



Bristol Hospital Admission and Discharge

Homelessness Prevention Protocol

Contents

Topic	Page(s)
Summary - Why do we need this Protocol for Bristol?	3
Who's Signed-up to the Protocol	4
Government Departments	4-5
The Principles of the Protocol	5
The Protocol's Main Messages	5
Sharing Information and Confidentiality	5-7
People with Mental Health Needs	7
Patients Aged Under 18	7
Asylum Seekers and Refugees	7-8
Eligibility for Welfare Services	8-9
Rough Sleepers	9
People Discharging Themselves	9
People with Drug and/or Alcohol Problems	9
Other Actions to Prevent Homelessness	10
Monitoring and Reviewing the Protocol	10
Preventing Homelessness - Key Actions	11
Hospital Homelessness Prevention Action List - General Wards	12-13
Hospital Homelessness Prevention Action List - Accident and Emergency	14-15
Hospital Homelessness Prevention Action List - Patients with Mental Ill Health	16-17
Contact Details	18
Poster for Hospital Wards	19

Summary – Why Do We Need This Protocol for Bristol?

1. This protocol applies to hospital patients who normally and usually reside in the city of Bristol, who are patients of hospitals in Bristol and neighbouring local authority areas e.g. South Gloucestershire
2. A significant but small group of have no safe or secure home to return to on discharge from hospital, or have their hospital stay extended, because they:
 - Were homeless before hospital admission with nowhere to stay and may have been sleeping rough.
 - Were in an institution such as prison.
 - Had a temporary arrangement – a hostel or staying with friends or family – and either cannot go back, or there is no bed reserved for them on their return.
 - Have just arrived in Bristol and have nowhere to stay here.
 - Had accommodation before admission but cannot go back.
 - Have accommodation but it needs adaptation following their treatment in hospital.
3. The government expects local authorities to prevent homelessness whenever possible, but it is also in the interests of patients – saving stress and anxiety – and of hospital and housing staff, to try to resolve the patient's housing needs well before discharge. It is not comfortable for either hospital or housing staff to know that a patient may leave a hospital with no appropriate accommodation to go to.
4. Without this Protocol, health and social care workers will spend much time trying to identify solutions for patients. However, hospital staff are not always familiar with housing organisations and how they work or with the best way to resolve a housing problem.
5. It is also difficult and time-consuming for housing staff to find an available and appropriate solution at very short notice, without access to necessary information.
6. Any delay in discharging a patient is costly to the health and social care system in the city, can put back the care of another patient who needs a bed, and can exhaust staff and build up bad feeling between organisations. This Protocol aims to remove those constraints and pressures wherever possible, with clear procedures, providing information on who does what, and by establishing clear roles and routes of communication.
7. Health, social care, housing, homelessness and support workers are not expected to memorise this protocol! The actions they can take are set out on simple single page flowcharts later on in this document
8. Please ensure that all relevant hospital wards have electronic and paper copies of this protocol and, especially, the flowcharts.

Who's Signed-Up to the Protocol

9. This Protocol has been developed by key agencies in Bristol that work with homeless people who may be admitted to hospital and those who may be discharged to homelessness without positive and professional interventions.

10. The Protocol has been signed-up to by:

- Bristol City Council Housing Options & Advice Service
- The Homeless Health Service for Bristol and South Gloucestershire (commissioned by Bristol Primary Care Trust)
- Avon and Wiltshire Mental Health Partnership Trust
- United Bristol Healthcare Trust
- North Bristol Healthcare Trust

Government Departments

11. The Department of Health issued guidance in 2003 which was explicit about the role of hospital trusts in ensuring that homelessness is prevented for patients leaving hospital:

“It is vital all hospitals consider the housing situation of patients to ensure that people are not discharged to inappropriate places, homeless or become homeless as a result of their stay in hospital.”

“All acute hospitals should have formal admission and discharge policies which will ensure that homeless people are identified on admission and their pending discharge notified to relevant primary care services and to homeless services providers. In addition, for patients in psychiatric hospitals/units a post-discharge care plan will be drawn up well in advance of discharge and procedures put in place to ensure that appropriate accommodation and continuity of care is in place for each person discharged.”

