Lewisham Adult Social Care, Housing and Health Joint Working Protocol

For residents with escalating need within the community or being discharged from hospital, with an identified housing need

October 2024

Document History

Next review date: April 2025

Document Location (URL): [insert link/ links]. Check here to ensure you have the most up-to-date version

Version #	Written By	Written On	Comments/Notes	Status
1	PPL	June 2024		Draft V.1
2	PPL	July 2024	Feedback from workshop 3 and stakeholder calls.	Draft V.2
3	PPL	August 2024	Feedback from Steering Group	Draft V.3
4	PPL	August 2024	Feedback from the executive and stakeholder calls	Draft V.4
5	PPL	September 2024	Operational Testing Group feedback	Draft V.5
6	PPL	September	Operational Testing Group and steering group feedback	Draft V.6
7	PPL	September	Operational Testing Group and steering group feedback	Draft V.7
8	PPL	October	Steering group feedback and 1-2-1 engagements	Draft V.8
9	PPL	October	Steering group feedback	Draft V.9

Protocol Signatories

Tom Brown

Executive Director of Adult Social Care & Health

Ceri Jacob

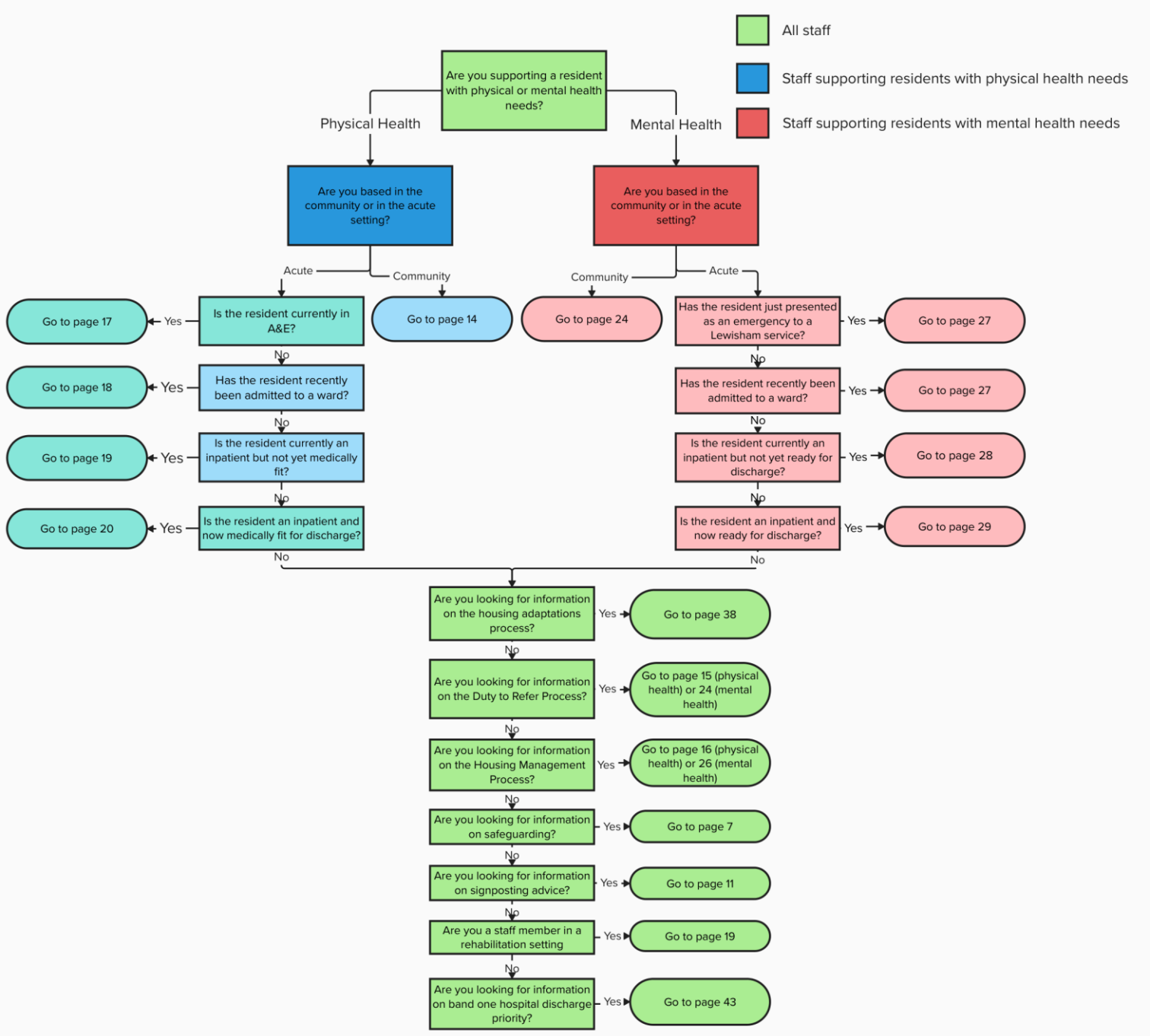
Place Executive Lead

Gillian Douglas

Executive Director of Housing

Contents

Navigation Tool



Introduction

There is an urgent need for a joint working protocol between Adult Social Care (ASC), Health and Housing within Lewisham.

The two population cohorts initially addressed are:

- residents with an identified housing need that are experiencing an escalation of need within the community, that could result in a crisis intervention; and
- residents with an identified housing need during a period of inpatient hospital stay

The scope of this protocol includes both physical and mental health needs. For ease of use, these have been outlined separately. Whilst this protocol has been designed for Lewisham residents within Lewisham ASC, Health and Housing services; it should be applied where possible for Lewisham residents in out-of-borough services as well.

This protocol has been developed in partnership across Lewisham ASC, Health and Housing, facilitated by an external partner PPL. This including the following activities:

- Collation of existing feedback and case studies
- Collation of documentation and data to provide a baseline of activity and performance
- Workshops with system stakeholders to co-develop the protocol and its implementation
- Rapid review and iteration of protocol with stakeholders

The purpose of this protocol is to synthesise and simplify the process for the resident cohorts. Staff from across the Lewisham system should be able to utilise this protocol, alongside supporting materials, to understand who is responsible for what at each step of a resident's pathway and journey.

Principles and definition of success

The principles for success have been clearly defined in the development of this protocol and have been used as key criteria in engagement activities. These will be used to evaluate the implementation of the protocol as it transitions to "business as usual".

The principles are:

- Clear joint processes for access and assessments
- Clear understanding of roles, responsibilities and accountability to support integrated working
- Effective information sharing, communication and no duplication
- Consistency in advice provided and management of resident expectations
- Timely identification and early intervention for residents with housing needs – including pathways into appropriate temporary/ permanent accommodation

Safeguarding

Unsafe discharge can trigger a safeguarding concern linked to:

- neglect or self-neglect
- acts of omission (failure to provide access to appropriate health, care and support)

Multi-agency adult safeguarding has led to increased scrutiny of poor hospital discharge practices highlighted by Safeguarding Adult Reviews (SARs) into the deaths of people at risk of or experiencing homelessness.

Section 42(1) referral

If a patient meets the full criteria for section 42(1) of the Care Act 2014, you should make an adult safeguarding concern referral to both:

- the local authority
- your NHS trust's safeguarding representatives

The patient meets the full criteria for section 42(1) if all the following are true:

- they have needs for care and support
- they are experiencing or are at risk of abuse or neglect
- because of those needs, they are unable to protect themselves against the abuse or neglect or the risk of it

For more guidance, see the Lewisham Adult Safeguarding Pathway.

