Essex Homelessness Hospital Discharge Protocol

Final – 01.08.23

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1. Introduction

This Protocol sets out arrangements between the Essex hospitals, the Local Housing Authorities in Essex (including Southend on Sea & Thurrock Unitary Councils), Essex County Council, the Essex ICBs, Southend Citizens Advice Bureau, and the Peabody Floating Support Team, in their collective work with patients of the hospitals in Essex who are homeless or at risk of homelessness.

The overall purpose of the Protocol is to:

- Reduce delayed transfers of care in Essex hospitals and to reduce the length of stay for patients where accommodation is a barrier to discharge
- Reduce the number of unplanned referrals to Essex Local Housing Authorities for patients recently discharged from hospital
- Reduce the health inequalities among homeless patients.

The participants to the Protocol are described below:

- **Mid and South Essex (MSE) Group of hospitals** - The Protocol is intended to cover patients of the 3 MSE Group hospitals:
    - Basildon University Hospital
    - Broomfield Hospital
    - Southend University Hospital.

- **Colchester Hospital.**

- **Local Housing Authorities (LHAs)** - The 14 LHAs in Essex are already committed to working together to tackle homelessness and have already established a common referral form for the Homelessness Reduction Act "Duty to Refer". Twelve of the councils are lower tier authorities and two Southend-on-Sea City Council and Thurrock Council are unitary authorities. See **Annex A** for full list and contact details.

- **Greater Essex Social Services Teams** from Essex County Council, Southend on Sea City Council and Thurrock Council in partnership with the Foundation Trusts, already play an important role working with patients leaving hospital.

- **Essex Integrated Commissioning Board (ICBs)** – The ICBs have an important role in supporting effective practice in this area, There are seven Mid Essex, North East Essex, Castle Point & Rochford, Basildon & Brentwood, West Essex, Thurrock, and Southend.

- **Essex Floating Support Service (EFS)** – this service is currently commissioned by Essex County Council and delivered by Peabody Trust. The service has been established to work with Essex households to prevent homelessness and works across the 12 Essex District Councils.

- **The Essex Community Hospitals** – Listed in Annex K

- **The Southend on Sea Citizens' Advice (SCA)** - commissioned by Southend on Sea City Council, provides Information, Advice and Guidance (IAG) to Southend on Sea residents. This support includes housing support.

The Protocol covers inpatients and outpatients attending the Essex hospitals as well as patients attending Accident and Emergency (A&E) services.

2. Aims of the Protocol

The main aims of the Protocol are:

1. To identify all patients who attend hospital who are homeless or at risk of homelessness and for this to be done as early as possible

2. To ensure that such patients are given appropriate advice and support as quickly as possible, including timely referral to the relevant Local Housing Authority (LHA) where this is a legal duty, or the most appropriate course of action

3. To ensure as far as possible that no patient leaves hospital without safe and suitable accommodation to go to

4. To minimise delayed transfers of care, and discharge as a result of patients not having safe and suitable accommodation to go to

5. To ensure as far as possible that patients continue to access appropriate health care after they leave hospital and that their course of treatment is effectively completed

6. To ensure that people leave hospital in a planned way to prevent homelessness

7. To minimise the possibility of future health problems due to lack of safe and suitable accommodation

8. To provide equality of health provision to homeless and rough sleeper populations

9. To maximise GP registration amongst the affected group.

To achieve the aims of the Protocol, the following principles need to be taken into account.

- NHS staff are not expected to be experts on homelessness legislation or to keep up to date on the services and policies in different LHAs

- LHAs require hospitals to develop a consistent approach to referrals based on the Protocol

- LHAs should work with patients referred from hospitals, who are homeless or at risk of homelessness, in as supportive a fashion as possible, within the resources available to them

- Hospitals should recognise the constraints on LHAs' ability to provide accommodation, and the limits to their legal obligations

- Hospitals should give as much notice as possible to the LHA in advance of discharging a homeless patient and referral to an LHA should be avoided, wherever possible

- NHS services should be responsible for identifying those patients at risk of homelessness as early as possible and to make prompt referrals to appropriate services

- Services to prevent homelessness among hospital patients should where possible begin prior to discharge or as soon as is practical after admission

- It is essential for hospitals to maintain contact with patients after discharge, where follow up treatment is required.

3. Scope of homelessness

The Protocol's target group are those that present to the hospital as homeless or at risk of homelessness and those that have become environmentally homeless while in hospital, often due to a worsening of their health condition. Therefore, the scope of homelessness for this Protocol covers:

- People who have been sleeping rough prior to attending hospital either at A&E or who have been admitted as an inpatient
- People who have no home of their own and have been staying with friends or family, including sofa surfing, before being admitted as an inpatient and friends or family are unwilling for them to return
- People who are unable, or who likely to be unable, to return to their previous home after admission to hospital. This may be for a number of reasons including:
    - threat of eviction or actual eviction by their landlord
    - accommodation being unsuitable for them to return to due to their health
    - accommodation being unsafe to return to e.g., because of a potential risk of violence or due to repairs
- People who were living in suitable accommodation but who cannot return home because of a change in their accommodation needs related to their medical condition and/or treatment. Where individuals have a social housing tenancy, they should be referred to the relevant landlord housing officer in the first instance as this may not be the council.
- People who can return home temporarily but who may be at risk of homelessness within the next 56 days
- People who are unable to return to their previous accommodation for other reasons.

The intervention for homeless patients may vary significantly depending on individual circumstances such as:

- Their access to accommodation
- Their physical and mental wellness
- Their financial situation
- What duty/ies are owed in accordance with the homelessness legislation

- The availability of suitable hostel accommodation, where the provision is available within an LHA
- The availability and affordability of private rented accommodation
- The availability of social housing and/or temporary accommodation
- Support from family and friends
- The suitability of their existing accommodation e.g., in terms of access, adaptations, damp & mould, etc
- The availability and location of health services
- Their wishes and preferences.

Depending on the circumstances, the best solution may be either to support a patient to keep their existing home if they have one, or to find alternative accommodation if they have no home to return to or it is not feasible to do so.
Alternative accommodation may include a range of short term and long-term solutions dependent on a number of factors and may not necessarily be social housing.

4. Duty to Refer under the Homelessness Reduction Act

This Protocol is written in the context of the 'Duty to Refer' (DtR) in the Homelessness Reduction Act, which, since October 2018, has placed a statutory duty on hospitals to refer homeless patients, or patients at risk of homelessness within 56 days, to the relevant Local Housing Authority for assistance. **Annex C** provides more detail on the Duty to Refer under the HRA. It is noted that a DtR is not a formal homelessness application but the start of a process.
The Duty to Refer applies to NHS Trust and NHS Foundation Trust hospitals and is only in connection with the provision of the following NHS services:

- Emergency department and urgent treatment centres[1]
- Inpatient treatment

The patient must give their consent and can choose which LHA to be referred to. However, if they do not have a local connection to the chosen LHA, they are likely to be referred on to the authority where they do have a connection. Referral to an LHA where the patient does have a local connection (there are agreed criteria for this) is therefore to be encouraged - so avoiding time delays and duplication.