12. The prevention of homelessness is the main element of the government's approach to homelessness.

13. To help local authorities and their partners in developing protocols aiming to prevent homelessness for people leaving hospital, guidance has been issued on behalf of Communities and Local Government department and the Department of Health with Homeless Link. recommending steps for developing a protocol for hospital discharge. The protocol will be fit for purpose if it:

- establishes a patient's housing status on admission
- includes procedures for obtaining patients' consent to share information
- includes procedures for ensuring that existing accommodation is not lost

- identifies key external agencies to notify about a homeless person's admission
- develops the resources and training needed
- involves voluntary sector agencies, primary care providers and local authorities throughout the discharge process

The Principles of the Protocol

14. The organisations signed-up to this protocol will work under the principle that every effort should be made to ensure that patients aren't discharged from hospital before appropriate housing options are identified:

- People leaving hospital in Bristol, after at least 3 nights' stay, will have their needs assessed in time to make appropriate referrals in advance of a discharge date
- No agency will rely on a hospital bed being available in place of suitable housing
- People leaving hospital in Bristol will have the best available and appropriate accommodation to meet their housing and support needs
- Bristol City Council Neighbourhood and Housing Services, and the agencies signed-up to this Protocol, will make every effort to prevent patients becoming homeless during their hospital stay
- Staff working in hospitals in Bristol will be provided with sufficient information and training to be able to make appropriate and timely referrals to housing and support agencies
- Staff working in all relevant agencies will know whom to contact to help to resolve any problems that arise in the process
- Agencies will work together effectively to jointly resolve housing problems, usually without a homeless application having to be made.

This Protocol's Main Messages

15. The Protocol sets out a number of steps to take, to:

- Avoid whenever possible a patient being homeless on discharge from hospital, including the process to be followed on admission
- Seek help from other agencies in finding accommodation and arranging support
- Provide information for display in hospital wards, for patients and staff.

Sharing Information and Confidentiality

16. An important feature of good working arrangements between agencies is that information is shared so that the person's problem can be resolved as quickly as possible. However, before any contact is made with housing and related

professionals by hospital staff, patient consent must be obtained.

17. Information should always be shared with the twin aims of helping the service user to obtain the most appropriate services to meet their needs, whilst preserving their dignity and privacy.

18. Information can best be shared by:

- All agencies ensuring that the patient has filled in a consent form - making sure that the service user has given written consent to information about them being shared in order to help them secure the right services to meet their needs.
- Sharing information in a positive way - that informs people about the needs of the service user and supports good decision-making, rather than trying to 'sell' their case.
- Ensuring that any information about known risks is shared – including to other service users, or to staff, are not hidden, even if this may lead to another agency making a decision that their services are not appropriate for the person at this point.
- Ensuring that information which is passed on to other agencies is based on known facts, professional judgements, and close involvement with the service user
- Basing good decision-making on documented information - this can be informal information which is constructive and supports other evidence, but can be verified.

Agencies to share information with:

19. This should include any agency which can help the service user to obtain or keep appropriate housing and support services. Such agencies should abide by the Data Protection legislation, and should have guidelines for staff about how and what information to share, how to store information, and what will happen if data protection rules are breached. The principles of good data protection, referring to information held on computer and some paper records, state that data must be:

- fairly and lawfully processed
- processed for limited purposes
- adequate, relevant and not excessive
- accurate
- not kept for longer than is necessary
- processed in line with patients' and professionals' rights
- secure
- not transferred to countries without adequate protection

Confidentiality

20. All organisations signed-up to this Protocol agree to ensure that information is not disclosed without the consent of the service user, and that it is not disclosed to people who are not entitled to have such information or do not intend to use it in the best interests of the service user. All parties will also agree to deal with any breaches of confidentiality by their staff or organisation.