Legislation and statutory guidance

When using this joint working protocol, it is essential to understand and have due regard to the relevant legislative and statutory frameworks:

- **General advice and information duties (housing and adult social care)**
- **Duty to refer** – public authorities referring admitted patients at risk of or experiencing homelessness to a local housing authority (section 213B, Housing Act 1996)
- **Care Act** - section 9 assessment if the patient appears to have care and support needs, section 11 referral if responsible clinician believes the patient lacks mental capacity to refuse the assessment, or will be at risk of neglect or self-neglect; adult safeguarding concern referral if patient meets full criteria (section 42(1))
- **Emergency accommodation provision** - pending full enquiries e.g. section 188 of the Housing Act 1996, section 19(3) of the Care Act 2014
- **Principles of the Mental Capacity Act 2005 and code of practice** - including a local authority cannot accept a homeless application made by a person who lacks mental capacity
- **Duties to prevent homelessness and provide temporary accommodation** - including priority need and vulnerability test (Hotak v Southwark LBC [2015] UKSC 30). Where a local authority is required to meet a person's accommodation needs under the Housing Act 1996, it must do so. Any care and support required to supplement housing is covered by the Care Act 2014. Provision of accommodation under Care Act 2014 is restricted to cases in which the authority is providing 'accommodation-related' services
- **Local connection** – someone has local connection to an area if they live there or have lived there recently (normal residence), are working there, have close family living in the area, receive care leavers support in the area, or were living there in asylum support housing. Exemptions and special circumstances apply (section 199, Housing Act 1996).
- **Normal residence in homeless applications** - residence for at least 6 months in an area during the previous 12 months, or for 3 years during the previous 5-year period. (chapter 10, Homelessness Code of Guidance, MHCLG, Feb 2018)
- A person's '**ordinary residence'** or 'local connection' is only relevant after the person has been assessed as eligible for accommodation and/or social care support. 'Ordinary residence' does not need to be settled
- **No Recourse to Public Funds (NRPF)** – it is not the responsibility of NHS trust staff to assess whether a person is eligible for such support; this is determined by the housing authority. It is the local authority's responsibility to consider whether duties and powers apply under the Care Act 2014 to provide accommodation for this cohort, as unable to under Housing Act
- **Section 117** - mental health aftercare to meet a need arising from or related to the person's mental disorder
- **Equality Act 2010** - need to ensure that policies and decisions do not amount to unlawful conduct under the Act and also comply with the public sector equality duty
- **Human Rights Act 1998** - when someone is receiving services from (or is on the receiving end of public functions carried out by) a public sector organisation or others who deliver services or carry out public functions on their behalf, they will also have rights under the Human Rights Act 1998

Glossary

Definitions

Duty to Refer - the requirement for certain public services to notify local authority housing departments when they have contact with a person who might be at risk of, or is already experiencing, homelessness. Relevant public authorities in this instance are: Accident and emergency services provided in a hospital, Urgent treatment centres, Hospitals in their capacity of providing in-patient treatment; and social service authorities

Disabled facilities grant – financial support for the cost of essential adaptation work to make a house suitable for a disabled person to live in. This is a means-tested grant and can be applied for if the resident owns their own home, rents privately; or a landlord applying on behalf of a disabled tenant.

Gateway - referral route for Adult Social Care in Lewisham

Housing need - For this protocol, "housing need" is defined as any issue relating to the safety, suitability and security of accommodation. This includes all forms of homelessness, accessibility, conditions and disrepair etc.

Out of borough - It is clear the resident does not have a local connection to Lewisham. In homelessness legislation, an applicant has a local connection to an area if they normally reside there. The Local Authority Agreement is the procedure for referrals of homeless applications to another local authority and defines normal residence as either six months' residence in the area during the past 12 months; or three years residence during the previous five years. Local housing authorities owe more duties towards homeless applicants who have a local connection with their area. It is the responsibility of the local housing authority to determine local connection, and this should be done on a case-by-case basis.

Out of Hours - in the context of this protocol, any time outside of normal business hours, 9am to 5pm, Monday to Friday.

Social Housing - housing provided by either housing associations (organisations that own, let, and manage social and affordable rented housing) or the local council.

Supported Housing - housing that is provided alongside support and/ or care to facilitate a resident living as independently as possible.

Temporary Accommodation - short term, generally high cost, housing for homeless residents with a priority need. This is not the only housing option and should be explored amongst others.

Abbreviations

Abbreviation	Meaning
A&E	Accident and Emergency
ASC	Adult Social Care
CHC	Continuing Healthcare
DTR	Duty To Refer
DC	Discharge
DFG	Disabled Facilities Grant
H&H coordinators	Health and Housing Coordinators
OT	Occupational Therapy
SLaM	South London and Maudsley NHS Foundation Trust
SPOA	Single Point of Access
VCSE	Voluntary, Community or Social Enterprise

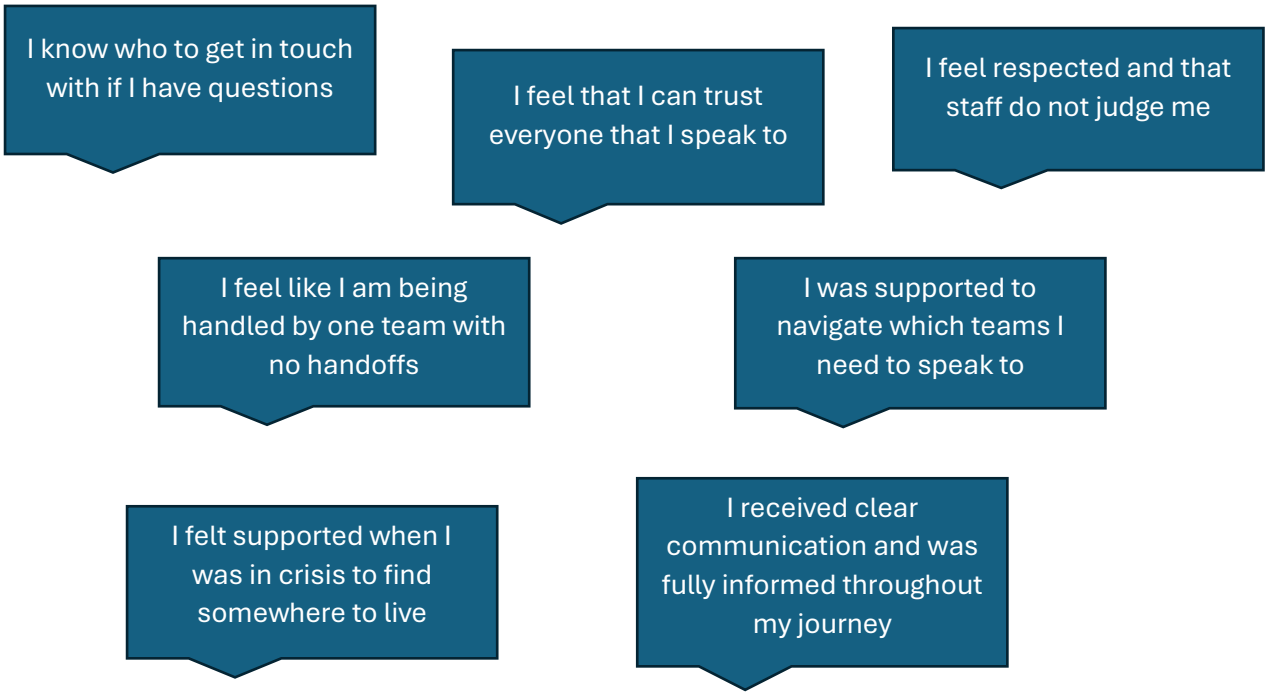
Signposting

The policies and guidance outlined below offer useful information for both staff and residents, aiding in the understanding of the protocol's details. Please use the below as a reference point, and not an exhaustive list.

