Hospital to home discharge protocol template

For application/adaptation to local setting as required.

#### Introduction

Local experience suggests that housing is not always considered early enough in the discharge process, resulting in some people remaining in mental health hospitals for longer than necessary, or being given unsuitable housing arrangements that may create a higher risk of breakdown (for example, due to living environments that do not meet people’s sensory needs).[[1]](#footnote-2)

This joint protocol sets out how local partners will work together to ensure that planning for people’s future housing needs starts as early as possible after admission to hospital and is undertaken in a fully joined-up way, in close co-production with the person and any family or loved ones.

It establishes the series of steps that lead organisations have agreed to adopt to ensure better outcomes for autistic people and people with a learning disability.

**Underpinning principles and rationale**

Underlying principles are set out in national guidance: [Building the Right Home](https://www.bing.com/ck/a?!&&p=9ee2edd96dc83640JmltdHM9MTY4OTIwNjQwMCZpZ3VpZD0yMjZmM2Q3ZC05NzJiLTYwOTQtM2FhMi0yZmI4OTZlNDYxMWEmaW5zaWQ9NTMwNw&ptn=3&hsh=3&fclid=226f3d7d-972b-6094-3aa2-2fb896e4611a&psq=building+the+right+home+nhs+england&u=a1aHR0cHM6Ly93d3cuZW5nbGFuZC5uaHMudWsvbGVhcm5pbmctZGlzYWJpbGl0aWVzL2NhcmUvaG91c2luZy8&ntb=1). This states that people should:

* be supported to live in their own home with the right support
* have a choice about who they live with, and where they live
* have housing that works for them and meets their needs
* be offered settled accommodation, or have access to short-term accommodation and support where needed, to enable them to continue living in the community
* know that their home is safe and secure, and (for example) that they have the right to decide who can and cannot enter their home
* be able to stay in their home even if their care and support needs change (such as through home ownership, or a secure tenancy)
* feel happy and safe in their home.

**Local principles and priorities**

In addition to the principles above, *[insert relevant governance body*] have agreed to these additional priorities or practices for this locality *[to agree locally]. Suggestions:*

* *Listen to people’s feedback about their own housing options and preferences and provide as much housing choice as possible.*
* *Provide support for each person to have a person-centred housing plan.*
* *Set up a regular meeting for signatories to this protocol to review how it is working.*

**Governance**

The *[insert name]* group is accountable for oversight and monitoring of this protocol and ensuring that timely corrective action is taken for all delays, with these escalated where appropriate. The aim of this protocol is to encourage decisions to be taken jointly and to ensure that the needs of individuals are addressed by the most appropriate agency within the national guidance, statutory legislation and good practice.

*[Appendix]* lists each of the signatory organisations, roles and responsibilities.

**Aims and objectives**

*[These are illustrative examples – actual objectives to be agreed at local level]:*

* *Ensure that people’s housing needs are assessed at the point of admission, or as soon after admission as possible, and regularly reviewed to take account of any changing requirements the person may have.*
* *All individual housing needs assessments should be person centred and based around the needs and wishes of individuals requiring housing.*
* *To ensure the health, social care and housing workforces are each aware of their responsibilities as well as the statutory and legal duties of the other people and teams working in this area.*

#### Steps in the protocol

1. Individual housing needs assessment with the person and those who know them best (and an advocate if involved), alongside planning for any care and support needs.
2. Personalised support in looking for the person’s new home (if needed).
3. Planning for the future once a new home has been identified (if needed), or to ensure the person’s original home is suitable for them to move back into.
4. Personalised support for the move itself.
5. **Individual’s** [**housing needs assessment**](https://www.england.nhs.uk/publication/brick-by-brick/)**:**