People with Mental Health Needs

21. **If a patient is likely to be discharged from a general hospital or Callington Road with nowhere to go**, ward staff should:
- Contact the Hospitals Discharge Housing Advisor arrange for them to visit the patient, and give advice on the best options for them, to include good information exchanges, hospital bed management and care planning to include housing options.
 - Clarify with the patient's mental health team/care coordinator that s/he is able to live independently, albeit in a supported housing setting, and then note all details to provide to the Hospitals Discharge Housing Advisor (see contact details). Please note that care coordinators are absolutely critical to this process.
22. Every patient with a serious mental illness should have a Care Coordinator. Care Coordinators are closely involved throughout the process in assessing housing and support needs and identifying the most appropriate accommodation and support.
23. The Care Coordinator will share with the Hospitals Discharge Housing Advisor a risk assessment and risk management plan, and work out a housing and support package, with the aim of securing the best option without the patient having to go into temporary accommodation.
24. A number of mental health inpatient units in general hospitals are likely to discharge people who are not seriously mentally ill and will not be subject to statutory mental health service or have a care coordinator. The patients should be referred by the same routes as set out on page 10, under 'General Wards'.

Patients aged under 18

25. Anyone under 16 should be referred to Bristol City Council's Children and Young People's Services (see contact details).
26. **Homeless people aged 16 or 17 may be in a priority group** and will usually be helped to find appropriate housing by The Hub Homelessness Prevention and Housing Advice Centre (see contact details).

Asylum Seekers and Refugees

27. **Asylum seekers who have not yet received immigration status** are accommodated by a range of providers. The best contact point is the National Asylum Support Service (NASS) - get a NASS reference number for the person

before ringing if you can (see contact details).

28. **Asylum seekers whose application for asylum has failed** cannot be housed through council or other public sector housing. Families are supported by NASS, but single people may have no accommodation. Contact Refugee Action and/or Bristol City Council Adult Care Services for advice (see contact details).
29. **Asylum seekers who are unaccompanied minors (under 18 years old)** are looked after by Bristol City Council Children and Young People's Services (see contact details).
30. **Refugees** are entitled to apply for housing in the same way as any other households.

Eligibility for Welfare Services

31. British Nationals Returning from Abroad

Need to be Habitually Resident in the Common Travel Area – UK, Republic of Ireland, Channel Islands and the Isle of Man.

Anyone returning to the UK following a long stay abroad would need to be interviewed by Bristol City Council (BCC) Neighbourhood and Housing Services (N&HS) and assessed regarding her/his Habitual Residence in the UK. If s/he is not deemed to be Habitually Resident the Housing Authority (Bristol City Council) would not have a duty to assist and a referral would need to be made to BCC Adult Community Care.

32. EAA Nationals – Original Member States – Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, Iceland, Norway and Liechtenstein.

If a person is only exercising an initial right to reside in UK with no restrictions they are not eligible for Housing.

A person would need to be Economically Active i.e. a worker, self-employed person, a person that has retained the status of a worker or a family member of someone who is currently eligible for assistance. Employment would also need to be deemed 'genuine and effective rather than marginal and ancillary' meaning that just being in work does not automatically confer eligibility for assistance.

A referral would need to be made to Adult Community Care if we had no duty to assist.

33. A8's – Poland, Lithuania, Estonia, Latvia, Slovenia, Slovakia, Hungary and Czech Republic.

Nationals of these countries, who have not been granted Indefinite Leave to remain. (Prior to 1st May 2004) would have to be working and their work would have to be registered through the Home Office to be eligible. S/he will have documentation to confirm that the work is registered with the Home Office. If they have been working for a year and completed the registration period, they would be treated the same as

an EAA national above.

If they are deemed not eligible a referral would need to be made to Adult Community Care as there is no duty to assist.

34. A2's - Bulgaria and Romania

Similar rules apply as to A8's but authorisation to work and registration with the Home Office must be sought before commencing work.

In all cases advice should be sought in advance from the HUB regarding the eligibility of any of client where there is in doubt.

Referrals to Adult Community Care are made under 1948 National Assistance Act Sect 21(1)(a)

Rough Sleepers

35. If the person was sleeping rough before they came into hospital, there is a range of services that can help. These can be accessed through the Hospital Discharge Housing Advisor (see contact details).

