



# Homelessness and Health Information Sheet

## Number 4 Hospital Discharge

### Homelessness and Health

Homeless people can face major barriers in accessing health services, while their life circumstances can often mean that they are among those most in need of treatment. Homeless people may often leave health problems untreated until they reach crisis point and then need to rely on treatment at Accident and Emergency (A&E) or will present at other primary health services with multiple and entrenched problems. This combines to make health problems more expensive to treat, hospital and A&E waiting lists longer and can lead to people being less able to support themselves and their families in their accommodation.

It is essential that local authorities and health services work together to provide accessible and appropriate services if health inequalities and homelessness are to be tackled. The Office of the Deputy Prime Minister and the Department of Health have issued guidance for all those involved in delivering health services to homeless and vulnerable people on developing shared positive outcomes. The guidance was published alongside a policy brief – *Addressing the Health Needs of Homeless People*. Both documents are available on the ODPM website at [www.homelessness.odpm.gov.uk](http://www.homelessness.odpm.gov.uk)

### Hospital Discharge and Homelessness

Homeless people can often have more severe medical problems than the population in general. Situations can arise where homeless people are hospitalised for treatment, then discharged into unsuitable accommodation or back into homelessness. This can be simply because of a lack of knowledge regarding the issues faced by homeless people, resulting in them being discharged by hospital staff with no contact being made with the relevant service providers. It is crucial that hospital staff take into account patients' accommodation circumstances to ensure that they are not discharged into unsuitable accommodation or homelessness or that they become homeless as a result of their stay in hospital.

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It is essential that there are strong links between the hospital, the local authority homeless persons unit, social services, the local supporting people team, the primary care trust and the voluntary sector. In recognition of this, in 2003 the Department of Health issued a publication aimed at assisting health and social care commissioners, managers and practitioners working in the statutory and independent sectors to improve local discharge policy and practice. The publication – Discharge from Hospital: Pathway, Process and Practice – can be viewed on the Department of Health website at [www.dh.gov.uk](http://www.dh.gov.uk). Further to this, Homeless Link will shortly be producing guidance on hospital discharge for homeless people, which will be available on their website at [www.homeless.org.uk](http://www.homeless.org.uk).

Hospitals should have in place formal admission and discharge policies, thereby ensuring that homeless people are identified on admission and relevant health and homelessness agencies notified when discharge is imminent. Good practice can be achieved when there is a clear understanding between hospitals and service providers on how appropriate and timely referral and joint working between agencies can be established.

#### **Homeless Patients Co-ordinators at University College London Hospitals**

Camden PCT employs two full-time Homeless Patients Co-ordinators (HPCs) as part of the Primary Care for Homeless People team. They provide a dedicated specialist service to effectively discharge homeless patients admitted to UCLH, recognising legal obligations to provide a safe discharge, linking patients into community services and attempting to minimise delayed discharges. The service aims to prevent unnecessary readmissions, and uses the opportunity afforded by a hospital admission to offer patients the chance to make changes to their lives.

On admission, patients recognised as having no fixed abode or being at risk of losing their accommodation are identified to the HPCs by ward staff, via a simple telephone referral system. The HPCs try to see patients on the wards as soon as possible after admission to assess their needs, including housing, substance misuse problems, access to health care services in the community, means of financial support, as well as mental and physical health issues. The HPCs will then continue to visit patients regularly during their admission, attempting to build up a relationship and to provide a consistent point of contact for the patient. There is a high incidence of self-discharging amongst the homeless population, but regular input from the HPCs can reduce this likelihood, as concerns or problems can be addressed as they arise.

The HPCs work in conjunction with hospital staff, the patient and relevant outside agencies to formulate an appropriate discharge plan. The aim is to offer the patient suitable accommodation and a range of referrals following their discharge from hospital. With particularly vulnerable patients the HPCs may, with the medical team's approval, delay discharge in order to make time to find suitable accommodation or to set up support networks. In the long-term, this can help to prevent readmissions as a patient's situation is less likely to reach crisis point if the discharge has been thoughtfully planned.

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## Cambridge City Council Housing Services – Information Sharing Protocol to Prevent Homelessness

Cambridge City Council, South Cambridgeshire District Council & the NHS Trust have identified a need to collect information which will assist those discharged from psychiatric wards to settle in the community. The target is to share information across housing, health and social care boundaries and promote joint working at the earliest possible opportunity, so that advice and support can be provided. The protocol aims to provide a framework for the secure and confidential sharing of information and joint working between organisations, to enable them to meet the needs of people who have come into contact with mental health services.

On admission to hospital or as soon as appropriate, ward staff assess a patient's accommodation needs. If it appears that there will be a housing need on discharge and/or the patient is not likely to be able to return to their former accommodation, ward staff will complete a referral form and fax it to housing advice staff. Where a patient is living in private rented accommodation prior to admission, a referral should be made as a matter of course so that Housing Advice Teams at Cambridge City Council and South Cambridgeshire District Council can assess the risk of an illegal eviction whilst the patient is in hospital. If the ward staff are unsure whether or not to refer, they can with the patient's consent contact housing advice staff and discuss the individuals' circumstances in order to clarify. When appropriate, a primary nurse will allocate the patient a social worker or care coordinator.

The referral form is handed to the principal housing officer on receipt and a housing officer allocated to the patient. The housing officer will then liaise directly with the patient and ward staff initially by telephone, but where required may visit the patient in hospital. Where relevant, the housing officer will make every effort to prevent homelessness and provide the appropriate advice and assistance to the patient. If, however, homelessness is unavoidable, the housing officer will need to make a decision on whether or not temporary accommodation should be provided in line with the Housing Act 1996 Part VII and provide advice as necessary. All housing officers must inform the principal housing officer of applicants who present as homeless after leaving hospital.