Where an individual is homeless, they are likely to be referred to the LHA where they do have a local connection. Therefore, patients should be encouraged to approach an LHA where they have a local connection avoiding time delays and duplication of workload, only one DtR for each patient should be submitted at a time. If a patient insists on referral to more than one LHA, this information should be included on all DtRs.

LHAs are expected to work with public authorities in their area to design effective referral mechanisms, which meet their local circumstances.

[1] Including accident and emergency services provided in a hospital.

Under this Protocol

- Essex County Council (EFS) can act on behalf of hospitals within the Essex County Council boundaries and make a referral under the Duty to Refer to an LHA be that inside or outside of Greater Essex.
- For Southend Hospital, Duty to Refers to the relevant Local Housing Authority should be made by the hospital, with the support, if needed, of the Southend Citizens' Advice service

Each of the Greater Essex LHAs has set up a designated email address for Duty to Refer (DtR) referrals. The LHAs and email addresses are listed in **Annex A.** All LHAs are asked to create an inbox specifically for this purpose which follows a common format – **dutytorefer@LA name.**

It is agreed that:

1. **Duty to Refer referrals will be made by the Essex County Council Floating Support (EFS) Services on behalf of Basildon, Broomfield, Colchester, and Essex Community Hospitals for those individuals that are referred to the service and are eligible - referrals will need to be clearly marked to this effect. Southend Hospital will continue to make their own Duty to Refer referrals directly to the relevant Local Housing Authority (LHA) - Support can be provided to Southend Hospital staff via Southend Citizens' Advice (SCA) service.**

2. **In Basildon, Broomfield, Colchester, and Essex Community Hospitals a named EFS case worker will lead on the case for the hospital and email and telephone contact details will be provided to the LHA and would support patients of the hospital independent of their last previous address. From time-to-time other case workers in the EFS team may cover for temporary absence.**

3. **In the case of Southend Hospital the hospital team, will endeavour to send the DtR to an LHA where the patient has a local connection This LHA could be both inside or outside Greater Essex.**

4. **The EFS service or in the case of Southend Hospital the hospital team, will ensure that one DtR is submitted per patient at a time; where more than one DtR is being submitted the referral will bring this to the attention of the relevant LHAs and the LHA where the individual has a local connection will lead. If the individual has a local connection with more than one LHA, then the LHAs will agree between them, which one will lead.**

5. **LHAs receiving referrals from a partner that is a party to this agreement will use their best endeavours to send an acknowledgement of referral receipt within one working day.**

6. **LHAs receiving referrals under the Protocol are encouraged to provide a substantive response indicating next steps and designating a named case worker (who may change depending on the stages) to lead on the case for an individual within 3 working days of receiving the referral.**

7. **If either the named LHA, EFS or Hospital case worker changes, notification of this will be made to partners without delay.**

5. The Hospital Housing Team

The **Essex County Council Floating Support (EFS)** service is a team of professionals, employed by Peabody Trust and funded in Basildon and Broomfield Hospitals by Essex County Council, and in Colchester Hospital by Essex County Council & the North Essex ICB. The EFS service works within and across Basildon, Broomfield, Colchester, and Essex Community Hospitals to provide support to patients at risk of homelessness from all 14 Greater Essex LHAs as well as those patients from outside Greater Essex.

The **Southend Citizens Advice service (SCA)** is commissioned by Southend on Sea City Council to provide Information, Advice and Guidance to Southend citizens including those that are either homeless or at risk of homelessness.

Both EFS and SCA teams are knowledgeable in the provision and operations of the Homelessness Reduction Act, as well as available resources and services locally in each area.

The EFS and SCA service will work closely with NHS staff, Social Services staff, and Housing Solutions teams in all the Greater Essex LHAs, as well as voluntary sector and other relevant housing providers.

The intention of the EFS service is to provide a 5-day per week office hours service across the three main hospitals and Essex Community Hospitals, including providing support to A&E patients who are homeless. This support may not always be direct face to face support but could include telephone, teleconference, and other indirect support.

In addition, SCA can provide Information, Advice and Guidance support to Southend Hospital patients over the telephone. The service is a Monday to Friday service 9am to 5pm.

6. Identification of a Risk of Homelessness

Responsibility for the initial identification of homelessness risk, or a housing issue, that is likely to affect the patient's successful recovery lies with Hospital staff, particularly, where present, the Integrated Discharge Teams (IDT).

Determination of care arrangements in supporting the adults/patients discharge from hospital, will be made by relevant health professionals within the hospital service in line with the Discharge to Assess guidance. Decisions about long term care and support arrangements may be made post discharge, and this may include any care and support being arranged by Adult Social Care, following a Care Act Assessment. Where an individual is homeless or at risk of homelessness, and is referred for a care assessment, the outcome of the assessment in the case of Basildon, Broomfield, Colchester, and the Essex Community Hospitals should be communicated to both the relevant housing authority and EFS service. Where an individual is assessed as eligible for social care, then both the EFS service and the relevant social worker teams will need to work together to identify appropriate outcomes, which may include the use of social care nomination rights to housing.

In the case of Southend Hospital the outcome of the assessment in the case should be made to the Ward staff .

The IDT in Basildon, Broomfield, Colchester, and Essex Community Hospitals will make a referral to the EFS service as early as possible following identification of a homelessness or housing issue. A flow chart is shown **Annex B** to describe the identification and **Annex J** the referral process.

The IDT in Southend Hospital will make a referral to the Southend on Sea Housing Solutions Team and a referral for support can be made to the SCA service. A referral should be made as early as possible following identification of a homelessness or housing issue.

The operational responsibility for making referrals under the Duty to Refer to LHAs, where applicable, is delegated by the NHS to the EFS service in the case of Basildon, Broomfield, Colchester and Essex Community Hospitals, subject to ensuring that the NHS legal responsibilities for the Duty to Refer continues to be fulfilled. It will need to be clear that a referral is being made on behalf of the NHS to ensure accurate recording (of data which is submitted to central government). Southend Hospital's legal responsibility for the Duty to Refer remains with the hospital.

The EFS, SCA service (where involved) will then work closely with the IDT, Greater Essex Social Service teams (where involved), the relevant LHA, landlords and the voluntary sector, as appropriate in each case, to provide a solution to support a timely discharge into suitable accommodation.

Some inpatients with mental health problems may have been transferred from a Greater Essex Mental Health (MH) hospital to receive non-mental health treatment at one of the four hospitals. Normally these individuals would return to the MH hospital from where they were referred, and the mental health IDT would make a referral under the Duty to Refer to the relevant LHA, if the individual is at risk of homelessness. Where the inpatient is to be discharged from one of the named protocol hospitals, then this Protocol will apply. If a patient has been transferred from a MH hospital to one of the four hospitals and is going to be homeless on discharge, rather than returning to the MH hospital, the DtR will need to clarify why a return to the MH hospital is inappropriate.