- **Lewisham Housing Allocations Policy**
- **Lewisham Council Housing Officer Directory**
- **Lewisham Partners and Duty to Refer**
- **Lewisham Duty to Refer Form**
- **Shelter Guidance on Information & Advice Duties**
- **Intensive Housing Advice and Support** – referrals should be sent to IHASS@thamesreach.org.uk
- **StreetLink**
- **Disabled facilities grant**
- **Lewisham Housing Vulnerable Residents Policy –** Available upon request from the supported housing team
- **Homeless Patients Legal Advocacy Service (HPLAS)**
- **Lewisham Housing Safeguarding Vulnerable Adults Policy**
- **Lewisham Adults Safeguarding Pathway**
- **Lewisham Hospital Adult Social Care Team Referral Form –** Available upon request from the Health & Housing Coordinators
- **Pathways Universal Assessment & Referral Form (PUARF) -** Available upon request from the supported housing team
- **Extra Care Housing Panel Protocol and Procedures –** Available upon request from the Lewisham Adult Social Care team
- **Self-Neglect and Hoarding Multi-Agency Guidance and Hoarding Toolkit -** Available upon request from the Lewisham Safeguarding Adults Board (LSAB@lewisham.gov.uk)

Residents Voice

In developing this protocol, HealthWatch reports were reviewed to create 'I' statements that reflect the residents' perspectives. By ensuring that staff are familiar with the protocol and understand the roles of various parts of the system, the goal is for residents to express the following sentiments:



'I' statements developed through reviewing HealthWatch publications around ASC, Housing & Health.

Physical Health Pathway

Escalation to crisis point within the community

This section provides an outline for residents with a known housing need that are within the community and are at risk of, or escalating to, crisis point. It details the steps, responsibilities, and timelines for all teams in identifying and addressing housing and health issues.

Pre-crisis			
Steps in process	**Who?**	**Timeline**	**Outcome**
Professional identifies a **housing need** within the community.	Any health or care professional	Immediately	Preventative housing measures can be put in place as early as possible.
Identify if the resident resides out of borough	Referring professional	Within 24 hours of identifying a need	If out of borough resident, then follow process of relevant borough.
If the housing need is an adaptation related to a change in health, follow the housing adaptations process in the appendix.	Referring professional	Within 24 hours of identifying a need	Know which housing route to follow for resident.
Ask the question "does your housing problem relate to a Lewisham Council tenancy?" If the answer is "yes" then follow route 2 - (page 16).	Referring professional	Within 24 hours of identifying a need	Know which housing route to follow for resident.
Ask the question 'are you homeless, at risk of homelessness, or unable to live safely in your current accommodation?' If the answer is "yes" follow Route 1 – (page 15)	Referring professional	Within 24 hours of identifying a need	Follow correct housing route for resident.
If the resident is either at risk of homelessness or already homeless, signpost resident to contact **housing team** directly via the triage phoneline [0808 178 0939].	Referring professional	Within 24 hours of identifying a need	
Where indicated, carry out a home visit and assessment to establish an appropriate management plan and mitigate acute hospital admission risk.	Responsible community professional	48 hours to 1 month depending on prioritisation	
If not appropriate to be managed in the community, resident is transported and assessed in acute setting.	Responsible community professional	48 hours to 1 month depending on prioritisation	

Independent living concerns

If you are concerned about a resident living independently in the community, contact ASC Gateway in the first instance via email or telephone; providing context and a clear description of need. The time taken to allocate a resident for support is dependent on the triage assessment and perceived level of need based on the information provided.

Route 1 - Duty to Refer Process:

This process should be followed if the resident does not currently have a tenancy with Lewisham Council and is homeless, at risk of homelessness; or unable to live safely in their current accommodation.

Route 1 – No existing tenancy with Lewisham			
Steps in process	**Who?**	**Timeline**	**Outcome**
Confirm which local authority the resident wishes to be referred to	Referring professional	24 hours	To understand which local authority the resident should be supported by. If there is an obvious local connection to another local authority, follow their DTR process.
If there is a clear local connection and/ or they choose Lewisham, submit **Duty to Refer Form** to generic Lewisham inbox DTR@lewisham.gov.uk	Referring professional. Note: All are requested but Accident and emergency services, Urgent treatment centres, Hospitals; and social service authorities have a legal duty		Referral to Housing team at Local Authority.
If resident chooses to be referred to another local authority, identify this early on and submit Duty to Refer form to appropriate local authority housing team	Referring professional		Complete a duty to refer notification to the borough the person is ordinarily resident in, or chooses.
Automated response from Lewisham Duty to Refer generic inbox to acknowledge receipt of referral.	Lewisham Homelessness Prevention and Assessment Team	Immediate	Resident and referrer know that referral has been received.
Named lead from appropriate housing team emails resident, copying in the referring professional to confirm a date for an assessment appointment.	Lewisham Homelessness Prevention and Assessment Team	5 working days from referral	Housing assessment appointment confirmed.
Housing assessment appointment is held.	Lewisham Homelessness Prevention and Assessment Team	Case specific	Information gathered for housing eligibility and options decision to be made.

Outcome letter is sent by email to resident and referrer detailing the outcome of the assessment, any documents outstanding; and any further information required.	Housing Officer	7 days from appointment	Resident and referrer are kept informed of progress and reminded of outstanding information requests.
Follow up email to resident and referrer reminding them of outstanding information.	Housing Officer	7 days from outcome letter (if information not received)	Resident and referrer are kept informed of progress and reminded of outstanding information requests.
If no response received within these 14 days, the case is closed.	Housing Officer	14 days from appointment (if no response)	
Once all documentation has been received and enquiries have been resolved, a decision regarding statutory homelessness duties can be made, including interim housing	Housing Officer	5 working days in the majority of cases 10 working days for complex cases	Enquiries into persons housing situation and processing medical information.
Confirmation of duty accepted and communicated to resident, copying in referring professional.	Lewisham Homelessness Prevention and Assessment Team	56 days statutory homelessness duty commences	Decision made regarding the resident's homelessness application, and advice provided on the next steps available to the resident.

Route 2 - Housing Management Process:

This process should be followed if a housing need has been identified and the resident answers "yes" when asked if they have a tenancy with Lewisham Council.

Route 2 – Existing Lewisham Tenancy			
Email housing management safeguarding generic inbox housingsafeguarding@lewisham.gov.uk with summary of patient details and situation.	Health & Housing coordinators	Within 24 hours of receiving a referral	
Email response outlining next steps and named point of contact for resident and referrer.	Housing Management Team	Within 24 hours of receiving the summary of patient details and situation	Resident and referrer know that the referral has been received, an overview of the next steps and who to contact if needed.
Email to resident and referrer from the named point of contact outlining the plan of action specific to the resident situation.	Housing Management Team	3 working days	Resident and referrer are aware of the next steps specific to resident situation.

Minimum of weekly email from named contact to resident and referrer outlining progress and next steps.	Housing Management Team	Weekly	Resident and referrer are aware of progress and next steps specific to resident situation.

Emergency presentation/ admission avoidance

This section outlines the process for residents who have had an emergency presentation to one of Lewisham's emergency services; and pathways that are available to support inpatient admission avoidance.

Emergency presentation			
Steps in process	**Who?**	**Timeline**	**Outcome**
Resident presents to an acute emergency department. Professional identifies a housing need.	Any health or care professional	Immediately	Preventative housing measures can be put in place as early as possible.
Co-ordinate potential crisis interventions.	A&E	Within 24 hours of identifying a need	Prevents Acute hospital admission
Consider transfer to recovery house if medical condition is stable to avoid full hospital admission	A&E	7-day maximum stay	Prevents Acute hospital admission
If the housing need is an adaptation related to a change in health, follow the housing adaptations process in the appendix.	Referring professional	Within 24 hours of identifying a need	Know which housing route to follow for resident.
If the housing need is not related to an adaptation, referral made to Health & Housing coordinators (details on page 33)	Responsibility of the first health or care professional to identify need.	Within 24 hours of identifying a need	Referral to Health & Housing coordinators within the hospital Complex Discharge Team.
Identify if the resident resides is out of borough	Health & Housing coordinators	Within 24 hours of receiving a referral	If out of borough resident, then follow process of relevant borough.
Ask the question "does your housing problem relate to a Lewisham Council tenancy?"	Health & Housing coordinators	Within 24 hours of receiving a referral	Know which housing route to follow for resident.
If the answer is "no" then follow route 1 (page 15), if the answer is "yes" then follow route 2 (page 16).	Health & Housing coordinators	Within 24 hours of receiving a referral	Follow correct housing route for resident.
Collate information for relevant referral: • Essential patient information (e.g. ID)	Health & Housing coordinators	Within 24 hours of receiving a referral	Correct information collated for referrals.

