Protocol for the Transfer of Care for People Experiencing Homelessness in Dublin

From Hospitals to Community

HSE Social Inclusion

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Purpose

The purpose of this protocol is to improve the health and social outcomes for people experiencing homelessness and those at risk of homelessness. This is achieved by ensuring planned, coordinated, and timely discharges from acute hospitals, along with appropriate onward referral. Prevention of homelessness is critical. This protocol engages essential supports and services, including suitable accommodation, to support this process. This protocol is initiated when someone who is experiencing homelessness or at risk of homelessness first contacts acute hospital services in the Dublin region and continues for all admissions and discharges to and from the hospital.

This protocol addresses standard discharges for patients experiencing or at risk of homelessness, **not delayed transfers of care**. Standard discharges involve planned transitions where patients leave as scheduled, with housing and follow-up services arranged. Delayed transfers occur when patients, though medically fit, remain in care due to unresolved issues like housing or support availability. These two categories employ different discharge processes.

A **stakeholder register** has been developed, outlining key contact details across housing, health, and the voluntary sector. These contacts should be used to coordinate the discharge process and the transfer of care for individuals experiencing homelessness or at risk of homelessness. To access the stakeholder register, please send a request to Sinead.Maguire6@hse.ie

Core Principles

1. Person-Centred Care:

- The **needs and dignity** of the person experiencing homelessness or at risk of homelessness are paramount at all stages of service delivery.
- The **healthcare wishes and preferences** of the person will be discussed with them by an appropriate professional, and **explicit consent** will be obtained before any care plans or discharge arrangements are made.

2. Open Communication:

- All service providers will maintain **transparency and foster a partnership approach** to service delivery.
- **Clear and consistent communication plans** will be implemented, ensuring all relevant parties are informed and engaged in the discharge process.
- Ensure clear and timely **transfer of information between settings**, including communication of any changes in support needs, medication, or abilities to all relevant parties, such as GPs, social care providers, local authorities (LA)/CPS, homeless service providers and other relevant services.

3. Planned Discharges:

- All transfers of care for people experiencing or at risk of homelessness should be **planned**, with discharge planning beginning at the first point of contact.
- **Always contact the LA/CPS upon admission** to report changes in support needs due to accommodation constraints, such as mobility-friendly spaces, single rooms, and medication management. Always confirm with the LA/CPS that ongoing care needs can be safely met before discharge. The variability in homeless emergency accommodation means that this cannot be assumed.
- Upon initial contact with LA/CPS, they will **identify key workers/case managers** through the PASS system, if the patient has one, and share the contact details with hospital staff. If a new client is registered as homeless, they won't have a key worker assigned initially. However, a key worker will be allocated once they arrive at their accommodation.
- When someone leaves homeless accommodation to enter acute services, **the LA/CPS will communicate** to homeless service provider should they be **planning the individual's readmission back to their services upon entry to hospital**.
- **Discharges should not occur without a comprehensive assessment of accommodation and support needs**, communicated with the LA/CPS, homeless service provider and integrated care team, and other relevant sectors such as disability services, nursing homes, and neurodiversity services, with patient consent.

4. Integrated Care Planning

- All relevant service providers and support persons (in both the hospital and community) should **support the assessment of need and integrated care planning** for transfer of care to assist during convalescence and in their continuity of care. This process should-**involve the patient**. As part of this integrated care team, a **key worker or case manager in the community must be identified** and regularly engage in care planning whilst the person is in hospital.
- The **role of the key worker or case manager** is to support the individual in navigating the health system, including providing assistance with following up on hospital appointments and ensuring that all clients have an active medical card.
- In the case of a service user **changing accommodation or service providers**, there should be a seamless **transfer of care between voluntary organizations**, with integrated care plans and case management assessments shared to ensure continuity and consistency in the support provided.

Pathways, roles and responsibilities that are defined within the protocol provide guidance for all staff members and representatives of the Health Services, Local Authorities and the Voluntary Sector who are supporting people experiencing homelessness and those at risk of homelessness being discharged from hospital. **See page 6 for roles clarification.**

Each hospital will develop an internal pathway or the coordination of work involved in the discharge of people experiencing homelessness and will liaise with the local authority, and other relevant stakeholders in the development of such pathways.

As part of this pathway, a hospital consultant and/or relevant hospital staff member/s will be identified as a **homeless discharge coordinator or liaison team** that will support LAs/CPS, the voluntary sector and other healthcare providers with care planning for people experiencing homelessness who have complex health and social issues. MDT meetings will be attended by all interested parties including Primary Care and other relevant health services. The homeless discharge coordinator/liaison team role is held by a clinical or HSCP staff member (e.g., MSW or other relevant clinical staff) rather than an administrative position.

