



# Safe and effective discharge of homeless hospital patients

January 2019

## Introduction

The specific needs and rights of homeless individuals and the range of services available to them are important fundamentals in providing informed, effective and compassionate care.

Homeless people tend to live chaotic lives and have difficulty accessing primary care and other support. Because of this, they often present at hospital with complex health and social problems. They experience some of the worst health outcomes and tend to be amongst the highest users of urgent and emergency care, with four times the usage of hospital services and eight times the cost of inpatient services as compared to the general population<sup>1</sup>. Following a hospital stay, they are often discharged to inappropriate, insecure places or back into homelessness.

This leads to unsafe, inequitable experiences, worsening health problems, increased use of emergency departments and repeated hospital readmission. This 'revolving door' scenario illustrates the missed opportunity to capture and build on the benefits of a hospital stay, to address underlying problems and to support the wider reduction of homelessness.

It is crucial to work in partnership across health, social care, housing and the voluntary sector in order to best support homeless patients and ensure, once medically fit, they are safely discharged to an appropriate setting where they can be supported back into healthy, independent and economically active life.

As highlighted in section 2.32 of the [NHS Long Term Plan](#), some hospitals such as University College London Hospitals have set up a specialist team, [Pathway](#), to support homeless hospital patients and to coordinate their discharge arrangements.<sup>2</sup>

## Meeting the Duty to Refer

The [Homelessness Reduction Act 2017](#) places a duty on hospital trusts, emergency departments and urgent treatment centres to refer people who are homeless, or at risk of becoming homeless within 56 days, to their local authority. This came into effect in October 2018 and requires as a minimum that the individual's contact

<sup>1</sup> [http://webarchive.nationalarchives.gov.uk/20130123201505/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_114250](http://webarchive.nationalarchives.gov.uk/20130123201505/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250)

<sup>2</sup> <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf>

details are passed to an agreed local housing authority, subject to the individual's consent. Referrals should be made for all patients at risk of or experiencing homelessness, even where the individual may have no recourse to public funds or may not be eligible or in priority need for housing assistance. In such cases, local authorities have a role in providing information and advice about homelessness prevention and alternative support options.

The Department of Health and Social Care and Pathway have produced guidance and resources to support trusts in meeting this duty, including a [template](#), [contact details for every local authority](#) and a [checklist](#):

<https://www.gov.uk/government/publications/homelessness-duty-to-refer-for-nhs-staff>  
<https://www.pathway.org.uk/homelessness-reduction-act/>

Wherever possible, this should involve joint working with the local authority and agreed protocols, rather than a passive referral. Identification of a patient's housing status and referral to the local authority should happen as early as possible on admission.

## Making effective links with local homelessness services

Strong links with the local authority (housing, social care and public health) local hostels, day centres and other homelessness services are essential. Involving these organisations in making safe and effective discharge arrangements and ensuring these are reflected across all organisations (for example in the local authority homelessness strategy) will help secure an ongoing coordinated approach.

Homeless Link, The Pavement Magazine and the London Housing Federation maintain directories of local homelessness services, which may be helpful in making contact with local services:

<https://www.homeless.org.uk/search-homelessness-services>  
<https://www.thepavement.org.uk/services>  
<https://lhf.org.uk/atlas/>

The [Combined Homelessness and Information Network](#) (CHAIN) database is another useful source of information. It provides comprehensive information about people sleeping rough and the wider street population in London. Some hospitals currently access this system, for example to establish a 'lead worker' who can support discharge planning. If your discharge coordinator (or similar role) does not currently have viewer access to the CHAIN database you can request this by email to: [chain@mungos.org](mailto:chain@mungos.org)

## Avoiding early self-discharge

Homeless patients sometimes self-discharge from hospital despite significant and urgent health needs. This can be related to more pressing priorities such as anxiety

about losing temporary accommodation, unmanaged mental health problems or drug and alcohol dependence.

On admission, enquiries should be made to understand any such vulnerability and to put a plan in place (such as a methadone prescription or agreement with the provider to keep a hostel bed available). Alongside this, establishing any links to local homeless services or a key-worker can help with support during a hospital stay and to coordinate discharge arrangements. The inclusion of a peer advocate or care navigator with lived experience of homelessness has also been shown to be effective in supporting patients to engage with services, leading to better outcomes<sup>3</sup>.

## Safeguarding and assessing mental capacity

There are situations where somebody sleeping rough refuses to accept help to reduce significant risk to them, for example by accessing medical attention or being removed from immediate danger. If there are any safeguarding concerns, a referral to the local safeguarding lead should be considered. Where an adult who is sleeping rough on the street is at risk, assessing and determining the individual's capacity to make decisions to live on the street must be carried out in accordance with the requirements of the [Mental Capacity Act \(2005\)](#). Published guidance on mental health service interventions for people who sleep rough, with practical screening and assessment tools, are available at:

<http://www.pathway.org.uk/services/mental-health-guidance-advice>

## No recourse to public funds

This is a particular challenge in London, where for example around 46% of people seen sleeping rough are non-UK nationals<sup>4</sup> and may therefore have no recourse to public funds. The legal and regulatory framework in this area is complex and local authorities will need to carefully consider an individual's rights in these circumstances. Expert advice may be needed to avoid unsafe discharge in these circumstances and can be accessed through the No Recourse to Public Funds Network:

<http://www.nrpfnetwork.org.uk/Pages/Home.aspx>

The Mayor of London is supporting a project at Guy's and St Thomas' Hospital, Royal London and University College Hospital, working with non-European Economic Area homeless migrants to identify pathways out of destitution. This project will provide support to migrants who have no recourse to public funds and who enter the health system having required emergency care, and become stuck in the system due to their inability to access publicly funded housing or support

<sup>3</sup> <http://groundswell.org.uk/what-we-do/health/homeless-health-peer-advocacy/hhpa-saving-lives-saving-money/>

<sup>4</sup> <https://data.london.gov.uk/dataset/chain-reports>

services. Findings will be disseminated once available to help address this issue in London.