• Medical reports and health needs			
IF OUT OF HOURS			
If homeless resident, contact Street Link.	A&E Department	Within 24 hours of identifying a need	StreetLink can support with outreach referrals
Housing need identified and referral made to Health & Housing coordinators (details on page 33)	Responsibility of the first health or care professional to identify need.	Within 24 hours of identifying a need	Referral to Health & Housing coordinators within the hospital Complex Discharge Team who will pick up referral in working hours.

Admission to Acute Hospital

This section provides an outline for the admission process within the Lewisham Adult Social Care (ASC), Housing, and Health pathway. It details the steps, responsibilities, and timelines for all teams **in identifying and addressing a housing need for patients as early as possible** after the point of admission.

Admission			
Steps in process	**Who?**	**Timeline**	**Outcome**
Identify housing need **as early as possible**. Ask "golden question" – is there anything worrying you about your discharge?	Any health or care professional	Immediately	Discharge planning can begin as early as possible.
If the housing need is an adaptation related to a change in health, follow the housing adaptations process in the appendix.	Referring professional	Within 24 hours of identifying a need	Know which housing route to follow for resident.
If the housing need is not related to an adaptation, referral made to Health & Housing coordinators (details on page 33).	Responsibility of the first health or care professional to identify need.	Within 24 hours of identifying a need	Referral to Health & Housing coordinators within the hospital Complex Discharge Team.
Identify if the resident resides out of borough	Health & Housing coordinators	Within 24 hours of receiving a referral	If out of borough resident, then follow process of relevant borough.
Ask the question "does your housing problem relate to a Lewisham Council tenancy?" If the answer is "yes" then follow route 2 - (page 16).	Health & Housing coordinators	Within 24 hours of receiving a referral	Know which housing route to follow for resident.
Ask the question 'are you homeless, at risk of homelessness, or unable to live	Health & Housing coordinators	Within 24 hours of receiving a referral	Follow correct housing route for resident.

safely in your current accommodation?' If the answer is "yes" follow Route 1 – (page 15)			
Collate information for relevant referral: • Essential patient information (e.g. ID) • Medical reports and health needs	Health & Housing coordinators	Within 24 hours of receiving a referral	Correct information collated for referrals.

For information related to **Band One Hospital discharge priority**, please see the appendix.

Period of inpatient stay and discharge planning

This section provides an outline of the process during a resident's inpatient stay in an acute setting, with an identified housing need. This process applies to staff working across Lewisham Adult Social Care (ASC), Housing and Health. It details the steps, responsibilities, and timelines for all teams in **planning for discharge before the resident is medically fit for discharge.**

Inpatient stay and discharge planning			
Steps in process	**Who?**	**Timeline**	**Outcome**
Identify housing need **as early as possible**. Ask "golden question" – is there anything worrying you about your discharge?	Any health or care professional	Immediately	Discharge planning can begin as early as possible.
Housing issues flagged at morning board round.	Ward staff	Within 24 hours of identifying a need	Multidisciplinary team aware of housing need to facilitate early discharge planning.
If the housing need is an adaptation related to a change in health, follow the housing adaptations process in the appendix.	Referring professional	Within 24 hours of identifying a need	Know which housing route to follow for resident.
Identify if the resident resides out of borough	Referring professional	Within 24 hours of identifying a need	If out of borough resident, then follow process of relevant borough.
If the housing need is not related to an adaptation, referral made to Health & Housing coordinators (details on page 33).	Responsibility of the first health or care professional to identify need.	Within 24 hours of identifying a need	Referral to Health & Housing coordinators within the hospital Complex Discharge Team.
Ask the question "does your housing problem relate to a Lewisham Council tenancy?" If	Health & Housing coordinators	Within 24 hours of receiving a referral	Know which housing route to follow for resident.

the answer is “yes” then follow route 2 - (page 16).			
Ask the question ‘are you homeless, at risk of homelessness, or unable to live safely in your current accommodation?’ If the answer is “yes” follow Route 1 – (page 15)	Health & Housing coordinators	Within 24 hours of receiving a referral	Follow correct housing route for resident.
Non-housing specific referrals relevant to resident made to facilitate discharge planning, including but not limited to: • Social worker • Southwark Law Centre • Substance misuse team	Health & Housing coordinators in partnership with ward staff	Within 24 – 48 hours of receiving a referral	
Work with housing team to complete forms specific to the resident’s situation. Examples can be found in the signposting section, but these are not exhaustive, speak to the housing officer assigned to the resident’s case if uncertain.	Health & Housing coordinators.	Within 14 working days	Housing team have relevant information to make housing options decision in a timely way.

For information related to **Band One Hospital discharge priority**, please see the appendix.

Multidisciplinary discharge process

This section outlines the possible routes of discharge for residents with an identified housing need **once the resident is medically fit for discharge**. Referrals to housing team should already have been made. If this has not yet happened, then please follow the step-by-step process outlined in the previous section.

Housing Team:

The housing team are responsible for confirming the discharge location, linked to the below discharge outcomes. All housing decisions will be made via the process outlined in the sections above by making a “Duty to Refer” submission to the Lewisham inbox [DTR@lewisham.gov.uk].

Discharge pathway	Description
Friends and Family	It should first be explored if the resident could live with any friends or family.
Sheltered Accommodation	These are advertised via the Lewisham FindYourHome website so applicants can bid. Applicants would either make a social housing application (part 6) to join the housing register, or make a homeless application (part 7).
Intensive Housing Advice and Support Service (IHASS)	If the resident is eligible, a referral can be made to the IHASS team for support. The referral will be completed by the Homelessness Prevention and Assessment Service; or the Accommodation Supply and Resettlement Service (temporary accommodation).

Emergency housing and temporary accommodation	This service is accessed through to Homelessness Prevention and Assessment service, as part of a statutory homelessness application.
General needs social housing (non-Lewisham council tenants)	A resident can access this service in two ways. Either by making a Part 6 application to join the housing register; or via a Part 7 application if the resident is at risk of homelessness or is homeless. A resident can only make one of these applications at a time.
Supported/ Specialist Housing	As part of a homelessness application, it may be determined that the resident requires supported or specialist housing. A referral can be made to the Move On Officer for support with entering the Supported Housing Pathway; via the Duty to Refer route outlined above.
Private Sector Housing	A resident can contact the homelessness team directly to discuss their housing situation, and where there is an issue in the property the Officer will refer the resident to the Private Sector Housing Team; who will investigate and liaise with the landlord.

Adult Social Care:

The below are discharge pathways are commissioned and managed by the Adult Social Care teams in Lewisham.

Discharge pathway	Description
Residential nursing/ care home	Ward MDT would decide on this discharge route and make a referral to Adult Social Care.
Extra Care placement	A Social Worker will complete a Care Act assessment; and the case will be presented to the extra care panel.

Hospital Step-Down:

The below are discharge pathways commissioned and managed by healthcare organisations in Lewisham. These are criteria-led, and a resident would not be admitted without a clear exit plan. They are accessible only on discharge from hospital.

Discharge pathway	Description
Temporary extra Care Placement	Accessed via the flow centre and the respective pathways
Temporary pathway two placement bed	Accessed via the flow centre and the respective pathways
Rehab bed	Accessed via the flow centre and the respective pathways

For information related to **Band One Hospital discharge priority**, please see the appendix.

Escalation route

Step 1 – Local team resolution

Most challenges resolved through negotiation between local teams, and reference to the protocol. Only need to escalate when there is an **unresolved difference of opinion, responsibility, course of action; or lack of response**. No need to escalate cases with delays for example, where these are known and everything is being done.