The homeless discharge coordinator or liaison team will oversee the **completion and timely dispatch of discharge summaries**. Discharge summaries will be accurate, complete, and **sent before the patient arrives at the receiving facility**. This will help ensure that receiving facilities/services (e.g. STA, SUSD, GP) have all necessary information in advance. Discharge summaries are to be shared with both primary care and community services (including homeless service providers). Discharge summaries should, at a minimum, include the following information: admission date, reason for admission, medical or psychiatric team responsible for care, discharge plan, and details of the services the patient is currently engaged with. Any hospital follow-up appointments must be noted to ensure continuity of care. **Use the discharge template to write and share the discharge summary. Discharge template can be accessed here.**

Information on the protocol should be provided to relevant hospital/community staff to ensure all staff involved have a clear understanding of the procedures involved and staff attendance should be supported at any relevant training for protocol implementation.

Full details of the protocol can be found here

Pathways

ED AND INPATIENT

1. Patient experiencing homelessness (or at risk of homelessness), source (i.e. STA, PEA, rough sleeping), their LA (i.e. DCC, FCC, SDCC, DLRCC) and housing application status is identified and recorded.
2. Patient is referred to and seen by MSW/IHT/dedicated homeless worker/homeless nursing service.
3. Upon *initial assessment, always contact the LA/CPS* and provide a clear, detailed account of any changes in support needs. LA/CPS contact is: homelesshd@dublincity.ie
4. When contacting LA/CPS, ask them to share key worker/case manager's contact details from PASS system.
5. Engage key worker/case manager and record their details.
6. Key worker/Case manager and Parent/Guardian/ Family (where possible/appropriate) involved in care planning and advocacy.
7. Direct communication with other relevant community providers (e.g. GPs, NGO's, Safetynet, PACT, Healthlinks teams, SUSD, CMHT), primary care services and clinicians to ensure concerns/ history and care plan conveyed.
8. Identify the need for further MDT assessments/meetings for patients with complex presentations.

1. Obtain *consent* from patient for liaison with integrated MDT, including local authority, other service providers and family/guardian (where appropriate).
2. Assess discharge needs (including housing needs and eligibility for Housing First tenancies or other supported accommodation e.g. STA, LTA, PEA and failed Housing First tenancies).
3. Immediate liaison with LA/CPS to secure most suitable discharge bed for current health presentation and ongoing health needs. LA/CPS should be informed of the ELOS and EDD within 24 hours of confirmation.
4. Once the discharge destination is known, the LA/CPS will contact homeless service provider to inform them of the admission and planned discharge.
5. Dedicated homeless discharge coordinator/IHT to develop or update integrated care plan with key worker/case manager, relevant community providers and parent/guardian/family where appropriate (Integrated MDT).
6. Record details of relevant service providers in the integrated MDT who are involved in discharge planning/integrated care plan.
7. Record and store relevant homelessness data including assessment of needs and care plans in a timely and standardised way.

Designated person to ensure **discharge summaries** sent to relevant people before the patient arrives at the receiving facility. Discharge summaries are to be shared with both primary care and community services.

DISCHARGE

1.	Formally communicate discharge plans with integrated MDT prior to discharge. For complex hospital discharges this may take the form of an MDT meeting. Share integrated care plan and discharge plan with integrated MDT.
2.	Send the discharge summary to both primary care and community services (including homeless service providers) before the patient arrives at the receiving facility. Use discharge template to write and share discharge summary.
3.	If patient leaves against medical advice, discharge summary/integrated care plan to be sent as soon as possible to relevant community service provider for follow-up (If appropriate services cannot be identified, the discharge summary can be sent to the Homeless Health-Link Teams and Safetynet In-Reach for patient follow-up, where possible. Given the limited capacity of these teams to follow up on all self-discharges, cases requiring follow-up should be prioritised based on urgency and need). If no plan is available key worker/case manager to contact ward for follow up.
4.	Out of Hours' discharges (outside Mon-Fri 9-5) should be avoided, if at all possible. While EDs discharge patients 24/7, homeless inpatients should ideally be discharged during the working hours of their accommodation provider, unless agreed arrangements are in place. However, if accommodation is unavailable during these hours, out-of-hours discharges may happen. In such instances, to access emergency accommodation outside of regular hours, contact the Homeless Freephone service at 1800 707 707.
5.	Referrals to PHN Community Services for dressings should be sent before the Friday of discharge to ensure weekend coverage. Homeless accommodation does not provide 24/7 nursing, so Primary Care must meet the client's needs over weekends. If intravenous therapy is required, it can be administered in the accommodation using CIT services.
6.	Key worker/case manager is responsible for coordinating ongoing care in the community and must involve Primary Care Services where applicable
7.	Regular interagency meetings should be held in the community to support continuation of care and integrated care planning

For patients at risk of homelessness,

1. **Identification:** During triage, assess the patient's tenancy status to identify those at risk of homelessness.