The EFS/SCA services are intended to provide a short-term intervention. The EFS/SCA services have a responsibility to handover individuals to other services to ensure that longer term support and any follow-up medical support can be provided. After handover the EFS/SCA services will maintain telephone contact with service users once every 3 months for up to a year to track outcomes – this may be carried out by their generic teams.

If not already registered with a GP, the EFS at Basildon, Broomfield, Colchester, and Essex Community hospitals will assist patients to register with a GP – either directly or in partnership with housing providers or others involved in supporting the patient.

It is agreed that:

8. **All Essex LHAs commit to working closely and flexibly with the EFS/SCA services and to respond to Duty to Refer referrals from the EFS service within a maximum of 3 working days and the EFS/SCA services will work with LHAs responding to the DtR to share all relevant information with the LHA to inform the homelessness assessment.**

9. **Patients' housing and medical outcomes will be tracked by the EFS/SCA services for the duration of their input. Outcomes to be tracked include the sustainment of suitable accommodation, successful completion of treatment plans, and any further hospital episodes.**

10. **An information sharing agreement will apply to all the parties involved with this protocol which is shown in Annex G. This agreement does not replace any existing data sharing protocols included in contracts for services.**

7. Partnership Working

The Housing Act 1996 Pt VII (as amended) expects LHAs and their partners to establish effective partnerships and working arrangements to facilitate appropriate referrals.

It is important that communication with patients about their Housing Solutions is realistic and that expectations are managed. Although dependent on individual circumstances, most patients are unlikely to be in priority need under homelessness legislation and are unlikely to be offered social housing.

Those who are assessed by the LHA as in priority need (see **Annex D**) are likely to be accommodated in emergency accommodation for a period of time before they are housed in settled accommodation, either in the private rented sector or social rented housing.

Although the Duty to Refer requires a referral to be made to the LHA if a person is at risk of homelessness within 56 days, there may be other circumstances where partnership working is likely to be required. Housing partners encourage earlier referral, where practicable after admission and not to wait for the 56 days to arise for complex cases thus giving an additional opportunity to try to find suitable accommodation for discharge which could include partnership working to retain existing accommodation, including any adaptations that many be required. Where an individual is a social housing tenant direct contact should be made with the relevant landlord housing officer in the first instance.

The Greater Essex hospitals may convene a six-monthly meeting with the EFS/Citizen Advice Bureau services and service commissioners to review the operation of the Protocol and Procedures and identify any ways in which joint working can be further improved.

It is agreed that:

11. **Whoever makes a referral, there will need to be a lead person identified who will co-ordinate the case on behalf of the Hospital and that person's name and contact details will be provided on the form for use by the LHA.**

12. **The lead on behalf of the hospital and the relevant case officer within the LHA will discuss at the first opportunity what steps are to be taken to try to prevent or relieve homelessness.**

8. Outcomes Monitoring and KPIs

The outcomes achieved through the operation of the Protocol will need to be recorded so that there is an understanding of how many patients were supported to retain or secure accommodation on discharge from hospital.

The Greater Essex hospitals and the EFS/CSCA services will monitor their own performance against the Protocol and will share monitoring results on request. All LHAs are obliged to record Homelessness Reduction Act outcomes in some detail by completing their H-CLIC data submissions for Department of Levelling Up, Housing and Communities (DLUHC).

The Key Performance Indicators (KPIs) for the Protocol are as follows:

KPIs	Targets (TBC)
1. Time between referral and engagement with patient	Lower is better
2. Percentage of engagements where patients accept support	Higher is better
3. Numbers leaving hospital without suitable accommodation	Lower is better
4. Numbers leaving hospital who end up sleeping rough	Lower is better
5. Numbers where homelessness is prevented by the LHA for those at risk of homelessness within 56 days (i.e. they can return home safely)	Higher is better
6. Numbers where homelessness is relieved by LHA helping individuals to secure suitable accommodation	Higher is better
7. Delay in discharge from hospital because of a lack of suitable accommodation to go to	Lower is better
8. Number of people who complete a treatment plan following discharge	Higher is better
9. Number of new GP registrations	Higher is better

10. Number of repeat hospital presentations where homelessness remains an issue	Lower is better

The lead responsibility for achieving these KPIs lies with the EFS/SCA services, but responsibility for success is shared by all parties.

It is agreed that:

13. **Essex County Council, Thurrock Council, and Southend on Sea City Council will develop a data reporting tool, in conjunction with the EFS/SCA services and health partners, which collates and reports on the outcomes of referrals made under this Protocol. These reports will be made available to all partners including the relevant hospitals.**

14. **The EFS and SCA services will incorporate the KPIs into the regular contract reporting process for the relevant commissioners.** Q**uarterly meetings between the providers, hospitals, local authorities should take place to ensure reporting is checked, issues identified, and potentially solved & good working practice shared.**

9. Dispute Resolution

Whilst all staff involved in delivering this Protocol are expected to work positively together in the interests of the patient, it is recognised that on occasion differences of opinion may arise. It is noted that this dispute resolution process will work alongside statutory legislation and dispute resolution under the protocol should not be confused with or used in place of statutory reviews of homelessness decisions.

Where a dispute arises, it should wherever possible be resolved through a discussion between those staff directly involved and, if not resolved, the area and reason for disagreement should be recorded.

If a solution cannot be agreed and a partner believes that another partner is failing to follow the underlying principles of the Protocol, they can refer the matter to the relevant senior officer in their organisation to review the case and determine a solution.

Those partners working within the hospital can refer the matter to the appropriate senior manager; for EFS/SCA services, the Contract Manager for the ECC; and the Local Housing Authority can refer the matter to the Senior Manager for Housing Solutions or similar role.

10. Managing Risks

All parties to this Protocol are responsible for managing risks to those subject to this Protocol and to the wider community. This includes taking into account the nature of temporary accommodation that is available to Local Authorities to offer to homeless applicants that are in priority need. Temporary Accommodation is usually located in properties accommodating multiple vulnerable homeless people, and in some cases single adults share facilities with families with children. Where those referred to the LHA under the Duty to Refer are placed in short term accommodation such as a hostel, it will also be important to manage risks.

11. Role of Social Care

This Protocol has been created to ensure effective cooperation around the housing needs of homeless inpatients on discharge from hospital services. Both parties recognise that ECC, Southend-On-Sea and Thurrock have far wider responsibilities in respect of health and social care services for people with mental health needs, which are not included in this Protocol.