## Managing delays in the transfer of care

The multiple, complex needs of some homeless people along with their unsettled status means that securing appropriate housing and support services can take time. NHS England's [delayed transfer of care guidance](#) states that 'medical optimisation is the point at which care and assessment could be continued at home or in a non-acute setting or the patient is ready to go home'.

Where a patient is 'medically optimised', establishing whether care and assessment can be safely continued in a non-acute setting is critical to safe and effective discharge:

- Where the individual has insecure accommodation such as a hostel, this will require liaison with the provider to establish whether ongoing care needs can safely be provided before discharge. The variability in hostel services means that this cannot be assumed.
- Where the individual is sleeping rough, the local authority may be able to access any available background from the rough sleeping database and advise on what support may be available.

Where the safe provision of ongoing needs cannot be met, utilising intermediate care or increasing intermediate care capacity should be considered ahead of an onward move to an appropriate setting. This may help avoid lengthy delays in the transfer of care from the hospital and allow sufficient time for ongoing assessments and for clinical staff to add medical weight to housing applications.

## Arrangements on discharge

Being discharged can be an anxious and difficult experience for homeless people. To manage this, they should be involved in decisions about their discharge which should be confirmed as far in advance as possible (both with the individual and their onward destination) with sufficient plans in place.

Communication and coordination are essential to avoid this leading to the individual being inadvertently discharged back into homelessness. For example, when housing providers are not notified of the discharge, transportation is not in place or there is a timing mismatch between leaving hospital and being able to access other services.

## Checklist for staff

A simple checklist for hospital staff on the practical steps they can currently take to support effective discharge of homeless patients is provided below, which can be adapted and aligned to local admission and discharge arrangements.

<p>Has this person been identified as homeless on admission or within 24 hours? <i>This should be done by asking ‘do you have somewhere safe to stay when you leave hospital?’</i></p>	<input type="checkbox"/>
<p>If they answer ‘no’ seek consent to make a referral to the local housing authority. This is a legal duty on the hospital and guidance can be found here: <a href="https://www.gov.uk/government/publications/homelessness-duty-to-refer-for-nhs-staff">https://www.gov.uk/government/publications/homelessness-duty-to-refer-for-nhs-staff</a></p> <p>If consent is given, the individual’s contact details and the reason for the referral (that they are homeless or threatened with homelessness) should be shared with the local housing authority. Details for every local authority can be found here : <a href="https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762487/Local_Authority_Duty_to_Refer_emails_06122018.pdf">https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762487/Local_Authority_Duty_to_Refer_emails_06122018.pdf</a></p>	<input type="checkbox"/>
<p>If consent to refer to the local authority is not given, discuss and identify the support they need to maintain their stay in hospital and to avoid early self-discharge. <i>For example, are they concerned about losing accommodation as a result of being in hospital or do they have a drug or alcohol need to be met?</i></p>	<input type="checkbox"/>
<p>Are there any safeguarding concerns, for example lacking mental capacity? If so, consider a referral to your local safeguarding lead. Assessing mental capacity is vital in the context of homelessness and requires clear, detailed documentation. Guidance can be found here: <a href="https://www.pathway.org.uk/services/mental-health-guidance-advice/">https://www.pathway.org.uk/services/mental-health-guidance-advice/</a></p>	<input type="checkbox"/>
<p>Have you explored relevant partners to involve in coordinating safe and effective discharge arrangements? In discussion with the patient, identify any case workers or other people who may have been involved with them and can support them and help with discharge coordination. Involve the patient and where relevant their ongoing discharge destination and support staff in making decisions about their discharge arrangements.</p>	<input type="checkbox"/>

<p>For people sleeping rough – have links been made with the local outreach team? Have you checked the <a href="#">CHAIN database</a> to contact a lead worker?</p> <p>This will help to understand the background and support offers that may be available in making discharge arrangements.</p>	<input type="checkbox"/>
<p>Have you assessed whether ongoing care, support and assessment can be carried out safely at the discharge destination?</p>	<input type="checkbox"/>
<p>Have you notified both the patient and, where relevant, their ongoing destination in advance of the planned discharge, so that the necessary arrangements can be put in place?</p> <p>Discharge arrangements such as timing, transportation and support should be agreed with the individual and the ongoing destination.</p>	<input type="checkbox"/>
<p>The local champion / link person / team for homeless patients to contact for support are <b>[to be completed locally]</b></p>	<input type="checkbox"/>
<p>Local homelessness services and partners to consider involving in discharge coordination are <b>[to be completed locally]</b></p>	<input type="checkbox"/>