2. **Immediate Referral and Support Access**: When a patient is at risk of homelessness, an immediate referral should be made to the MSW or homeless discharge coordinator. These teams should provide information on housing applications, HAP, and relevant voluntary services, while seeking assistance from CPS/LA for particularly vulnerable patients. LA/CPS are responsible for determining if an individual is at risk of homelessness.

3. **Prevention, Tenancy Protection and Service Awareness**: MSWs and homeless discharge coordinators should ensure awareness of tenancy protection services by actively promoting these resources among staff, displaying relevant information prominently in ED waiting rooms, and fostering direct communication with a designated LA/CPS staff member for support. Additionally, they play a crucial role in prevention services by identifying at-risk individuals early, coordinating referrals to tenancy sustainment programs, and collaborating with housing and social support agencies to prevent homelessness where possible. See stakeholder register for other prevention services.

Activity Measures

Each hospital will develop monitoring and review mechanisms in line with the below homeless hospital discharge **activity measures.** These will be reported on a bi-annually basis to: Sinead.Maguire6@hse.ie

1. General:

- % of staff who have read, understood, and agreed to adhere to the protocol, and have been trained in its implementation (Target 85%)

2. Assessment and Care Planning:

- % of patients identified as experiencing homelessness or at risk of homelessness within 24 hours of hospital admission (Target: Increased identification by 50-60%).
- % of Key Workers/Case Managers engaged with patients within 48 hours of hospital admission (Target 85%)
- % of patients discharged from the hospital out of hours (Target 0-5%)
- % MDT involvement in discharges for patients with complex needs, with documented meetings and care plans (integrated care planning) shared with all relevant stakeholders (Target 85%)
- % of Homeless patients who left the Emergency Department before being medically assessed (Target 0-10%)

3. Accommodation:

- % of homeless individuals discharged from hospital to accommodation
- % of times when the LA/CPS has been involved at the early stage when the patient has complex/ unmet housing needs (Target -100%)

4. Care in The Community:

- % of times where discharge plans are followed and continuity of care is maintained post-discharge for homeless individuals (Target 85%)

Glossary of Terms

CIT: Community Intervention Team

CMHT: Community Mental Health Team

CPS: Central Placement Service

Complex hospital discharge: Agreed definition in extended protocol

DCC: Dublin City Council

DLRCC: Dún Laoghaire-Rathdown County Council

EDD: Expected Discharge Date

ELOS: Expected Length of Stay

FCC: Fingal County Council

HAP: Homeless Assistance Payment

Housing First: See programme description in extended protocol

HSCP: Health and Social Care Professionals

IHT: Inclusion Health Team (or Inclusion Health Service)

LA: Local Authority

LTA: Long-Term Temporary Accommodation

MDT: Multi-Disciplinary Team (hospital staff)

Integrated MDT: Multi-Disciplinary Team including hospital staff and community-based staff (such as HSE Social Inclusion staff, LA staff, homeless service provider, key worker/case manager, etc.)

MSW: Medical Social Worker

NGO: Non-Government Organisation

PASS: Pathway Accommodation and Support System (Database)

PACT: Private Emergency Accommodation Assertive Case Management Team

PEA: Private Emergency Accommodation

PHN: Public Health Nurse

SafetyNet: See organisation description in extended protocol

SDCC: South Dublin County Council

SUSD: Step-Up Step-Down medical residential service

STA: Supported Temporary Accommodation

Role Clarity and Responsibilities

Purpose

This section delineates the roles and responsibilities of key stakeholders involved in the discharge of individuals experiencing homelessness or at risk of homelessness. A clear role definition is essential to ensure that the protocol's objectives—improving health and social outcomes through planned, coordinated, and timely discharges—are effectively met.