Determination of care arrangements in supporting the adults/patients discharge from hospital, will be made by relevant health professionals within the hospital service in line with the Discharge to Assess guidance. Decisions about long term care and support arrangements can be made post discharge, and this may include any care and support being arranged by Adult Social Care, following a Care Act Assessment

10. Summary of Commitments

Duty to Refer

1. **Duty to Refer referrals will be made by the Essex County Council Floating Support (EFS) Services on behalf of Basildon, Broomfield, Colchester, and Essex Community Hospitals for those individuals that are referred to the service and are eligible - referrals will need to be clearly marked to this effect. Southend Hospital will continue to make their own Duty to Refer referrals directly to the relevant Local Housing Authority (LHA) - Support can be provided to Southend Hospital staff via Southend Citizens' Advice (SCA) service.**

2. **In Basildon, Broomfield, Colchester, and Essex Community Hospitals a named EFS case worker will lead on the case for the hospital and email and telephone contact details will be provided to the LHA and would support patients of the hospital independent of their last previous address. From time-to-time other case workers in the EFS team may cover for temporary absence.**

3. **In the case of Southend Hospital the hospital team, will endeavour to send the DtR to an LHA where the patient has a local connection This LHA could be both inside or outside Greater Essex.**

4. **The EFS service or in the case of Southend Hospital the hospital team, will ensure that one DtR is submitted per patient at a time; where more than one DtR is being submitted the referral will bring this to the attention of the relevant LHAs and the LHA where the individual has a local connection will lead. If the individual has a local connection with more than one LHA, then the LHAs will agree between them, which one will lead.**

5. **LHAs receiving referrals from a partner that is a party to this agreement will use their best endeavours to send an acknowledgement of referral receipt within one working day.**

6. **LHAs receiving referrals under the Protocol are encouraged to provide a substantive response indicating next steps and designating a named case worker (who may change depending on the stages) to lead on the case for an individual within 3 working days of receiving the referral.**

7. **If either the named LHA, EFS or Hospital case worker changes, notification of this will be made to partners without delay.**

Identification of Risk of Homelessness

8. **All Essex LHAs commit to working closely and flexibly with the EFS/SCA services and to respond to Duty to Refer referrals from the EFS service within a maximum of 3 working days and the EFS/SCA services will work with LHAs responding to the DtR to share all relevant information with the LHA to inform the homelessness assessment.**

9. **Patients' housing and medical outcomes will be tracked by the EFS/SCA services for the duration of their input. Outcomes to be tracked include the sustainment of suitable accommodation, successful completion of treatment plans, and any further hospital episodes.**

10. **An information sharing agreement will apply to all the parties involved with this protocol which is shown in Annex G. This agreement does not replace any existing data sharing protocols included in contracts for services.**

Partnership Working

11. **Whoever makes a referral, there will need to be a lead person identified who will co-ordinate the case on behalf of the Hospital and that person's name and contact details will be provided on the form for use by the LHA.**

12. **The lead on behalf of the hospital and the relevant case officer within the LHA will discuss at the first opportunity what steps are to be taken to try to prevent or relieve homelessness.**

Outcomes Monitoring and KPIs

13. **Essex County Council and Southend on Sea City Council will develop a data reporting tool, in conjunction with the EFS/SCA services and health partners, which collates and reports on the outcomes of referrals made under this Protocol. These reports will be made available to all partners including the relevant hospitals.**

14. **The EFS and SCA services will incorporate the KPIs into the regular contract reporting process for the relevant commissioners.** Q**uarterly meetings between the providers, hospitals, local authorities should take place to ensure reporting is checked, issues identified, and potentially solved & good working practice shared.**

Confirmation of Agreement by Participant Organisations

This Essex Homelessness Hospital Discharge Protocol is agreed by the following organisations.

Basildon Borough Council

Name: **Position:**

Date:

Braintree District Council

Name: **Position:**

Date:

Brentwood Borough Council

Name: **Position:**

Date:

Castlepoint Borough Council

Name: **Position:**

Date:

Chelmsford City Council

Name: **Position:**

Date:

Colchester City Council

Name: **Position:**

Date:

Epping Forest District Council

Name: **Position:**

Date:

Harlow District Council

Name: **Position:**

Date:

Maldon District Council

Name: **Position:**

Date:

Rochford District Council

Name: **Position:**

Date:

Southend-on-Sea City Council

Name: **Position:**

Date:

Tendering District Council

Name: **Position:**

Date:

Thurrock Council

Name: **Position:**

Date:

Uttlesford District Council

Name: **Position:**

Date:

Essex County Council

Name: **Position:**

Date:

Mid and South Essex Hospitals NHS Foundation Trust

Name: **Position:**

Date:

Colchester Hospitals NHS Foundation Trust

Name: **Position:**

Date:

Basildon & Brentwood Integrated Commissioning Board

Name: **Position:**

Date:

Mid Essex Integrated Commissioning Board

Name: **Position:**

Date:

Southend Clinical Integrated Commissioning Board

Name: **Position:**

Date:

Thurrock Clinical Integrated Commissioning Board

Name: **Position:**

Date:

Essex Floating Support Service

Name: **Position:**

Date:

Southend Citizens' Advice Bureau

Name: **Position:**

Date:

Annex A: Local Housing Authorities

The LHAs and their contact details are:

District:	Duty to Refer Email:
Basildon	dutytorefer@basildon.gov.uk
Braintree	dutytorefer@braintree.gov.uk
Brentwood	dutytorefer@brentwood.gov.uk
Castle Point	dutytorefer@castlepoint.gov.uk
Chelmsford	dutytorefer@chelmsford.gov.uk
Colchester	dutytorefer@colchester.gov.uk
Epping Forest	dutytorefer@eppingforestdc.gov.uk
Harlow	dutytorefer@harlow.gov.uk
Maldon	dutytorefer@maldon.gov.uk
Rochford	dutytorefer@rochford.gov.uk
Southend-on-Sea	HousingSolutionsTeam@southend.gov.uk
Tendring	dutytorefer@tendringdc.gov.uk
Thurrock	dutytorefer@thurrock.gov.uk
Uttlesford	dutytorefer@uttlesford.gov.uk

Annex B: Outline Operational Flow

An outline customer journey model for an individual patient is as follows:

1. When a patient is first admitted as an inpatient to a hospital, or attends A&E, their housing situation should be recorded. It is recognised that data recording on homelessness needs to improve as the main code used by hospitals is 'NFA'.

2. Where attendance at A&E does not result in an admission to inpatient care then an individual who is homeless should be referred to the local EFS team or in the case of Southend Hospital the Southend on Sea Housing Solutions Team. If the referral is made out of hours details should be provided by email together with contact details for the individual referred. The individual can then be contacted the next day during the EFS/ Southend on Sea Housing Solutions Team service hours and the services can refer the individual to an LHA under the Duty to Refer. If the case is out of hours and relates to an urgent rough sleeping issue then a referral should be made to the National Streetlink service by visiting www.streetlink.org.uk, or by calling 0300 500 0914.

3. In the case of inpatients, Ward Managers will refer patients to the Integrated Discharge Team (IDT), where present, and where they have any concerns about homelessness.

4. The IDT, or ward staff where IDT are not present, starts working with inpatients to plan discharges soon after they have been admitted to hospital. Through this process the IDT will be able to identify those who are homeless and have not already been referred by Ward Managers.

5. The IDT or ward staff where IDT are not present, will refer patients to the local EFS service in the case of Basildon, Broomfield, Colchester, and Essex Community hospitals to ensure that the patient's housing situation is assessed to determine as soon as possible whether a housing referral is required under the Duty to Refer, and any Care Act Assessment made shared with relevant partners or in the case of Southend Hospital referrals should be made via the hospital team to the Southend on Sea Housing Solutions Team.