Step 2 – Ad-hoc professionals meeting

If no resolution, officers and Team Leads to convene ad-hoc professionals meeting to discuss. Agreement on the need for the meeting should be sought from relevant Head of Service in advance. **The aim of these meetings is to develop a clear plan for next steps with actions, owners, and deadlines.** The meeting should be **arranged within 5 working days** and follow-up actions completed within 5 working days.

Step 3 – Joint Working Protocol Steering Group

If no resolution is reached from step 2, case should be **escalated to ASC, Health and Housing senior management** for discussion at the next Joint Working Protocol Steering Group (meet monthly). A **response is expected following this meeting within 5 working days.**

Mental Health Pathway

Pre-crisis in the community

This section provides an outline for residents with a known housing need that are within the community and are at risk of, or escalating to, crisis point. It details the steps, responsibilities, and timelines for all teams in identifying and addressing housing and health issues for residents.

Pre-crisis			
Steps in process	**Who?**	**Timeline**	**Outcome**
Professional identifies a housing need within the community.	Any health or care professional	Immediately	Preventative housing measures can be put in place as early as possible.
Identify if the resident resides out of borough	Referring professional	Within 24 hours of identifying a need	If out of borough resident, then follow process of relevant borough.
Ask the question "does your housing problem relate to a Lewisham Council tenancy?" If the answer is "yes" then follow route 2 - (page 26).	Referring professional	Within 24 hours of identifying a need	Know which housing route to follow for resident.
Ask the question 'are you homeless, at risk of homelessness, or unable to live safely in your current accommodation?' If the answer is "yes" follow Route 1 – (page 25)	Referring professional	Within 24 hours of identifying a need	Follow correct housing route for resident.
Support the resident to contact housing team directly via the triage phoneline [0808 178 0939].	Referring professional	Within 24 hours of identifying a need	
Home visit and assessment is conducted to establish an appropriate management plan and mitigate acute hospital admission risk.	Responsible community professional	48 hours to 1 month depending on prioritisation	
If not appropriate to be managed in the community, resident is transported and assessed in acute setting.	Responsible community professional	48 hours to 1 month depending on prioritisation	

Route 1 - Duty to Refer Process:

This process should be followed if the resident does not currently have a tenancy with Lewisham Council and is homeless, at risk of homelessness; or unable to live safely in their current accommodation.

Route 1 – No existing tenancy with Lewisham			
Steps in process	**Who?**	**Timeline**	**Outcome**
Confirm which local authority the resident wishes to be referred to	Referring professional	Within 24 hours of identifying a need	To understand which local authority the resident should be supported by. If there is an obvious local connection to another local authority, follow their DTR process.
If there is a clear local connection and/ or they choose Lewisham, submit **Duty to Refer Form** to generic Lewisham inbox DTR@lewisham.gov.uk	Referring professional. Note: All are requested but Accident and emergency services, Urgent treatment centres, Hospitals; and social service authorities have a legal duty		Referral to Housing team at Local Authority.
If resident chooses to be referred to another local authority, identify this early on and submit Duty to Refer form to appropriate local authority housing team	Referring professional		Complete a duty to refer notification to the borough the person is ordinarily resident in, or chooses.
Automated response from Lewisham Duty to Refer generic inbox to acknowledge receipt of referral.	Lewisham Homelessness Prevention and Assessment Team	Immediate	Resident and referrer know that referral has been received.
Named lead from appropriate housing team emails resident, copying in the referring professional (and LewishamRightCare@slam.nhs.uk) to confirm a date for an assessment appointment.	Lewisham Homelessness Prevention and Assessment Team	5 working days from referral	Housing assessment appointment confirmed.
Housing assessment appointment is held.	Lewisham Homelessness Prevention and Assessment Team	Case specific	Information gathered for housing eligibility and options decision to be made.
Outcome letter is sent by email to resident and referrer detailing the outcome of the assessment, any documents outstanding; and any further information required.	Housing Officer	7 days from appointment	Resident and referrer are kept informed of progress and reminded of outstanding information requests.

Follow up email to resident and referrer reminding them of outstanding information.	Housing Officer	7 days from outcome letter (if information not received)	Resident and referrer are kept informed of progress and reminded of outstanding information requests.
If no response received within these 14 days, the case is closed.	Housing Officer	14 days from appointment (if no response)	
Once all documentation has been received and enquiries have been resolved, a decision regarding interim accommodation duty can be made.	Housing Officer	5 working days in the majority of cases 10 working days for complex cases 56 days statutory homelessness duty commences	Enquiries into person's housing situation and processing medical information.
Confirmation of duty accepted and communicated to resident, copying in referring professional.	Lewisham Homelessness Prevention and Assessment Team		Decision made regarding the resident's homelessness application, and advice provided on the next steps available to the resident.

Route 2 - Housing Management Process:

This process should be followed if a housing need has been identified and the resident answers "yes" when asked if they have a tenancy with Lewisham Council.

Route 2 – Existing Lewisham Tenancy			
Email housing management generic inbox housingsafeguarding@lewisham.gov.uk with summary of patient details and situation.	Referring professional e.g. SLaM	Within 24 hours of receiving a referral	Housing management aware of tenant's health situation.
Email response outlining next steps and named point of contact for resident and referrer.	Housing Management Team	Within 24 hours of receiving the summary of patient details and situation	Resident and referrer know that the referral has been received, an overview of the next steps and who to contact if needed.
Email to resident and referrer from (and LewishamRightCare@slam.nhs.uk) the named point of contact outlining the plan of action specific to the resident situation.	Housing Management Team	3 working days	Resident and referrer are aware of the next steps specific to resident situation.
Minimum of weekly email from named contact to resident and referrer outlining progress and next steps.	Housing Management Team	Weekly	Resident and referrer are aware of progress and next steps specific to resident situation.

Emergency presentation/ admission avoidance

This section outlines the process for residents who have had an emergency presentation to one of the Lewisham emergency services, and pathways that are available to support inpatient admission avoidance.

Emergency presentation			
Steps in process	**Who?**	**Timeline**	**Outcome**
Resident presents to an acute emergency department. Professional identifies a housing need.	Any health or care professional	Immediately	Preventative housing measures can be put in place as early as possible.
Mental health need is identified, and referral is made to SLaM	A&E	Within 24 hours of identifying a need	SLaM take over responsibility for care coordination.
Co-ordinate potential crisis interventions.	A&E	Within 24 hours of identifying a need	Prevents Acute hospital admission
Consider transfer to recovery house if medical condition is stable to avoid full hospital admission	A&E Psychiatric Liaison	7-day maximum stay	Prevents Acute hospital admission
Identify if the resident resides out of borough	Referring professional	Within 24 hours of identifying a need	If out of borough resident, then follow process of relevant borough.
Ask the question "does your housing problem relate to a Lewisham Council tenancy?" If the answer is "yes" then follow route 2 - (page 26).	A&E Psychiatric Liaison	Within 24 hours of identifying a need	Know which housing route to follow for resident.
Ask the question 'are you homeless, at risk of homelessness, or unable to live safely in your current accommodation?' If the answer is "yes" follow Route 1 – (page 25)	A&E Psychiatric Liaison	Within 24 hours of identifying a need	Follow correct housing route for resident.
Collate information for relevant referral: • Essential patient information (e.g. ID) • Medical reports and health needs	A&E Psychiatric Liaison	Within 24 hours of identifying a need	Correct information collated for referrals.

Admission to Acute Mental Health Hospital

This section provides an outline for the admission process within the Lewisham Adult Social Care (ASC), Housing, and Health pathway. It details the steps, responsibilities and timelines for all teams **in identifying and addressing a housing need for patients as early as possible** after the point of admission.