Hospitals:

1. **Discharge Planning**: The Homeless Discharge Coordinator/Liaison Team oversees discharge planning from admission, working with local authorities/CPS, community services, and healthcare providers to secure appropriate accommodation. Hospitals must **notify the local authority/CPS upon patient admission** to report accommodation-related support needs (e.g., mobility access, single rooms, medication management). Always confirm with the local authority/CPS that ongoing care needs can be safely met before discharge, as homeless emergency accommodation varies greatly. When contacting local authority/CPS, always ask for key worker/case managers contact details.

2. **Needs Assessment**: Within 24 hours of referral, the team assesses the patient's housing and health needs with the hospital's multidisciplinary team (MDT).

3. **Documentation & Consent**: The team documents the patient's housing status, ensures discharge summaries are shared with service providers, including primary care services and community service providers (including homeless service providers), and **obtains patient consent for information sharing**.

4. **Community Collaboration**: For patients without secure housing, the team coordinates with local authorities to arrange accommodation.

5. **Emergency Department (ED) Role**: The ED identifies homeless patients during triage and flags them for the Homeless Discharge Coordinator/MSW. The ED also communicates with accommodation providers and assists with transport arrangements where possible.

6. **Multidisciplinary Team (MDT) Involvement in the Hospital**: The team participates in MDT meetings to discuss complex cases and ensure that care and discharge plans are integrated. They represent the patient's needs and advocate for coordinated care across hospital and community settings.

7. **Integrated MDT Involvement**: The team in the hospital works closely with the key stakeholders in the community (e.g. key worker/case manager, HSE Social Inclusion staff, homeless service provider, local authority, etc.) to ensure integrated care plans and manage complex discharges. Meetings are held for complex cases to ensure community care providers are involved and a follow-up care plan is established and implemented.

8. **Advocate for Patients at Risk of Homelessness**: For patients identified as at risk of homelessness, the team works with MSWs and other support services to provide housing-related advice and referrals. They assist in accessing tenancy protection, HAP, and voluntary services to help secure stable housing. Information on homelessness prevention services and associated risk factors is displayed in hospital settings.

9. **Care Packages:** The hospital MSW is responsible for ensuring that all necessary home care packages are arranged with adequate funding prior to the client's discharge, if needed. The PHN may need to order equipment, such as a hospital bed or mattress, which requires an up-to-date Medical Card. Acute Services will liaise directly with the PHN before the client's planned discharge to ensure all supports are in place.

Local Authority/Central Placement Service (CPS):

1. **Collaboration in Discharge Planning**: local authorities/CPS are engaged early in discharge planning to secure suitable accommodations before patients are discharged, especially in complex cases.

2. **Hospital Discharge Waiting List Management**: Local authority/CPS maintains a dedicated waiting list for patients eligible for social housing supports, prioritising placements in 24-hour Supported Temporary Accommodation (STA) and easing pressure on both hospital beds and emergency services.
3. **Coordination with Hospital Teams and Homeless Service providers**: Local authority/CPS works closely with Homeless Discharge Coordinators/Liaison Teams/IHT/MSW to secure suitable accommodation. Once a discharge destination is confirmed, local authority/CPS notifies the homeless service provider of the expected length of stay (ELOS) and estimated discharge date (EDD). At least 24 hours before discharge, CPS confirms the patient's care arrangements with the homeless service provider to ensure readiness for their arrival.

4. **Dedicated Liaison Contacts**: local authority/CPS designates senior staff or liaison officers to assist hospitals with discharge cases, directly supporting accommodation identification and discharge timing.

5. **Participation in Integrated MDT Meetings**: CPS attends Integrated MDT meetings to facilitate integrated care planning with hospitals and community organisations for complex discharge cases.

6. **Monitoring and Service Review**: CPS collaborates with the Dublin Homeless Health Coordination Group to review discharge processes and adjust services to meet emerging needs.

7. **Emergency Support for Complex Cases**: In cases where accommodation cannot be identified, CPS continues to work with hospital staff to find suitable options. For patients who self-discharge, CPS is informed (with consent) to provide follow-up support as needed.

Homeless Service Providers:

Homeless service providers play a critical role in ensuring smooth transitions for patients experiencing homelessness who are discharged from hospitals. Key responsibilities include:

1. **Engagement in Discharge Planning**: Homeless service providers are notified by the local authority/ CPS of a patient's admission. Providers receive the ELOS and EDD within 24hr of these being known to facilitate planning.

2. **Communication Before Discharge**: Providers are contacted at least 24 hours before discharge to confirm care arrangements and ensure readiness to receive the patient.

3. **Participation in Integrated MDT Meetings**: For complex cases, accommodation providers are invited to participate in Integrated MDT meetings to help develop discharge plans. If unable to attend, they should communicate any concerns regarding discharge arrangements.