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## **Bristol City Council Neighbourhood and Housing Services – Hospital Discharge Homelessness Prevention Worker (HDHPW)**

This post is currently delivered by Avon and West Wiltshire Mental Health Partnership, but will soon be transferred to Bristol PCT where it will be incorporated into a new primary medical service for homeless people.

The HDHPW works in close partnership with Bristol City Council housing options and advice services staff, health care professionals, hospital social work teams and Bristol's homelessness services, to ensure the accurate assessment of housing, care and support needs of homeless people who are currently in hospital. The service is aimed at people who have a history of rough sleeping and/or are likely to be homeless and in priority need when leaving hospital. The HDHPW also works jointly with outreach teams, night centre staff and other initiatives and agencies who deal directly with rough sleepers in order to facilitate discharge to suitable accommodation and drug treatment if appropriate.

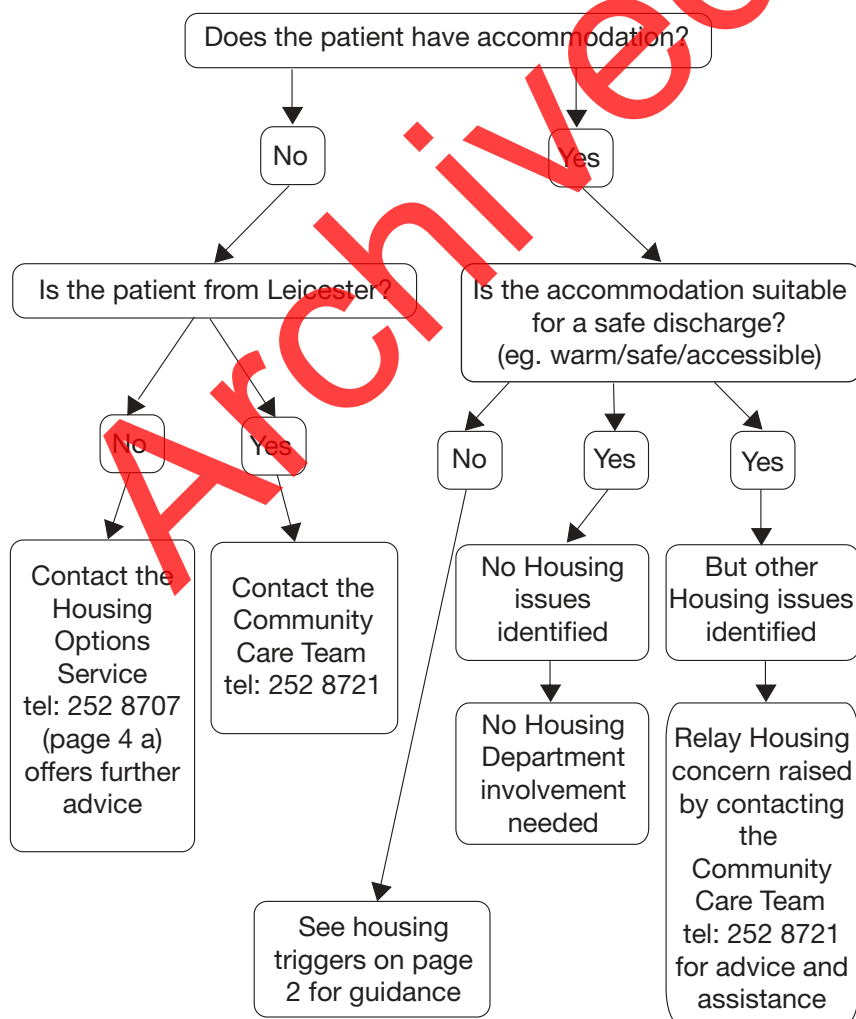
The HDHPW also aims to

- promote the service as widely as possible amongst hospital staff to encourage suitable referrals which are made on admission or as soon as appropriate.
- assist in ongoing development of the Hospital Discharge Protocol, to facilitate effective working procedures between all agencies involved in the housing, care and support of homeless people being discharged from hospital.
- provide specialist advice on the suitability of housing and support services available to individual patients.
- collate information on the number of homeless, or potentially homeless, people in Bristol's hospitals and on their needs, to inform strategic development.
- develop links and protocols with neighbouring local housing authorities in order to facilitate the referral of patients for whom those authorities appear to have a housing duty.
- facilitate training to increase awareness and understanding of current and future policy and procedures.

**Leicester City Council Housing, Social Care & Health and Leicester Homeless Primary Health Care Service**

Leicester have had a protocol in place to promote partnership working between social care, health, and Leicester City Council Housing Services since 2000. Both housing and social services in Leicester have recognised the importance of developing clear guidelines on hospital discharge, which not only assists hospital ward staff and the social work team to contribute to a process of planned discharge into suitable accommodation, but enables effective planning across housing services and lessens any potential anxiety for the patient on leaving the ward. This ensures that the Housing Community Care Team can take a holistic approach to patient assessments, offering housing advice and assistance and housing options prior to discharge.

The procedure which is followed for patients in housing need is demonstrated by the flow chart below.



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## List of Contacts

### Homeless Patients Co-ordinators at University College London Hospitals

Contact: Paul Daly, Primary Care for Homeless People Team Manager, Camden PCT  
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### Cambridge City Council Housing Services – Information Sharing Protocol to Prevent Homelessness

Contact: David Greening, Single Homeless and Rough Sleepers Coordinator,  
Cambridge City Council  
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### Bristol City Council Neighbourhood and Housing Services – Hospital Discharge Homelessness Prevention Worker (HDHPW)

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### Leicester City Council Housing, Social Care & Health and Leicester Homeless Primary Health Care Service

Contact: June Green, Housing Community Care Services Manager, Leicester City Council  
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