People Discharging Themselves

35. People who have no accommodation may be more inclined to discharge themselves, or to leave A&E, before accommodation is found for them. This makes it very difficult to engage them in drug or alcohol treatment, or treatment for mental health problems, as well as engaging them in a programme of help to get back into settled housing. Hospital and social work staff are asked to try to encourage people not to leave before they have been helped by housing staff.

Having obtained the patient's consent, hospital staff should call the Hospitals Discharge Housing Advisor at the earliest point, to alert her/him that a patient is homeless and is likely to leave the hospital before any work can be done to enable access to housing and support services.

People with Drug and/or Alcohol Problems

36. People with drug and/or alcohol problems may not yet be in contact with treatment agencies. Adult Community Care teams in hospitals will assess care needs if the patient has possible needs for personal care and arrange that this is provided. Nursing staff should arrange as soon as possible into the admission for referral to the BSDAS (or the hospital's own) liaison nurse to complete an assessment.

The Hospitals Discharge Housing Advisor can advise homeless patients with drug and alcohol problems about treatment options and dry accommodation.

Other Actions to Prevent Homelessness

37. If the patient's home is unsuitable to meet her/his current needs, this could be because:
- S/he has drug or alcohol problems, or other problems, which lead to the view that they cannot manage their home at the moment.
 - Sheltered housing could be more suitable for her/him.
 - The home is no longer suitable as s/he needs aids and adaptations to be in place before they can return.
 - The home needs physical adaptations but this is not possible or cannot be done at reasonable cost.
38. If any of the circumstances above apply, hospital staff should discuss with the patient and, if consent is given, contact the council's Health and Housing Team at the earliest opportunity (see contact details).

Monitoring and Reviewing the Protocol

39. The Hospital Discharge and Homelessness Prevention Task Group which has developed this Protocol will meet initially after 6 months or earlier if necessary, and then twice a year, to monitor the implementation of the Protocol, and to review the document to see if any changes are needed. Any changes needed will be agreed by all agencies signed-up to it.
40. Meetings involving Hub and Bristol Compass Centre staff (particularly the Homeless Health Service) will also be useful for reviewing any changes to staffing, systems and structures, and provision, and keeping all agencies up-to-date, as well as for general liaison.
41. Outputs and outcomes from the Protocol will be monitored through use of the following:
- Numbers of people leaving hospital who are seeking help as homeless
 - Cases raised at regular meetings of the Task Group
 - Monitoring information about delayed transfer of care, which identifies reasons for delay and is validated by the Trusts, Children's and Young People's and Adult Community Care Services.
42. The Task Group will try to ensure that there is one officer (council or NHS) who ensures that the protocol is a working and live document, to ensure that the protocol is as effective as intended by this protocol.
43. Joint training will be provided by all parties who have signed up to this protocol. These will be arranged by a single nominated council officer.

PREVENTING HOMELESSNESS - KEY ACTIONS

- Posters will be displayed in all wards, reminding patients that they can ask for help at any time if they are worried about possible homelessness.
- On longer stay wards, hospital staff will check that the patient can return to suitable accommodation - as soon as possible after admission (and no less than a week before discharge).
- On short stay wards, hospital staff will check that the patient can return to suitable accommodation, ideally on admission, but at least 3 days before discharge – the longer the notice that housing agencies have, the more time to arrange supported or emergency accommodation.
- If there is no accommodation identified for a patient to return to, either the hospital staff or a social worker will contact the Hospitals Discharge Housing Advisor, at least 3 days before the discharge is likely.
- Patients may need to be advised that their welfare benefits (including Housing Benefit) may be reduced after 4 or 6 weeks in hospital. It is very important that action is taken to make sure that the patient is aware of this reduction so that rent arrears do not build up.

HOSPITAL HOMELESSNESS PREVENTION ACTION LIST

General Wards

Hospital staff should gain patient consent to information sharing any patient information with a housing or related staff.

STEP 1

Check the patient's housing situation

On admission, ask every patient for their address and whether this is the address they expect to return to.