6. The IDT or ward staff where IDT are not present, will also identify those who are not homeless but who are unable to return home as their accommodation is unsuitable or requires adaptations. These inpatients will need to be referred to the local EFS service in the case of Basildon, Broomfield, Colchester Hospitals and Essex Community hospitals, although they may not require a referral to the relevant LHA under the Duty to Refer. In the case of Southend Hospital referrals should be made via the hospital team to the Southend on Sea Housing Solutions Team.

7. The Hospitals data systems does not have a flag for homelessness and cannot report on the number of homeless people who become inpatients nor those who become homeless during their hospital stay. This may change in the future, should changes be made to the data systems.

8. The IDT or ward staff where IDT are not present, contacts in the case of Basildon, Broomfield, Colchester, and Essex Community hospitals the local EFS service through submitting a referral form electronically (**Annex E**) via email to efsco-

ordinator@peabody.org.uk and for Southend Hospital should contact the Southend on Sea Housing Solutions Team via email to HousingSolutionsTeam@southend.gov.uk

9. The EFS service in the case of Basildon, Broomfield, Colchester and Essex Community hospitals, will arrange an appointment with the patient, either face to face or via the telephone during office hours. The appointment with the patient will be made, independent of which housing authority the patient was residing in prior to their admission (even if this is outside of Greater Essex) and as soon as possible by the EFS service and within a maximum of 2 working days. Face to face appointments are likely to be on the ward. In the case of Southend Hospital referrals should be made via the hospital team to the Southend on Sea Housing Solutions Team via email HousingSolutionsTeam@southend.gov.uk

10. The EFS service in the case of Basildon, Broomfield, Colchester, and Essex Community hospitals, will make an assessment of the patient's housing needs and the best way for these to be addressed. This may involve a discussion with medical staff, social services staff, and the relevant LHA, as necessary.

11. The EFS service in the case of Basildon, Broomfield, Colchester, and Essex Community hospitals or in the case of Southend Hospital referrals should be made via the hospital team will then agree a plan for that individual, considering their:
    - housing needs including any specialist accommodation needs
    - medical needs including a need for ongoing treatment after discharge from hospital.
    - their likely length of stay in hospital if any
    - their likely status under homelessness legislation
    - the availability of accommodation in their home area
    - the availability of support services in their home area, where applicable
    - financial situation and benefit entitlement, where applicable.
    - any adaptations needed in order for them to return home, where applicable.

12. This plan will identify the need for emergency short-term accommodation, if suitable settled accommodation is not available, and work with LHAs and others, as applicable, to ensure that such accommodation is made available. Patients will not necessarily be assessed as being in 'priority need' and the LHA may not, therefore, owe a duty to provide temporary or longer-term accommodation.

13. Whenever the threshold for referral is met (and the patient consents) a referral will be made to the LHA under the Duty to Refer as this is a statutory requirement. Either a direct referral can be made online via the LHA's website, or an email sent to the LHA using the address shown in **Annex A**. (See **Annex F** for DLUHC template referral form). Where the patient doesn't give consent then the EFS in the case of Basildon, Broomfield, Colchester, and Essex Community hospitals will look to support the patient to prevent homelessness but a referral to the LHA will not be made. In the case of Southend Hospital, the hospital teams can be supported by Southend Citizens' Advice (SCA)

service via email: enquiries@citizensadvicesouthend.org.uk or telephone 08082 78 79 78.

14. The LHA will agree responsibility for actions and interventions with the referrer, after a full housing assessment on the patient and the completion of a Personal Housing Plan (PHP), and with the customer's consent. A successful prevention/relief outcome will be recorded as part of the LHA's H-CLIC return to government and if prevention/relief interventions are unsuccessful the LHA will determine whether or not the 'main' homelessness duty is owed.

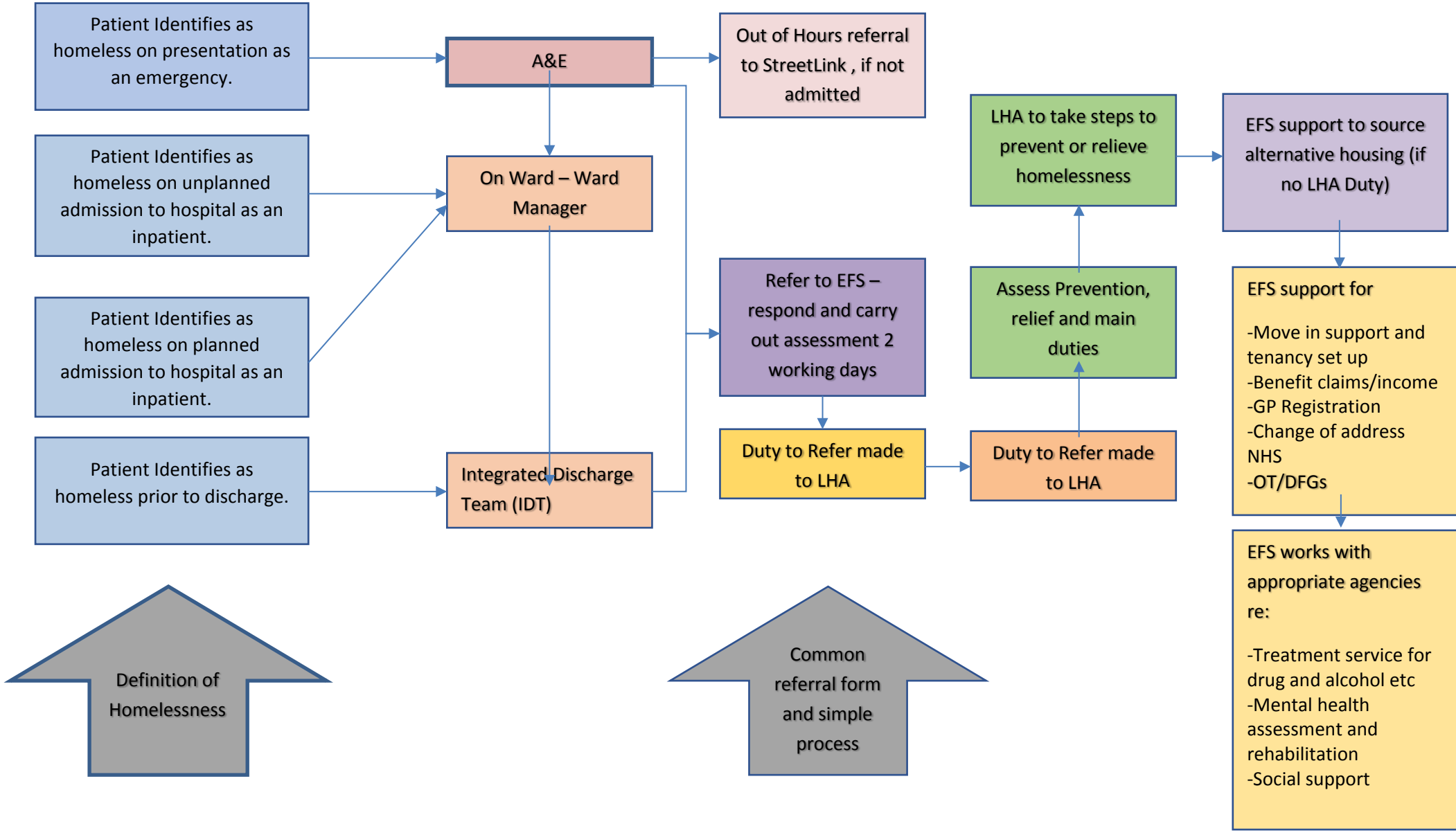
15. The referrer will help to ensure that if a move to new accommodation is taking place, that arrangements are made to ensure transport, storage of belongings is achieved, registration for benefits, and utility bills are made, as necessary. This will often not require the EFS service/Hospital staff to carry out those functions, however, as the responsibility for this may lie elsewhere.

