North West London Homelessness Hospital Discharge Protocol

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Context

- North West London ICS : 7 West London boroughs (Kensington & Chelsea, Hammersmith & Fulham, Ealing, Brent, Harrow, Hounslow & Hillingdon) with a history of sub-regional working, including several joint projects to prevent & tackle rough sleeping, plus Westminster
- High levels of homelessness and rough sleeping (Westminster has the highest no of rough sleepers in the country)
- Big differences between inner & outer Boroughs, with highest levels of homelessness in Ealing & Brent
- 8 acute hospitals , serving people across borough boundaries

Background

- Increased collaboration between health & homelessness during pandemic: Everyone In : health assessments in hotels, GP registrations, vaccination programme
- Successful OOHCM bid
- Includes 2 hospital-based specialist homelessness health care teams(inclusion health or Pathway); one started on Monday (inner NWL: Imperial Group); 2nd in Brent/Ealing (Northwick Pqrk/Ealing Hospitals)

Objectives

- To avoid discharge from hospital to the street
- To avoid delays in discharge due to lack of suitable housing

Protocol development

- Started from a homelessness perspective – what homelessness services will do; what we want from hospitals, inclusion heath teams, integrated discharge teams, A&E, adult social care, rough sleeping outreach teams
- Homelessness managers have agreed it, working with health & ASC to further develop and get sign off

Hospitals (generally)

- Identify patients who are/will be homeless or at risk of homelessness when discharged at earliest stage
- Refer to inclusion health team, where it exists, or to borough, under Duty to Refer

Inclusion health team (hospital –based specialist homeless health care team) or hospital-based link worker

- Case manage homeless patients; discharge planning (to meet health, care & housing needs)
- Establish where patient has local connection & ordinary residence & if they have recourse to public funds, if possible
- If vulnerable with care needs, refer to ASC of borough of ordinary residence for Care Act assessment where appropriate
- Make duty to refer referral to local connection borough or LA they have greatest connection; LA of choice if none
- Liaise with LA homeless team to ensure discharge into suitable accommodation when ready, including stepdown where needed
- Secure continuity of care & support in community prior to discharge

Integrated discharge teams

- Triage referrals from ward teams relating to homeless patients to Inclusion Health teams
- Support Inclusion Health teams to navigate systems, process and relationships within hospital

A&E Depts (this is what we'd like)

- Identify rough sleepers & refer to Street Link (or outreach where possible)
- Identify those who may be homeless or at risk of homelessness or rough sleeping & make Duty to Refer referral
- If they have nowhere to go support them to call the LA homelessness or out of hours service for urgent assistance
- Refer to ASC for Care Act assessment where appropriate

Borough homelessness teams

- Respond to Duty to Refer referrals within 3 days or earlier if marked urgent as discharge is imminent
- Rapid assessment as to whether a homeless application is needed & if there's a duty to accommodate
- If threshold met, take application & take urgent action to prevent homelessness
- Complete assessment, determine whether prevention or relief duty owed, agree PHP, seek to prevent homelessness before discharge
- If not possible to prevent homelessness before discharge & if no reason to believe in priority need, but reason to believe eligible, will seek to provide interim accommodate & help secure longer term accommodation
- If homeless & vulnerable with care needs but not eligible, refer to ASC for Care Act assessment where appropriate
- Secure emergency accommodation for those with NRPF where possible
- Seek to relieve homelessness by helping to secure accommodation e.g. private rented, supported housing, return to family/friends
- If no local connection & can establish local connection elsewhere, may refer

Borough outreach teams

- Check on CHAIN to see if known rough sleeper
- Respond immediately to Street Link referrals
- Provide emergency accommodation & carry out full assessment
- Refer to borough of local connection for homeless assessment
- Seek appropriate move-on accommodation & support

Adult Social Care (what we want)

- Respond to referrals from A&E immediately or within 2 hours, if expected that patient won't be admitted & is likely to sleep rough
- Respond to referrals of inpatients within 72 hours
- Carry out assessment where appropriate including where patient is expected to sleep rough or return to unsafe accommodation, including those with NRPF
- Secure accommodation &/or care where required
- If accommodation &/or care is needed to prevent an unsafe discharge & ordinary residence has not been established, ASC for borough where hospital is will provide initially