Ward staff are asked to be particularly careful to ask this question where:

- The patient was noted by A&E as being homeless (No Fixed Abode - NFA)
- The patient is known to be staying at a hostel or other temporary accommodation
- The patient has been admitted following an **overdose** and referral from the Psychiatric Liaison Team

STEP 2

Check if the patient comes from Bristol and why they may be homeless

If the patient has no accommodation, or is not confident that they can return to that address, ask the following questions before deciding what to do next:

- **Does the patient come from Bristol or need to be here?**
- **Can s/he return to appropriate accommodation elsewhere?**
- **If s/he had a home before coming into hospital, why are they not able to go back there?**

People from outside Bristol

For people who do not come from Bristol, and do not wish to stay in the city, the Hospital Discharge Housing Advisor will contact the relevant council area.

- **If the patient is homeless, hospital staff should go to step 3...**

STEP 3

If the patient is homeless and needs help to find somewhere in Bristol, contact the Hospitals Discharge Housing Advisor

The Hospitals Discharge Housing Advisor will either take relevant details over the phone, or will arrange a visit if there are complex/pressing needs, with a longer interview is needed. This will take place within 48 hours on working days (or sooner if this is possible), and particularly if it is known that the person was admitted for a stay of less than 24 hours).

The Hospitals Discharge Coordinator or her colleagues will need to know

Full name and date of birth; Previous address, and type of housing (e.g. council tenancy, or hostel); Names and ages of any dependants; How long the person has been in Bristol; Any other agencies involved with the patient; Details of any risks posed by the patient or linked to their health; Any particular needs which should be taken into account

The Hospitals Discharge Housing Advisor, and his/her colleagues, will have time to make their decisions, and to help to find accommodation for the patient, if they receive clear information well before the patient is going to be discharged.

If the decision to discharge is made late on a working day, it is unlikely that accommodation will be found that night. In that case, hospital staff will try to ensure that a bed remains available for the patient until the next day

HOSPITAL HOMELESSNESS PREVENTION ACTION LIST

Accident & Emergency

This checklist applies to A&E patients who are likely to be admitted. Those who are not and will be discharged following treatment should be offered a Housing Advisor contact card.

Hospital staff should gain patient consent to information sharing any patient information with a housing or related staff.

STEP 1

Check the patient's housing situation

On admission, ask every patient for their address and whether this is the address they expect to return to.

STEP 2

Check if the patient comes from Bristol and why they may be homeless

If the patient has no accommodation, or it is not clear that they can return to the address s/he gave, ask the following questions before deciding what to do next:

- **Does the patient come from Bristol or need to be here?**
- **Can s/he return to appropriate accommodation elsewhere?**
- **If s/he had a home before coming into hospital, why are they not able to go back there?**

Nursing staff should take every opportunity to check whether the person can go back to the address they have given.

If the patient is homeless, A&E staff should go to step 3...

STEP 3

If the patient is homeless and needs help to find somewhere in Bristol, contact the Hospitals Discharge Housing Advisor

The Hospitals Discharge Housing Advisor will either take relevant details over the phone, or will arrange a visit if there are complex/pressing needs, with a longer interview is needed. This will take place within 48 hours on working days (or sooner if this is possible), and particularly if it is known that the person was admitted for a stay of less than 24 hours).

The Hospitals Discharge Housing Advisor or her colleagues will need to know:

Full name and date of birth; Previous address, and type of housing (e.g. council tenancy, or hostel); Names and ages of any dependants; How long the person has been in Bristol; Any other agencies involved with the patient; Details of any risks posed by the patient or linked to their health; Any particular needs which should be taken into account

The Hospitals Discharge Housing Advisor and his/her colleagues will have time to make their decisions, and to help to find accommodation for the patient, if they receive clear information well before the patient is going to be discharged.

If the decision to discharge is made late on a working day, it is unlikely that accommodation will be found that night. In that case, hospital staff will try to ensure that a bed remains available for the patient until the next day.

HOSPITAL HOMELESSNESS PREVENTION ACTION LIST

Patients with Mental Ill Health

Hospital staff should gain patient consent to information sharing any patient information with a housing or related staff.