16. The EFS in the case of Basildon, Broomfield, Colchester, and Essex Community hospitals will arrange for the patient's medical records to be updated to reflect this change of address. The EFS service will ensure that appropriate contacts are maintained between relevant NHS staff and the patient following discharge to ensure that treatment programmes may be continued and follow up carried out.

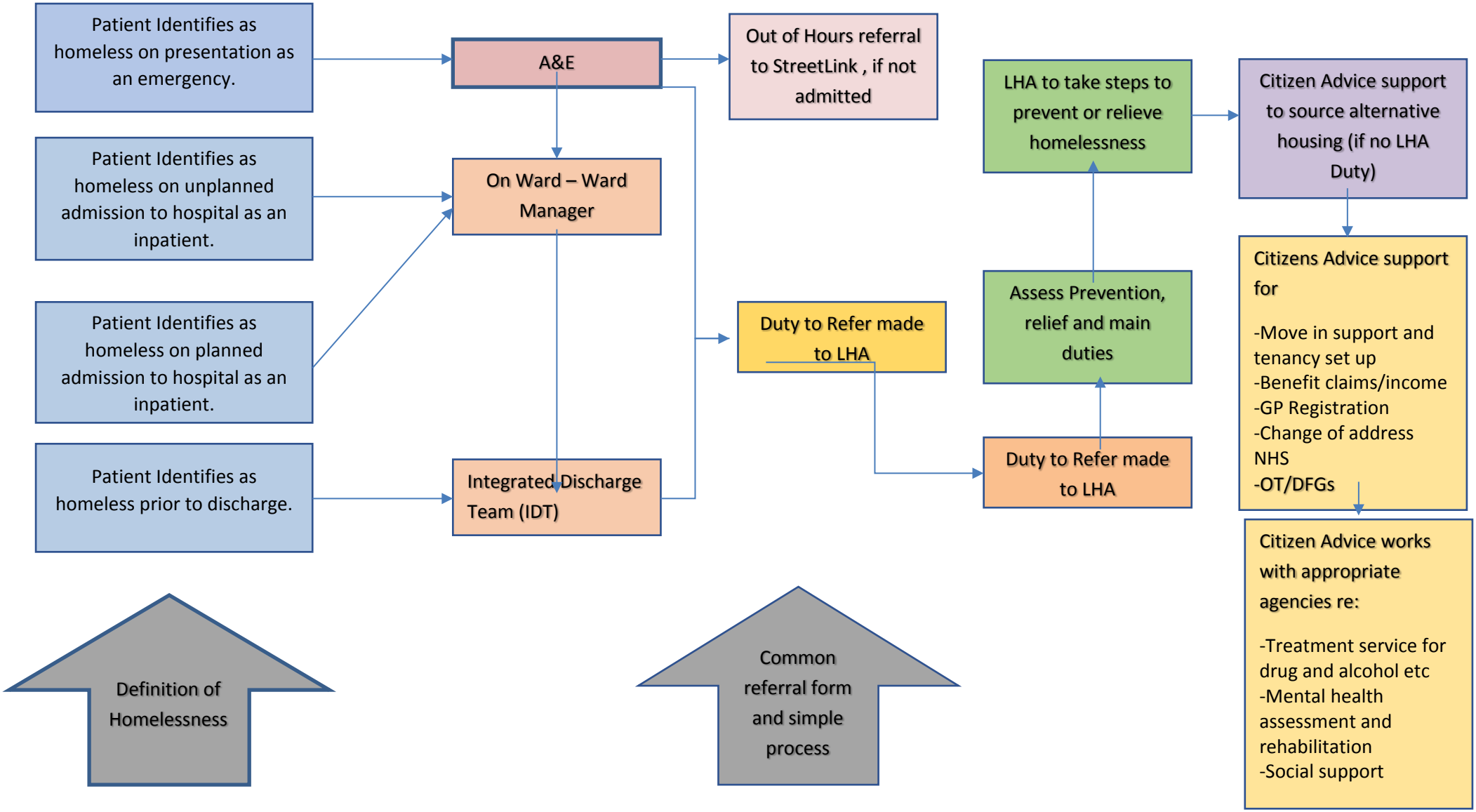
17. The EFS in the case of Basildon, Broomfield, Colchester, and Essex Community Hospitals will work to ensure that all discharged patients are registered with a local GP.

18. Within reason, the EFS in the case of Basildon, Broomfield, Colchester, and Essex Community hospitals will perform a trouble-shooting function to attempt to re-establish contacts between discharged patients it has worked with and medical staff, if these are lost.

Essex Hospital Discharge Protocol Basildon, Broomfield, Colchester & Essex Community Hospitals



Essex Hospital Discharge Protocol Southend Hospital



Annex C: Duty to Refer

The Homelessness Reduction Act 2017 significantly reformed England's homelessness legislation by placing duties on local housing authorities to intervene at earlier stages to prevent homelessness in their areas, and to provide homelessness services to all those who are eligible.

Additionally, the Act introduced a duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to the local housing authority.

The duty to refer will help to ensure that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities. It is also anticipated that it will encourage local housing authorities and other public authorities to build strong partnerships which enable them to work together to intervene earlier to prevent homelessness through, increasingly integrated services.

Public authorities with a duty to refer

As of January 2022 the specified public authorities subject to the duty to refer are (in England only):

- Prisons
- young offender institutions
- secure training centres
- secure colleges
- youth offending teams
- probation services (including community rehabilitation companies)
- Jobcentres in England
- social service authorities (both adult and children's)
- emergency departments
- urgent treatment centres
- hospitals in their function of providing inpatient care
- Secretary of State for defence in relation to members of the regular armed forces

Requirements of the duty to refer

The duty requires the specified public authorities to identify and refer a service user who is homeless or may be threatened with homelessness, to a local housing authority of the service user's choice.

The service user must consent to the referral being made. The consent can be made in writing or given orally, although the person referring should follow the agreed processes set out in their agency's internal guidance, if applicable.