Admission			
Steps in process	**Who?**	**Timeline**	**Outcome**
Identify housing need **as early as possible**. Ask "golden question" – is there anything worrying you about your discharge?	Any health or care professional	Immediately	Discharge planning can begin as early as possible.
Housing need identified and SLaM housing practitioner informed.	Responsibility of the first health or care professional to identify need.	Within 24 hours of identifying a need	Begin Duty to Refer process.
Identify if the resident resides out of borough	Referring professional	Within 24 hours of identifying a need	If out of borough resident, then follow process of relevant borough.
Ask the question "does your housing problem relate to a Lewisham Council tenancy?" If the answer is "yes" then follow route 2 - (page 26).	Lewisham Right Care Team	Within 24 hours of identifying a need	Know which housing route to follow for resident.
Ask the question 'are you homeless, at risk of homelessness, or unable to live safely in your current accommodation?' If the answer is "yes" follow Route 1 – (page 25)	Lewisham Right Care Team	Within 24 hours of identifying a need	Follow correct housing route for resident.
Screening tool is completed for all admissions.	Lewisham Right Care Team	Within 24 hours of identifying a need	Identify housing need if not identified already. Begin collating information for Duty to Refer form.
Collate information for Duty to Refer form: • Essential patient information (e.g. ID) • Medical reports and health needs • Information from friends and family	Lewisham Right Care Team	Within 24 hours of identifying a need	Correct information collated for Duty to Refer form.

For information related to **Band One Hospital discharge priority**, please see the appendix.

Period of inpatient stay and discharge planning

This section provides an outline of the process during a resident's inpatient stay in a mental health setting, for those with an identified housing need. This process applies to staff working across Lewisham Adult Social Care (ASC), Housing and Health. It details the steps, responsibilities and timelines for all teams in **planning for discharge before the resident is clinically ready for discharge.**

Inpatient stay and discharge planning			
Steps in process	**Who?**	**Timeline**	**Outcome**
Identify housing need **as early as possible**. Ask "golden question" – is there anything worrying you about your discharge?	Lewisham Right Care Team	Immediate	Discharge planning can start as early as possible
Housing issues flagged at board round.	Lewisham Right Care Team	Within 24 hours of identifying a need	Multidisciplinary team aware of housing need to facilitate early discharge planning.
Identify if the resident resides out of borough	Referring professional	Within 24 hours of identifying a need	If out of borough resident, then follow process of relevant borough.
Ask the question "does your housing problem relate to a Lewisham Council tenancy?" If the answer is "yes" then follow route 2 - (page 26).	Lewisham Right Care Team	Within 24 hours of identifying a need	Know which housing route to follow for resident.
Ask the question 'are you homeless, at risk of homelessness, or unable to live safely in your current accommodation?' If the answer is "yes" follow Route 1 – (page 25)	Lewisham Right Care Team	Within 24 hours of identifying a need	Follow correct housing route for resident.
Visit accommodation ahead of being clinically ready for discharge	Lewisham Right Care Team	Within 56 days	Identifies any additional discharge concerns.
Specialist teams specific to needs of resident invited to ward round to facilitate discharge planning	Lewisham Right Care Team	Within 56 days	Facilitate speedy discharge once clinically ready.

For information related to **Band One Hospital discharge priority**, please see the appendix.

Multidisciplinary discharge process

This section outlines the routes for multidisciplinary discharge of residents with an identified housing need **once the residents are clinically ready for discharge**.

Housing Team:

The housing team are responsible for confirming the discharge location of the below discharge outcomes. All housing decisions will be made via the process outlined in the sections above: a Duty to Refer submission to the Lewisham inbox [DTR@lewisham.gov.uk].

Discharge pathway	Description
Friends and Family	It should first be explored if the resident could live with any friends or family.
Sheltered Accommodation	These are advertised via the Lewisham FindYourHome website so applicants can bid. Applicants would either make a social housing application (part 6) to join the housing register, or make a homeless application (part 7).
Intensive Housing Advice and Support Service (IHASS)	If the resident is eligible, a referral can be made to the IHASS team for support. The referral will be completed by the Homelessness Prevention and Assessment Service; or the Accommodation Supply and Resettlement Service (temporary accommodation).
Emergency housing and temporary accommodation	This service is accessed through to Homelessness Prevention and Assessment service, as part of a statutory homelessness application.
General needs social housing (non-Lewisham council tenants)	A resident can access this service in two ways. Either by making a Part 6 application to join the housing register; or via a Part 7 application if the resident is at risk of homelessness or is homeless. A resident can only make one of these applications at a time.
Supported/ Specialist Housing	As part of a homelessness application, it may be determined that the resident requires supported or specialist housing. A referral can be made to the Move On Officer for support with entering the Supported Housing Pathway; via the Duty to Refer route outlined above.
Private Sector Housing	A resident can contact the homelessness team directly to discuss their housing situation, and where there is an issue in the property the Officer will refer the resident to the Private Sector Housing Team; who will investigate and liaise with the landlord.

Adult Social Care:

The below are discharge pathways commissioned and managed by the Adult Social Care teams in Lewisham.

Discharge pathway	Description
Residential nursing/ care home	Ward MDT would decide on this discharge route and make a referral to Adult Social Care.
Extra Care placement	A Social Worker with complete a Care Act assessment and the case goes before an extra care panel.

Acute Mental Health Step-Down:

Discharge pathway	Description

Orchards (short term)	SLaM-funded and SLaM-wide supported unit for individuals stepping down from hospital with temporary barriers preventing them from returning home or waiting availability of longer-term accommodation.
Castlebar block beds (short term)	Four LBL ASC-funded block respite beds for Lewisham residents in crisis in the community and at risk of admission, or stepping down from hospital with temporary barriers preventing them from returning home or waiting availability of longer-term accommodation.

Escalation route

Step 1 – Local team resolution

Most challenges resolved through negotiation between local teams, and reference to the protocol. Only need to escalate when there is an **unresolved difference of opinion, responsibility, course of action; or lack of response**. No need to escalate cases with delays for example, where these are known and everything is being done.

Step 2 – Ad-hoc professionals meeting

If no resolution, officers and Team Leads to convene ad-hoc professionals meeting to discuss. Agreement on the need for the meeting should be sought from relevant Head of Service in advance. **The aim of these meetings is to develop a clear plan for next steps with actions, owners, and deadlines.** The meeting should be **arranged within 5 working days** and follow-up actions completed within 5 working days.

Step 3 – Joint Working Protocol Steering Group

If no resolution is reached from step 2, case should be **escalated to ASC, Health and Housing senior management** for discussion at the next Joint Working Protocol Steering Group (meet monthly). A **response is expected following this meeting within 5 working days.**

Review and monitoring

The implementation and delivery of this protocol is the responsibility of the Joint Working Protocol steering group. This protocol should be formally reviewed bi-annually and updated (at least) every twelve months to ensure accuracy of information; and to include relevant pathway developments.

Information sharing

To enact the joint working protocol, an information sharing agreement should be agreed across the Lewisham Adult Social Care, Housing and Health teams.

In the meantime, consent can be gained from the resident to share their information with appropriate agencies to facilitate their health and care needs. A consent form that is consistent across all agencies can be found in the appendix for this purpose.