* *A named member of staff (eg the lead health or care professional co-ordinating discharge planning – to be determined locally)* should co-ordinate (or delegate to another named person) the housing needs assessment in partnership with the person and their family. Contributions will likely be needed from a range of sources, possibly including housing officers, support providers, advocates, clinicians, occupational therapists, social workers and probation officers.
* The views of the person and those who know them best should be at the heart of this process. The online housing guide for people and families (Learning Disability England) is a useful resource to support these conversations.
* If the person co-ordinating the housing needs assessment is not someone with housing expertise, then a person with this type of expertise should be nominated to support the process. This should result in a housing specification that is co-produced with the person him or herself and any family members or carers, and agreed by all parties. The specification should take account of:
* The overall design of the home, which should be informed by the person’s own preferences – for example, their favourite colours, their interests, what helps them to feel calm and happy, and how they like to spend their time.
* Any need in the home for robust materials or anti-ligature features, or any other requirements to ensure the person’s wellbeing and safety and that of any staff who will be supporting the person in the home.
* A sensory profile.[[2]](#footnote-3) This should be completed to record any sensory needs the person may have and thereby enable personalised housing design, alongside consideration of trauma-informed design principles[[3]](#footnote-4) if needed.
* Requirements for assistive technology in the home to support the person’s independence and wellbeing.
* Consider any heating, ventilation and other energy requirements, while aiming to minimise future energy and utility costs that will need to be paid for.
* Location needs, such as proximity to friends or family, access to transport and other services, noise and housing density levels, safeguarding risks, the need for broadband and mobile signal, and any requirements for private outdoor space.

All of this work should be underpinned by the person’s overall life plan, listening to the person and those who know them well, capturing their strengths, relationships and activities that underpin their wellbeing. There should be a focus on enabling the person to maintain relationships, make their future home their own and follow their interests – balanced with the management of any identified risks in the home or the community.