A person is considered homeless if:

- they do not have any accommodation which is available for them which they have a legal right to occupy; or,

- it is not reasonable for the person to occupy their current accommodation, for example, because they would be at risk of domestic abuse.

Someone is defined as being threatened with homelessness where they are likely to become homeless within 56 days or have been served with a valid notice under section 21 of the Housing Act 1988 by their landlord, which expires within 56 days.

Identifying when a referral might be required

Staff in public authorities will usually know if a service user is sleeping rough and therefore actually homeless. They may also become aware of service users who are homeless but not roofless (sometimes described as 'sofa surfers') if they provide 'care of' addresses or frequently change their address.

The following are factors that would indicate that a service user may be threatened with homelessness and should be asked about their housing circumstances:

- problems with debt, particularly rent or mortgage arrears
- problems with a landlord, being threatened with eviction or served notice to leave
- being a victim of domestic abuse, or other forms of violence, threats, or intimidation
- approaching discharge from hospital, armed forces, or release from custody, with no accommodation available to them
- having previously been in care, the armed forces or in prison.

Choosing which local authority to refer to

The duty allows service users to choose which local housing authority they are referred to. However, when discussing the referral and offering guidance to the service user, it is important to be aware that local housing authorities owe more duties towards homeless applicants who have a local connection with their area.

If a person asks to be referred to an area, they do not have a local connection to, the local housing authority might subsequently refer them on to another local housing authority to which they do have a local connection.

In general, a service user is likely to have a local connection to an area if they live or have lived there, work there, or have a close family connection. However, a service user should not be referred to an area where they would be at risk of violence.

In addition to the usual rules about local connection, care leavers have special provision. This provides that where the service user is a care leaver aged 18-21, in addition to any local connection they may have elsewhere, they will have a local connection with the local authority that looked after them.

In areas where there is a county council and district councils (often referred to as two-tier areas), care leavers will have a local connection with every local housing authority (district council) that falls within the area of the local authority (county) that cared for them.

Process for referrals

Local housing authorities should make referral mechanisms as simple as possible, based on the minimum information required by law for a public authority to make a legitimate referral – this is the, contact details and agreed reason for referral.

Where a local housing authority has not established referral mechanisms, or has not provided information that is readily available about these a simple form can be used by public authorities to make a referral.

The duties of the local housing authority

The Homelessness Reduction Act 2017 places duties on local housing authorities to take reasonable steps to prevent and relieve an eligible applicant's homelessness. Once the local housing authority has agreed that the applicant is eligible for assistance (based on their immigration status) and that they are homeless or threatened with homelessness, they will work with the applicant to develop a personalised housing plan.

The plan will identify the reasonable steps that the service user and the local housing authority will take to ensure the applicant has and is able to retain or obtain suitable accommodation.

If the applicant is homeless during the 56-day relief stage and may have priority need, the local housing authority must provide them with temporary accommodation.

Annex D. Priority Need

Local housing authorities are required to secure accommodation for an applicant if they have reason to believe that the applicant **may** be homeless, eligible for assistance and have a priority need. The following categories of applicant have a priority need for accommodation:

(a) a pregnant woman or a person with whom she resides or might reasonably be expected to reside
(b) a person with whom dependent children reside or might reasonably be expected to reside
(c) a person who is vulnerable as a result of old age, mental illness, learning disability or physical disability or other special reason, or with whom such a person resides or might reasonably be expected to reside
(d) a person aged 16 or 17 who is not a 'relevant child' or a child in need to whom a local authority owes a duty under section 20 of the Children Act 1989
(e) a person under 21 who was (but is no longer) looked after, accommodated, or fostered between the ages of 16 and 18 (except a person who is a 'relevant student')
(f) a person aged 21 or more who is vulnerable as a result of having been looked after, accommodated, or fostered (except a person who is a 'relevant student')
(g) a person who is vulnerable as a result of having been a member of Her Majesty's regular naval, military or air forces.
(h) a person who is vulnerable as a result of:
    (i) having served a custodial sentence
    (ii) having been committed for contempt of court or any other kindred offence; or
    (iii) having been remanded in custody
(i) a person who is vulnerable as a result of ceasing to occupy accommodation because of violence from another person or threats of violence from another person which are likely to be carried out
(j) a person who is homeless, or threatened with homelessness, as a result of an emergency such as flood, fire, or other disaster.

Once a local housing authority has notified an applicant that they have a priority need and have been accepted as owed a duty it cannot subsequently change that decision if the applicant subsequently ceases to have a priority need (e.g. because a dependent child leaves home), except where a review has been requested and the change takes place before the review decision. Any change of circumstance prior to the decision on the homelessness application should be taken into account. However, once all the relevant inquiries are completed, the housing authority should not defer their decision on the case in anticipation of a possible change of circumstance.

Annex E – Referral Form for EFS

ESSEX OUTREACH REFERRAL FORM

What type of referral is this?	Self ☐	Agency ☐
Date of referral	/ /	
By submitting and agreeing to this referral the customer understands that Peabody will store and process this information as outlined in the Peabody privacy notice. The customer has rights under the Data Protection Act 2018, and they can exercise these rights at any time by contacting Peabody. Signed: _____ (customer or referrer)		
Do you/does the customer have any special communication needs e.g. Large print, alternative language/interpretation etc?		
Has the customer agreed to this referral?	Yes ☐	No ☐
Name of referrer:	Agency:	
Telephone:	Email:	

Name Of customer:			
Address			
Postcode		Local Authority	
Tel. nos.		Email:	
Date of birth:		NI no.	
Gender: Male ☐ Female ☐ Other ☐		Marital status:	
Sexuality:		Religion:	
Ethnic origin:		Nationality:	

What is the customer's accommodation status?			
Homeowner ☐	Tenant ☐	Living w/family ☐	Living w/friends ☐
Length of time at this address		How long have you lived in this area?	
Is the customer homeless or at risk of losing their accommodation?		Homeless ☐	At risk ☐
If the customer is a tenant, please provide landlord details:			

Does the customer have a next of kin? If so, please provide details:		
Name and relationship		
Contact numbers.		
Address		
May we contact the next of kin if required?	Yes ☐	No ☐

What is the customer's source of income?					
Employed:			Temp ☐	P/T ☐	F/T ☐
Other income/welfare benefits:					
UC ☐	IS/ESA /JSA ☐	PIP (DLA/AA) ☐	Pension /PC ☐	No income ☐	Other (please state):

Is the customer registered with a GP?	Yes ☐	No ☐
Does the customer consider themselves to be disabled?	Yes ☐	No ☐
Please describe the disability:		
Is this an urgent referral?	Yes ☐	No ☐
Please describe the immediate need:		

Are there any other needs?

