

Safe and effective discharge of homeless hospital patients

January 2019

# 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.

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| Has this person been identified as homeless on admission or within 24 hours?  *This should be done by asking ‘do you have somewhere safe to stay when you leave hospital?’* |  |
| 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: <https://www.gov.uk/government/publications/homelessness-duty-to-refer-for-nhs-staff>  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 :  <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762487/Local_Authority_Duty_to_Refer_emails_06122018.pdf> |  |
| 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.  *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?* |  |
| 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:  <https://www.pathway.org.uk/services/mental-health-guidance-advice/> |  |
| 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. |  |
| For people sleeping rough – have links been made with the local outreach team? Have you checked the [CHAIN database](https://www.mungos.org/work-with-us/chain/) to contact a lead worker?  This will help to understand the background and support offers that may be available in making discharge arrangements. |  |
| Have you assessed whether ongoing care, support and assessment can be carried out safely at the discharge destination? |  |
| 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?  Discharge arrangements such as timing, transportation and support should be agreed with the individual and the ongoing destination. |  |
| The local champion / link person / team for homeless patients to contact for support are **[to be completed locally]** |  |
| Local homelessness services and partners to consider involving in discharge coordination are **[to be completed locally]** |  |