**2. Personalised support in looking for the person’s new home:**

* Allocate responsibility for specific actions in determining the person’s future housing solutions. Ensure that an occupational therapist is involved, alongside someone with housing expertise (including knowledge of housing benefit rules and how they apply).
* The person and their family (and any advocate) should be at the heart of all housing planning from the outset.
* Start the housing planning process at the point the person is admitted to hospital, or soon after.
* Consider whether the person already owns a home, holds a tenancy or wants to return to the family home. Identify whether home adaptations are needed (initiating any required works and considering the use of a [Disabled Facilities Grant](https://www.bing.com/ck/a?!&&p=0aea33c80f6eb58aJmltdHM9MTY4OTIwNjQwMCZpZ3VpZD0yMjZmM2Q3ZC05NzJiLTYwOTQtM2FhMi0yZmI4OTZlNDYxMWEmaW5zaWQ9NTIwMQ&ptn=3&hsh=3&fclid=226f3d7d-972b-6094-3aa2-2fb896e4611a&psq=disabled+facilities+grant&u=a1aHR0cHM6Ly93d3cuZ292LnVrL2Rpc2FibGVkLWZhY2lsaXRpZXMtZ3JhbnRz&ntb=1) to fund this). Ensure that rent or mortgage payments are being covered if the property is vacant.
* Explore any finances the person may have or will require to support them to access a wider variety of housing options – for example, by purchasing a home through [Home Ownership for People with Long-Term Disabilities (HOLD).](https://www.bing.com/ck/a?!&&p=cbf0ac4b17200af8JmltdHM9MTY4OTIwNjQwMCZpZ3VpZD0yMjZmM2Q3ZC05NzJiLTYwOTQtM2FhMi0yZmI4OTZlNDYxMWEmaW5zaWQ9NTE5Mw&ptn=3&hsh=3&fclid=226f3d7d-972b-6094-3aa2-2fb896e4611a&psq=hold+shared+ownership+scheme&u=a1aHR0cHM6Ly93d3cub3dueW91cmhvbWUuZ292LnVrL3NjaGVtZS9ob2xkLw&ntb=1)
* Identify a housing provider (if needed) to support the person’s discharge into their own home. It is important to ensure that all relevant housing, care and support partners are involved as early as possible in planning with the person.
* Consider the housing-related support expectations of the landlord, and whether intensive housing management support will be needed (for example, if it is anticipated that property repairs may be required on an ongoing basis).
* A housing specification should be developed (based on the person’s housing needs assessment, sensory profile and occupational therapy assessment).[[4]](#footnote-5) This should be agreed by all agencies involved in the person’s future housing and support arrangements.
* Identify and agree the (in principle) capital and revenue funding arrangements to support the person in their own home.
* Search for and identify the person’s new home, based on the housing specification. Possible options could include an existing suitable supported living vacancy (if available), an adapted property from the open market, a home purchased by the family or via the HOLD scheme, a home from the social housing register, a modular home or a new build. Innovative solutions should be considered, potentially making creative re-use of public land.[[5]](#footnote-6)
* Ensure a clear separation between the housing tenancy (if relevant) and care arrangements, in accordance with the [Real Tenancy Test](https://www.ndti.org.uk/resources/the-real-tenancy-test1).
* Ensure financial, quality and governance due diligence is undertaken, including by the local authority housing department. Ensure that any registered provider identified to provide the person’s housing has been assessed as compliant by the [Regulator of Social Housing](https://www.bing.com/ck/a?!&&p=f5e34bab5c76d32eJmltdHM9MTY4OTIwNjQwMCZpZ3VpZD0yMjZmM2Q3ZC05NzJiLTYwOTQtM2FhMi0yZmI4OTZlNDYxMWEmaW5zaWQ9NTIwNA&ptn=3&hsh=3&fclid=226f3d7d-972b-6094-3aa2-2fb896e4611a&psq=regulator+for+social+housing&u=a1aHR0cHM6Ly93d3cuZ292LnVrL2dvdmVybm1lbnQvb3JnYW5pc2F0aW9ucy9yZWd1bGF0b3Itb2Ytc29jaWFsLWhvdXNpbmc&ntb=1).[[6]](#footnote-7),[[7]](#footnote-8),[[8]](#footnote-9)
* The person leading the individual’s housing needs assessment and planning process (*job role will vary locally*) should liaise directly with the housing provider, and not rely on the care provider to find the housing solution.

**3. Planning for the future once a new home has been identified:**

* Ensure the housing benefit team in the local authority have agreed proposed rent levels.[[9]](#footnote-10),[[10]](#footnote-11) If, due to the person’s needs, it is anticipated that intensive housing management services will be required, any additional costs should be explored with the housing provider and factored into the housing-related charges to be covered by housing benefit.
* Ensure handover arrangements are agreed, including those to the housing provider, support provider and any other services who will support the person in the community, such as community mental health services. Personalised plans, co-produced with the person and those who know and love them, should underpin these handover arrangements.
* It is good practice to have a partnership agreement with both the landlord and the care provider, covering responsibilities in relation to the property and to mitigate any potential risks and issues.
* Supported by an occupational therapist, ensure that home adaptations are made in accordance with the housing specification (based on the housing needs assessment).
* Establish whether the person has the mental capacity to sign their tenancy. If not, check the person’s status with the courts, such as if a Lasting Power of Attorney (LPA) is in place, and ensure that alternative arrangements are made, with legal advice as needed.[[11]](#footnote-12),[[12]](#footnote-13) Note that LPA and Court of Protection processes can take a significant time to complete, so this should be factored into planning.
* Ensure that the property is of a good standard, and that the housing provider service agreement contains provision for ongoing home maintenance.
* Agree a plan to ensure that any utility bills will be affordable.[[13]](#footnote-14)
* Check whether a voids insurance/voids agreement is in place, to secure the property during periods when the tenancy may be vacant.