RISK SCREENING

Does the customer pose any known risks to themselves or others?	Yes ☐	No ☐
Does the customer have any criminal convictions or cautions?	Yes ☐	No ☐

Risk type	Details/triggers/management	Risk to whom
Environmental Detail any risk factors from service user's accommodation or surrounding areas • Poor accessibility • Standard of accommodation (internal/common areas /external) • Other		Self ☐ Visitors ☐ Neighbours ☐ Staff ☐ Others ☐
Vulnerablility Detail any risks to the customer from others e.g. • Known neighbourhood issues • Inapproriate relationship building • Risk of abuse • Domestic Violence • Other • Child protection concerns		Self ☐ Visitors ☐ Neighbours ☐ Staff ☐ Others ☐
Substance misuse Any known problems in this area, details of the extent of the problem, whether any help is being sought or provided etc.		Self ☐ Visitors ☐ Neighbours ☐ Staff ☐ Others ☐
Mental Health Any known risks in this area • Suicide/self harm • Eating disorders • Diagnosis • Engagement with services		Self ☐ Visitors ☐ Neighbours ☐ Staff ☐ Others ☐

• Other		
Risks from the customer Any known risks to others e.g. • Physically/sexually abusive • Verbally/mentally abusive • Inappropriate relationship building/behaviour • Weapons • Other		Self ☐ Visitors ☐ Neighbours ☐ Staff ☐ Others ☐
Physical Health • Mobility issues • Life limiting conditions • Contagious/transferrable conditions • Other		Self ☐ Visitors ☐ Neighbours ☐ Staff ☐ Others ☐
Other Risks		Self ☐ Visitors ☐ Neighbours ☐ Staff ☐ Others ☐

Other agency involvement
Please use this space to advise of any other agencies/professionals that you are aware of being involved with the customer.

Name	**Agency/position**	**Phone/email**
Involvment		
Name	**Agency/position**	**Phone/email**
Involvement		

Please return to efsco-ordinator@peabody.org.uk

Annex F – Duty to Refer Referral Form

Please insert the name of the local housing authority that the service user is being referred to.	
NOTE: Service users can choose which local housing authority they wish to be referred to. However, it is advisable for them to choose a local authority with which they have a local connection. In general, a service user is likely to have a local connection to an area if they live or have lived there, wok there or have a close family connection. However, a service user should not be referred to an area where they would be at risk of violence. A guide to the duty to refer includes advice on the duty to refer and local connection.	
(1A) Written Consent to share information I agree to the information on this form being shared with _____ Council. I understand that the Council may use this information to contact me, and to help assess my needs for assistance with housing and that I am not making a homelessness application. I have read _____ privacy notice and understand how my data will be processed. Signed: _____ Date: _____ NOTE: The service user must give consent to the referral. Referrers are advised to obtain signed consent to the referral; however, oral consent can be provided. The referrer must therefore complete box 1B.	
(1B) Oral Consent to share information Having discussed the accommodation status of _____ (*insert service username)* the service user, I can confirm that they provided me with oral consent to refer their case to _____ Council. I explained to the Service User that the Council may use this information to contact them and to help assess their needs for assistance with housing and that this is not a homelessness application.	

Signed	**Public authority**	**Date**

Core information Please note that sections 2 – 4 must be filled in.

(2) About the referring professional (to be completed by the professional)	
Public authority referring (e.g. prison, hospital, etc.)	
Role of person referring (e.g. social worker)	
Name of referrer	
Address of referrer	
Email address of referrer	
Phone number of referrers	
Name and contact details of any other person who could be contacted for further information, if not the referrer (e.g. a support provider)	
(3) Information and contact details for the service user being referred	
Name	

Household composition (e.g. single person, couple, family with X children/X adults)	
Current address (if applicable)	
Home telephone number	
Mobile number	
Email address	
Gender	
Date of birth	
Language and communication needs (identify any assistance the service user will need for an assessment to be completed)	
(4) Main reason for referral	
What is the main reason you are referring the individual?	I believe they are homeless / I believe they are threatened with homelessness
Please explain your answer (e.g. "they are facing eviction from their home")	

Additional information

Please provide any additional information you are aware of which may help Housing Solutions officers support the individual.

(5) Current accommodation	
What type of accommodation is the individual currently living in?	
If the service user is threatened with homelessness, on what date are they likely to become homeless?	
If the service user is due to leave prison or hospital, or is leaving the armed forces, with no accommodation available, please state when the release/ discharge will take place.	
(6) Are there any additional needs/risks to be aware of?	
Additional needs/risks might include: • previous history of sleeping rough • lack of support from family/friends • history of substance misuse • risk of domestic or other abuse	
(7) Relevant medical information	
Please provide information on any physical or mental health needs that the service user has, and any treatment that they are receiving	
(8) Other information	
Please provide any additional information. In particular, are there any known risks to staff visiting the service user at home or any other issues that we need to be aware of prior to initial contact?	

Annex G. Information Sharing Agreement

This agreement relates to the sharing of information between the Essex partners and their staff who are involved in the implementation of the Protocol.
The aim of the partners in co-operating under the terms of this Protocol is to ensure that information supplied regarding patients will be used solely by staff for the purpose of planning and delivering appropriate services to such patients and to fulfil the associated monitoring requirements.

Information will be shared between partners where consent has been obtained from the patient and where the information will be used in a positive manner to enable the effective implementation of the protocol. In accordance with relevant allocation policies etc, partners should seek to consider each case on its own merit.

Confidentiality

Partners shall ensure that any information supplied to them relating to patients and any disclosures made by patents, remain confidential except where there are overriding issues of public interest.

Any exchanges of information under this protocol shall require all partners to act in accordance with the Data Protection Act 2018 and General Data Protection Regulations 2018, or any superseding or amending statutory requirements and no partners shall act in any other manner or way which is deemed to be unlawful. In addition, due care will be given to any requirement of the Human Rights Act 1998.

Breaches of confidentiality should be investigated and where necessary, dealt with as a disciplinary issue by the employer of the staff member involved. Breaches may result in exclusion from the protocol.

Annex H: Service Specification for the Essex Floating Support Service

EFS Servcie Specification.pdf

Annex I: Service Specification for Southend IAG Specification

IAG Service Specification.pdf

Annex J: Referral Process by Hospital to the Floating Support Service

i. **Basildon Hospital –** Referral to be made electronically using the referral form (Annex E) and sent to efsco-ordinator@peabody.org.uk
ii. **Broomfield Hospital –** Referral to be made electronically using the referral form (Annex E) and sent to efsco-ordinator@peabody.org.uk
iii. **Colchester Hospital –** Referral to be made electronically using the referral form (Annex E) and sent to efsco-ordinator@peabody.org.uk
iv. **Essex Community Hospitals –** Referral to be made electronically using the referral form (Annex E) and sent to efsco-ordinator@peabody.org.uk
v. **Southend Hospital –** Can not use the EFS service but should make referrals direct to Southend on Sea Housing Solutions Team using the Duty to Refer form (Annex F) and sent to HousingSolutions@southend.gov.uk. The SCA service can support patients through this process, via email: enquiries@citizensadvicesouthend.org.uk or telephone 08082 78 79 78.

Annex K: Essex Community Hospitals

Essex Community Hospitals.docx