STEP 1

Check the patient's housing situation

On admission, ask every patient for their address and whether this is the address they expect to return to. If there is any chance that the patient may be homeless or inappropriately housed on discharge, the Care Coordinator should begin discussing housing and support options with the Hospitals Discharge Coordinator. If the patient is not 'seriously mentally ill' it will be necessary to follow the procedures set out under 'General Wards' (see also paragraph 21, 'People With Mental Health Needs').

STEP 2

Check if the patient comes from Bristol and why they may be homeless

If the patient has no accommodation, or it is not clear that they can return to the address s/he gave, ask the following questions before deciding what to do next:

- **Does the patient come from Bristol or need to be here?**
- **Can s/he return to appropriate accommodation elsewhere?**
- **If s/he had a home before coming into hospital, why are they not able to go back there?**

If the patient could be discharged homeless, go to step 3...

STEP 3

If the patient is homeless and needs help to find somewhere in Bristol, contact the Hospitals Discharge Housing Advisor

The Hospitals Discharge Housing Advisor will either take relevant details over the phone, or will arrange a visit if there are complex/pressing needs, with a longer interview is needed. This will take place within 48 hours on working days (or sooner if this is possible), and particularly if it is known that the person was admitted for a stay of less than 24 hours).

The Hospitals Discharge Housing Advisor or her colleagues will need to know: Full name and date of birth; Previous address, and type of housing (e.g. council tenancy, or hostel); Names and ages of any dependants; How long the person has been in Bristol; Any other agencies involved with the patient; Details of any risks posed by the patient or linked

to their health; Any particular needs which should be taken into account

The Hospitals Discharge Housing Advisor, and his/her colleagues, will have time to make their decisions, and to help to find accommodation for the patient, if they receive clear information well before the patient is going to be discharged.

If the decision to discharge is made late on a working day, it is unlikely that accommodation will be found that night. In that case, hospital staff will try to ensure that a bed remains available for the patient until the next day.

CONTACT DETAILS

Hospitals Discharge Housing Advisor

Name(s): Ruth Sutherland

Phone: 0117 914 1466 **Mobile:** 07795446494 **Email:** ruth.sutherland@bristol.gov.uk

Address: The Hub Homelessness Prevention and Housing Advice Centre, 13-17 Cumberland Street, St Pauls, Bristol BS2 8NL

OTHER USEFUL CONTACTS

Homelessness Health Service

Name(s): Sandra McIntyre, Senior Health Link Worker

Phone: 0117 944 0583 **Fax:** 0117 944 0584

Email: Sandra.McIntyre@nhs.net

Address: Bristol Homeless Health Service, The Compass Centre, 1 Jamaica Street, Stokes Croft, Bristol BS2 8JP

The Hub Homelessness Prevention and Advice Centre

Name(s):	Phone:
Bruce Duffy, Senior Housing Adviser	0117 914 1467
Tom Rhodes, Housing Adviser	914 1462
Tom Simpson, Housing Adviser	914 1464
Peter Pearce, Housing Adviser	914 1465
James Cogan, Housing Adviser	914 1468
Kate Elton Housing Adviser	914 1469
Kevin Davis/Anna Sopwith	
Housing Advisers (Job Share)	914 1461

Emails (Checked Hourly): firstname.surname@bristol.gov.uk

e.g. bruce.duffy@bristol.gov.uk the.hub@bristol.gov.uk

Address: The Hub Homelessness Prevention and Housing Advice Centre, 13-17 Cumberland Street, St Pauls, Bristol BS2 8NL



DO YOU NEED HELP WITH HOUSING?

**IF YOU'RE HOMELESS OR IF
YOU DON'T HAVE SAFE,
SECURE HOUSING TO
RETURN TO AFTER YOUR
STAY IN HOSPITAL...**

**YOU CAN TALK
CONFIDENTIALLY WITH A
MEMBER OF HOSPITAL
STAFF, WHO WILL PUT YOU
IN TOUCH WITH PEOPLE
WHO CAN HELP**

DON'T DELAY!