**4. Personalised support for the move itself**

* The person (and those who know them well) should be involved in planning their new home’s design and furniture – unless this does not help the person from a wellbeing perspective (but this should be on an exceptional basis).
* Where a care provider has been identified, they, along with the housing provider, should visit the person in hospital well ahead of the planned discharge date, to get to know each other and prepare for the move.
* Personalised support should be provided to prepare people for their future move. For example, for some people, day trips may help people to familiarise themselves with their new home and neighbourhood or say hello to their new neighbours. For others, less involvement may be preferable, to minimise anxiety and support wellbeing.

**Once the person has moved into their new home**

* While some people will feel excited and happy about their move, others may feel anxious or sad to leave a familiar environment – alongside many other possible emotions. Everyone will feel and react differently, and it is important that a person-centred approach is taken to help individuals settle into their new home.
* After the person has moved in, it is likely that not everything will go as planned, or the person may change their mind about some things. Adaptations may be needed to the property or to how the space is used. A flexible approach should enable this.

1. [Considering and meeting the sensory needs of autistic people in housing – Local Government Association](https://www.local.gov.uk/our-support/partners-care-and-health/autistic-and-learning-disabilities/autistic/housing) [↑](#footnote-ref-2)
2. [Supporting autistic people flourishing at home and beyond: considering and meeting the sensory needs of autistic people in housing - NDT](https://www.ndti.org.uk/resources/publication/supporting-autistic-people-flourishing-at-home-and-beyond-considering-and-meeting-the-sensory-needs-of-autistic-people-in-housing) [↑](#footnote-ref-3)
3. [Design and technology - Learning Disabilities - Topics - Resources - Housing LIN](https://www.housinglin.org.uk/Topics/browse/HousingLearningDisabilities/design-and-technology/) [↑](#footnote-ref-4)
4. Consider using the [Safe Home Environment Assessment (SHEA) tool](https://portal.spft.nhs.uk/shea/) [↑](#footnote-ref-5)
5. Maslova S, Holmes H, Burgess G (2021). [Deploying modular housing in the UK: exploring the benefits and risks for the housebuilding industry](https://www.cchpr.landecon.cam.ac.uk/files/media/modular_housing_report_250621_final.pdf). Cambridge Centre for Housing & Planning Research [↑](#footnote-ref-6)
6. [Regulatory judgements and notices, and gradings under review – GOV.UK](https://www.gov.uk/government/publications/regulatory-judgements-and-regulatory-notices?trk=public_post_comment-text) [↑](#footnote-ref-7)
7. [Specialised supported housing: guidance for local government and NHS commissioners – Local Government Association](https://www.local.gov.uk/publications/specialised-supported-housing-guidance-local-government-and-nhs-commissioners) [↑](#footnote-ref-8)
8. [Supported housing: national statement of expectations – GOV.UK](https://www.gov.uk/government/publications/supported-housing-national-statement-of-expectations) [↑](#footnote-ref-9)
9. [Policy statement on rents for social housing – GOV.UK](https://www.gov.uk/government/publications/direction-on-the-rent-standard-from-1-april-2020/policy-statement-on-rents-for-social-housing) [↑](#footnote-ref-10)
10. [Housing Benefit guidance for supported housing claims – GOV.UK](https://www.gov.uk/government/publications/housing-benefit-guidance-for-supported-housing-claims/housing-benefit-guidance-for-supported-housing-claims) [↑](#footnote-ref-11)
11. [Court of Protection forms and guidance – GOV.UK](https://www.gov.uk/government/collections/court-of-protection-forms) [↑](#footnote-ref-12)
12. [Shelter Legal England - Housing for people with mental health needs – Shelter England](https://england.shelter.org.uk/professional_resources/legal/housing_options/housing_options_for_people_with_care_and_support_needs/housing_for_people_with_mental_health_needs) [↑](#footnote-ref-13)
13. [Cost of Living Resources – Learning Disability England](https://www.learningdisabilityengland.org.uk/cost-of-living-resources/) [↑](#footnote-ref-14)