

Appendix 2 – Case Studies

Two case studies are provided below, the first is from the Community Navigator service, and the second is from one of the embedded housing worker's based in health.

Case Study 1

Summary

- Working couple with joint income of circa £60,000, living in private rented sector (PRS) accommodation with 2 dependent children (one with ASD)
- The father had an undiagnosed chronic condition that affected his mobility.
- The family had previously applied to the general register (GR) for an adapted home but were declined based on income
- The father was hospitalised following a decline in the chronic condition and was subsequently advised that it was unlikely that he would be able to work, resulting in a large loss of income (father on SSP)
- The father was subsequently discharged from the JR and inappropriately placed in a respite dementia home without a care package in place
- A complaint was made about the placement. Social services accepted the error and the father was permitted to return home. This resulted in him being in a bed in the living room with no access to washing facilities and no on-going care
- In addition there was no confirmed diagnosis of the conditions and the hospital had stated that this must come either from ward staff or the patient's GP

Actions taken / Timeline

- The community navigator (CN) worked with the family to re-apply to go on the GR and request an OT assessment of existing home
- The LHA requested that diagnosis & change in income be confirmed and other relevant information be provided
- CN supported the family to obtain full discharge summary and a documented diagnosis of condition by connecting them with Adult Social Care at the JR
- Advised the family to demand a social care assessment so that a care package could be put in place at existing residence
- CN supported the mother to approach Citizens Advice in respect of financial/benefits situation
- The CN advocated on behalf of the family with the assessment officer at the LHA. This involved exploring the possibility of securing PRS accommodation (with modifications) that was proactively identified by the mother

Key Outcomes

- The couple have been accepted on to the LHAs GR, albeit there is a lack of appropriate stock so a long wait may be incurred
- The mother contacted adult social services and an OT community assessment was completed on their existing property. This was forwarded to the LHA with recommended adaptations
- The couple have attended Citizens Advice sessions and approached JCP to open a Universal Credit Claim. This was approved but there have been significant issues with the payments since
- The family identified 2 PRS properties (in absence of anything suitable on the GR) and with the support of the CN approached the LHA to utilise their bond scheme. One was deemed inappropriate but the second has been secured with a bond
- The CN worked with the LHA to ensure that a swift OT assessment of the new property was completed

- Minor works are required on the property and the OT is liaising directly with the LHA to streamline the process. The OT has ordered all of the required aids and equipment
- The LHA is currently considering the family's eligibility for a disabled facilities grant to fund the works. This should be approved
- The family remain on the GR and will be offered suitable accommodation when it becomes available

Learning & Reflections

- Lots of people involved but not everyone connected, CN often the focal point for all parties at the beginning
- Better connections have now been built between OTs and housing team at LHA
- Why was the individual discharged a) to a dementia home, b) without a home assessment completed?
- Significant delays between hospital discharge and OT assessment. Only through active self-advocacy/CN/Floating Support/MP involvement was this facilitated
- UC errors have had detrimental impact on the ability of the couple to pay their rent. This has resulted in the couple feeling defeated by the system
- Often little feedback provided to the family about on-going processes. They expressed a feeling of being lost in the system
- The case highlighted the lack of understanding about the support available to people requiring adaptations or money for a deposit (Bond)

Case Study 2

Case Summary

- A patient with learning disabilities living in accommodation that he jointly owned with his brother. Recently admitted to hospital but that was medically fit for discharge
- The patient's brother and his sister in law refused to allow the patient to return home
- The patient remained in hospital as a delayed discharge with no provisional discharge date

Actions taken

- Embedded worker advised hospital staff of the relevant legislation regarding homelessness, in that the housing authority would be unable to accept a housing duty as the patient was not homeless in law
- Embedded worker advised the patient had a legal right to occupy the property he co-owned
- Embedded worker advised the patient should be discharged with support and advice to ensure the patient's fair treatment by his family

Key Outcomes

- The patient was discharged to his home successfully reducing delayed discharge
- The hospital bed was made available at a time of peak demand
- The patient will be receiving support to ensure his rights are protected
- An ineffective homeless application/presentation was avoided

Additional Achievements

- Training needs/ information resources identified for discharge staff
- The brother and sister in law's own support needs were identified