team.[4]

- An application form should be completed and accompanied by an official letter (on headed paper) from the Social Work Department confirming that they agree to the person being granted a tenancy, and guaranteeing that all necessary support will be provided to meet the individual's requirements.

- The "special circumstances" section of the application form should be completed to indicate that details of the support package are attached / or will follow accordingly.

- The Assistant Area Manager responsible for the Central Area Housing Team, will pass the case to the appropriate area team as soon as possible.

- Where re-housing is sought in various areas, then the area team where they last had settled accommodation/have relatives will deal with the application.

- Assistant Area Manager responsible for the Area Team is responsible for following the case through to conclusion and would be involved in any necessary meetings after discharge.

3. Flexible Allocation Process

The miscellaneous category within the Council's Allocation Policy includes a specific category for Community Care Service Users, defined as:

- ❖ People who are being discharged from long-term hospital care
- ❖ People who are leaving residential care to move into the community
- ❖ People who are at risk of reception into residential care
- ❖ People who are at risk of being admitted into hospital

The miscellaneous category should be checked for Community Care Applicants before allocating **all** properties.

[4] Janette Nightingale (01563 576627)