Appendix

ASC, Health & Housing Teams

Team	Description	Contact Details
	ASC	
Hospital Complex Social Work Team	• Social work team covering Lewisham patients in hospital.	• HASCFlowCentre@lewisham.gov.uk • 0203 192 6218 (Business support team 9 -5 Mon to Fri) • 07827 662990 (A & E patients physically in the department, number is covered 8am to 8pm)
D2A Team	• Discharges from hospitals where there is a new or increased social care need (Pathway 1 discharges) • Team of Social Workers, OTs, Physios and nurses who undertake D2A initial Assessment via a home visit within first week of discharge, to establish the ongoing pathway	• HASCFlowCentre@lewisham.gov.uk • Interim Lead Operational Manager (Full-time) 07876 038 274 Francisco.Menendez@lewisham.gov.uk • Interim Lead Operational Manager (Part-Time) 07793906918 Fern.Sutcliffe@lewisham.gov.uk
Enablement Care Team	• Councils in-house care and support team that looks at re-ablement and rehabilitating clients alongside the Discharge to Assess team for those returning home following acute admission • Referral to the Enablement Care Team via the Gateway or Hospital teams • Make the decision on whether the resident meets the criteria to instigate a request for interim package of care, and subsequent assessment under the Care Act based on presentation of and eligibility needs	07502 756706
Brymore Rehab	• Lewisham Residential Rehab unit based at Brymore House in Grove Park with 14 beds • Multidisciplinary team of Physio, OT, nursing and SW	0208 314 7323

	• Patients stay for **up to** six weeks, with an average stay of 4 weeks subject to progress achieving their goals • Referrals can only be made by therapy or medical staff for step-up from the community • Must have agreed clear and safe discharge destination available	
ASC Gateway	• Single point of access for all client referrals requiring consideration under the Care Act, Enablement, or carers assessment and Safeguarding	• gateway@lewisham.gov.uk • 0208 314 7777
Joint ASC, Housing & Health		
Health and Housing Discharge Team	• Support patients based at Lewisham Hospital who are either homeless or have any housing related issues that may prevent / delay their discharge	• Joe.Anyinsah@Lewisham.gov.uk 07407892207 • Ellie.Andrews@Lewisham.gov.uk 07876 816158
Neighbourhood coordinators (ASC & Health)	•	•
Housing		
Homelessness Teams		
Housing Advice and Early Intervention Team **Homelessness Prevention and Assessment Team**	• Provide housing advice related to possible homelessness or when presenting as homeless, as well as housing options available • Undertake homeless prevention work to keep clients in their accommodation • Review possible unlawful evictions to assist clients to remain in their homes • Complete homelessness assessments and provide decisions on what duty is owed by the Council • Investigate basic landlord and tenant law related cases • Assess affordability	• 0808 178 0939 • Housingoptionsenquiry@lewisham.gov.uk

	• Assess and make decisions on cases related to Domestic Abuse • Create personal housing plans and review regularly until homelessness has been relieved, or accommodation is secured • Complete Housing Needs Assessments and Suitability Assessments • Complete homelessness investigations, issue outcome decisions and Intentionally Homeless Decisions • Work with the Temporary Accommodation Teams to secure emergency accommodation and temporary accommodation	
Accommodation		
Assessment, Allocations and Lettings Team (AALT)	• Book emergency and temporary accommodation • Shortlist clients for suitable emergency and temporary accommodation • Complete suitability assessments • Discharge duty where applicants refuse offer of accommodation	• TA.AssessmentsandLettings@lewisham.gov.uk 0808 178 0939
Tenancy Management and Resettlement Team (TMRT)	• Undertake housing management of clients in both emergency and temporary accommodations (dealing with repairs, ASB and any housing related issues) • Complete suitability assessments • Action change of circumstances • Assist with housing register bidding issues • Discharge duty where applicants refuse offer of accommodation • Undertake eviction and Notice to Quit actions	• TA.MgmtandResettlement@lewisham.gov.uk • 0808 178 0939
Temporary Accommodation Housing Team (TAHT)		• TempHousing@lewisham.gov.uk • 0808 178 0939

	• Work with the housing providers to resolve repair issues	
Private sector housing enforcement	• Licensing and enforcing standards in private properties • Responding to complaints from private tenants about management standards and property conditions in their home	• pshe@lewisham.gov.uk
Housing repairs	• For existing Council tenants This service is also available out of hours for emergency repairs	• 0800 028 2028.
Housing Management	• Provides support to existing Council Tenants	Housingmanagment@lewisham.gov.uk or housingsafeguarding@lewisham.gov.uk for urgent welfare or safeguarding concerns
Housing register, assessment and allocations	• Housing Register: Part 6 assessment for access to Lewisham FindYourHome (LFYH) • Permanent Allocations: Advertising and allocating properties on LFYH • Medical Assessment Service: Carrying out medical assessments for Part 6 & Part 7 applicants • Initiatives: Providing support for applicants on the HR and alternative housing solutions • Independent Move On Referral (IMOR): Facilitates moves for single applicants ready to leave supported housing	• LewishamFindYourHomeApplications@lewisham.gov.uk • Initiatives@lewisham.gov.uk • Initiatives@lewisham.gov.uk • housingmedicaladvisor@lewisham.gov.uk
Housing Improvements Team	• Offer a range of grants, loans, and assistance to help residents to carry out essential repairs and adapt their homes to their changing needs • Primarily assist disabled residents with adaptations allowing them to continue	• grantsandloans@lewisham.gov.uk • 020 8314 6622

	thriving in their own homes through the Disabled Facilities Grant (DFG), under the Housing Grants, Construction and Regeneration Act 1996.	
Health		
Flow Centre (ToCH)	• Discharge Coordinators supporting the planning of complex discharges out of Lewisham Hospital for any adult patients from any borough	• lg.flowcentre@nhs.net • 0208 333 3000 ext 8181
NHS @ Home	• Supports patients to remain in their own environment by combining technology, clinician reviews and monitoring • Service for patients on an early support discharge from hospital or an admission avoidance pathway.	• All clinicians are asked to contact 0203 929 4999, 08.00 – 18.00, Monday to Sunday to refer a patient onto NHS @home service. Virtual Wards | One Health Lewisham
District Nursing	• Providing district nursing to housebound patients across the Borough.	• 020 8314 7777 option 2 • LH.adultreferrals@nhs.net • Single point of access opening hours: Monday to Friday 8am to 5pm
Health Equity Fellow	•	•
PCNs	•	•

Housing Adaptations Process

Process 1 – Community Housing Minor Adaptations Process

This process should be followed if a housing need required is a minor adaptation (less than £1,000 worth of work) because of changes in health.

Route 1 – Community Housing Adaptations Process - Minor			
Steps in process	**Who?**	**Timeline**	**Outcome**
If the resident is a housing association tenant or with Lewisham Housing, contact should be made directly with them to see if they are able to carry out the adaptation themselves.	Any health or care professional	24 hours	Refer request to appropriate Housing Provider
If owner occupied or privately rented, or the housing association will not carry out the work, refer to gateway	Referring professional to complete minor requests referral form	24 hours	Referrals received by ASC Gateway to begin the adaptations process
Patient is triaged and referred to OT	ASC Gateway Triage	24 hours	Referral made to community OT
Review Care Act eligibility and authorise adaptation	ASC OT	5 days	Adaptation is authorised
Duty OT completes the referral form out and sends to the minor adaptations team	ASC OT	Within the 5 days	Referral is made
Raise an order and send out to builder	Minor adaptations Team	2 days	Builder is aware of adaptations
Adaptations carried out	Contracted builder	Up to 10 days	Adaptations are completed

Process 2 – Community Housing Major Adaptations Process

This process should be followed if a housing need required is a major adaptation (more than £1,000 worth of work) because of changes in health. There are three different routes that a resident may take depending on who manages the property.

Disabled Facilities Grant process should be followed for:

- Owner occupiers
- Tenants of registered social landlords who do not fund their own adaptations
- Private renters

Disabled Facilities Grant			
Steps in process	**Who?**	**Timeline**	**Outcome**

Identify concerns regarding difficulties a client is experiencing in their own home.	Any health or care professional	24 hours	Refer to ASC Gateway
Refer the client or resident contacts ASC gateway	Any health or care professional	24 hours	Referrals received by ASC Gateway to begin the adaptations process
Patient is triaged and referred to OT	ASC Gateway Triage	24 hours	Referral made to community OT
Referral is triaged and prioritised on the waiting list	ASC OT	5 days	Resident is added to the waiting list
Home assessment carried out	ASC OT	8 months	Required adaptations identified
The case is taken to the OT adaptations panel for agreement. If not agreed, an alternative recommendation will be made.	ASC OT	3 weeks	Adaptations approved or declined.
Referral made to Lewisham Housing Improvement Team	ASC OT	5 days	Referral with adaptation request made to Lewisham Housing Improvement Team
A letter is sent to the resident to inform them of the progress	ASC OT	5 days	The resident is kept informed.
Referral reviewed and home assessment arranged	Lewisham Housing Improvement Team Coordinator	5 working days	Home assessment appointment with the surveyor is arranged
Surveyor carried out a visit and identified work required	Lewisham Housing Improvement Team Surveyor	2 weeks	Adaptation work can be costed
DFG coordinator approves plans	DFG coordinator	5 days	Adaptation work agreed
Tender documents are prepared and sent to contractors	Lewisham Housing Improvement Team Coordinator	3 weeks	The cost of the work can be determined.
Application form & contract sent to the resident If needed, an appointment is offered within a week if the resident needs support completing the form.	Lewisham Housing Improvement Team Coordinator	1 week	The resident can be assessed for adaptations support through Lewisham Council.
Application form assessed	Lewisham Housing Improvement Team Coordinator	1 week	The resident can be assessed for adaptations support through Lewisham Council.
If the assessed application is valid, sent to the Grants and Loans manager for approval	Lewisham Housing Improvement Team Coordinator	1 week	Funding can be obtained.
If the application is invalid, close the case and inform the resident	Lewisham Housing Improvement Team Coordinator	48 hours	The resident can be informed of the rejected application and advised to

			start alternative arrangement planning.
Once Grants and Loans approval is gained, pre-start meeting is arranged with contractor and client for agreement on adaptation work start	Lewisham Housing Improvement Team Coordinator	Within 1 month	Adaptation work commences and the resident is kept abreast with progress.

Throughout the DFG process, the ASC DFG coordinator updates the resident and ensures progress is being made.

If the resident is a **Lewisham Council** tenant:

Lewisham Council Tenants			
Steps in process	**Who?**	**Timeline**	**Outcome**
Identify concerns regarding difficulties a client is experiencing in their own home.	Any health or care professional	24 hours	Refer to ASC Gateway
Refer the client or resident contacts ASC gateway	Any health or care professional	24 hours	Referrals received by ASC Gateway to begin the adaptations process
Patient is triaged and referred to OT	ASC Gateway Triage	24 hours	Referral made to community OT
Referral is triaged and prioritised on the waiting list	ASC OT	5 days	Resident is added to the waiting list
Home assessment carried out	ASC OT	8 months	Required adaptations identified
The case is taken to the OT adaptations panel for agreement. If not agreed, an alternative recommendation will be made.	ASC OT	3 weeks	Adaptations approved or declined.
Recommendations sent to the major adaptations team	ASC OT	5 days	Major adaptations team are aware of work that is required.
A letter is sent to the resident to inform them of the progress	ASC OT	5 days	The resident is kept informed.
If surveyor input is needed, recommendations will be drawn up by the surveyor	ASC Surveyor	4 weeks	Detailed plans can be drawn up
Drawings are reviewed and approved	ASC OT	1 week	Planned work is appropriate
Works are sent out for tender	ASC Surveyor	3 weeks	Builders can agree to works
Recommends a builder that the work be completed by	Senior Adaptations Officer	1 week	A building firm is identified
Approval of the works and building company gained	ASC OT lead operational manager	1 day	Building works are confirmed

Order is raised on the system	Senior adaptations officer	1 day	Building works are tracked
Works are sent to the builder to complete the works	Senior adaptations officer	4-6 weeks	The building company can begin the works.
Once the works are completed, review of works completed and signs off case	Senior adaptations officer	5 days	Confirmation that the work has been carried out to a satisfactory standard.

Throughout the process, the senior adaptations officer has ongoing conversations with the builder to monitor progress.

If the resident is a **Phoenix or L&Q Tenant:**

Phoenix or L&Q Tenants			
Steps in process	**Who?**	**Timeline**	**Outcome**
Identify concerns regarding difficulties a client is experiencing in their own home.	Any health or care professional	24 hours	Refer to ASC Gateway
Refer the client or resident contacts ASC gateway	Any health or care professional	24 hours	Referrals received by ASC Gateway to begin the adaptations process
Patient is triaged and referred to OT	ASC Gateway Triage	24 hours	Referral made to community OT
Referral is triaged and prioritised on the waiting list	ASC OT	5 days	Resident is added to the waiting list
Home assessment carried out	ASC OT	8 months	Required adaptations identified
The case is taken to the OT adaptations panel for agreement. If not agreed, an alternative recommendation will be made.	ASC OT	3 weeks	Adaptations approved or declined.
Recommendations sent to the adaptations team of the housing association	ASC OT	5 days	Housing adaptation team within the housing association are aware of the adaptations required
Write to the resident to inform them that the recommendations have been sent to the housing association	ASC OT	5 days	The resident is informed

Process 3 – Acute Major Housing Adaptations Process

This process should be followed if the housing need is an adaptation required because of changes in health. This process should not delay discharge, and the resident should be discharged in a micro-environment until the adaptation work is completed. If this is not possible, then other discharge arrangements need to be considered.

Acute Housing Adaptations Process			
Steps in process	**Who?**	**Timeline**	**Outcome**
A housing need is identified that may require an adaptation	Any health or care professional	24 hours	Housing need identified
D2A referral completed	Referring professional	24 hours	D2A referral sent to initiate adaptation process.
If the request is an adaptation only, with no therapy goals, the referral is sent to ASC OT (follow adaptations process one or two)	D2A Triage Coordinator	24 hours	Refer to ASC OT. Follow process one or two from point of ASC OT involvement, depending on the type of adaptation and the tenancy
If the request is an adaptation with other therapy goals, referral triaged and sent to D2A OT	D2A Triage Coordinator	24 hours	Whether this needs to go via D2A OT
Home assessment carried out	D2A OT	72 hours	Required adaptations identified
If a major adaptation is required, the referral is sent to ASC OT (follow adaptations process two)	D2A OT	24 hours	Refer to ASC OT. Follow process 2 from point of ASC OT involvement, depending on the tenancy
If a minor adaptation is required, make a referral to the minor adaptations team (follow process one from the point of minor adaptations team involvement)	D2A OT	24 hours	Minor adaptations referral sent

Band One Hospital Discharge Priority

Residents currently admitted to an NHS hospital who are unable to be discharged due to the lack of suitable accommodation, and require a specially adapted home due to a medical condition; will be granted Emergency Medical Priority upon the recommendation of the Council's Medical Advisors.

Additionally, residents deemed vulnerable and unsuitable for general temporary accommodation may also be assigned Band One status by the Housing Panel.

Applicants must be referred to the Council by a relevant agency, and the Housing Panel must be satisfied that the applicant or a member of their household has an urgent need for rehousing i.e. if they are not rehoused:

- their life will be in serious danger,
- they will suffer from a severe physical or mental illness,
- the welfare of any child within the household will be seriously prejudiced, or
- public safety will be severely endangered

Band One Hospital Discharge Priority			
Steps in process	**Who?**	**Timeline**	**Outcome**
Confirm which local authority the resident has local connection with	Housing & Health Coordinators	24 hours	To understand which local authority the resident should be supported by. If there is a local connection to another local authority, follow their DTR process.
If there is a local connection to Lewisham, submit **Duty to Refer Form** to generic Lewisham inbox DTR@lewisham.gov.uk.	Housing & Health Coordinators	24 hours	Referral to Housing team at Local Authority.
Automated response from Lewisham Duty to Refer generic inbox to acknowledge receipt of referral.	Lewisham Homelessness Prevention and Assessment Team	Immediate	Resident and referrer know that referral has been received.
Assessment takes place to ascertain if the resident meets band one priority criteria	Lewisham Homelessness Prevention and Assessment Team	5 working days	Referrals sent to the housing panel for approval
Housing panel approve band one priority	Housing panel (senior housing team)	Panel held on ad-hoc basis when required	Band one priority is approved
If all documentation has been provided, the resident is awarded a direct offer	Housing Register Assessment & Allocations Service	3 working days (this will be delayed if the referrer has not provided all	Application is on the system

		necessary documentation)	
Property is sourced	Housing Register Assessment & Allocations Service	12 weeks (this will vary depending on the property requirement)	Resident can leave hospital