4. **Accommodation Input**: If unable to accommodate a patient upon discharge, the provider must notify local authorities/CPS immediately to allow alternative arrangements. If concerns arise regarding the patient's needs, providers should consult with the medical doctor or social worker in covering the case as soon as possible. Provider should further notify local authority/CPS and HSE Social Inclusion.

5. **Receipt of Discharge Summary**: With patient consent, providers receive the discharge summary at least 24 hours before discharge, giving them necessary medical, care plan, and follow-up details.

6. **Support Coordination**: Providers collaborate with hospital and community teams to co-ordinate appropriate care packages for patients with high support needs, facilitating their adjustment post-discharge.

7. **LTA Assessments**: Long-Term Accommodation (LTA) providers assess patients in hospital to ensure they are prepared to support the patient upon discharge into LTA settings.

Key Workers/Case Managers:

Key workers and case managers provide essential support to patients experiencing or at risk of homelessness during hospital stays and post-discharge transitions.

1. **Primary Contact for Patients**: Serving as the patient's main contact throughout their hospital stay and discharge process, key workers/case managers are engaged early to support discharge planning and ensure continuous care.

2. **Care Coordination**: Key workers/case managers collaborate with hospital discharge teams and local authorities/CPS to establish and update the patient's care plan. This involves coordinating appropriate care upon discharge.

3. **Continuity of Care**: They support with follow-up needs, including arranging outpatient appointments, securing a medical card, and connecting patients to essential services. In cases where the patient transfers between services, the key worker/case manager provides a thorough handover with all relevant care and assessment details. This handover must be documented in writing and recorded in the client's records; a verbal handover alone is not sufficient.

4. **Local Knowledge and Referral Support**: Key workers/case managers maintain up-to-date knowledge of local services, enabling them to refer clients to appropriate health, housing, and social support resources, while offering guidance on health promotion and local initiatives.

5. **Patient Advocacy**: Acting as patient advocates, key workers/case managers assess individual needs, including urgent or emergency situations, to facilitate appropriate referrals for physical, substance use or mental health concerns.

6. **Medication Adherence and Medical Concerns**: They support medication adherence and escalate concerns about patient health to relevant community or NGO healthcare teams, including PACT nurses if the patient resides in PEA. They ensure clients have an up-to-date prescription and prompt them to collect medications from the pharmacy when needed. They also remind clients to attend hospital appointments.

7. **Participation in Integrated MDT Meetings**: Key workers attend Integrated MDT to represent and advocate for patient needs, ensuring all aspects of the care plan align with the patient's well-being.

8. **Discharge Summary and Information Sharing**: With patient consent, key workers receive discharge summaries and other relevant information, allowing them to understand the patient's treatment and discharge plan and to ensure follow-up care is implemented effectively.

Primary Care and Community Health Services:

Primary Care Providers/Public Health Nurses (PHNs):

- Take over the patient's care post-discharge as outlined in the integrated care plan.
- Collaborate with the key worker/case manager to ensure that the patient's healthcare needs are met in the community. Please note that if this client is referred to the PHN, they will be added to the PHN caseload, and the PHN will make any necessary referrals, such as to Physio, OT, etc.
- Attend Integrated MDT meetings and provide input on the patient's ongoing health requirements.
- Primary care is involved in supporting ongoing medical needs. Community services play a key role, with GPs responsible for ongoing scripting.
- All clients should be linked with a GP before referral to PHN services. A Medical Card (not a GP Visit Card) is required for any equipment the PHN needs to order.

Community Mental Health Teams (CMHT):

- Provide mental health support to patients during their hospital stay and after discharge.
- Collaborate with the hospital and other community-based teams to integrate mental health needs into the overall care plan.
- Attend MDT meetings in the hospital when applicable.

- Ensure clients remain linked to the CMHT if they relocate, as this is a significant challenge when clients move to different areas.
- Facilitate ongoing injections within the client's accommodation if required.
- Establish a care pathway for clients who disengage from community services.
- Engage with the client's accommodation and introduce themselves to the key worker/case manager.
- Provide a contact number for mental health support to the accommodation provider during a client crisis and ensure follow-up.

Social Inclusion Services in the Community (e.g., Step-Up Step-Down, Healthlink teams, PACT, ACESS Team, Inclusion Mental Health Team):

- Provide specialised support during the transition from hospital to community care.
- Engage with the key worker/case manager to ensure that the patient's care plan is followed and that any issues that arise during the convalescence period are addressed promptly.
- Attend Integrated MDT meetings as needed
- Support engagement of people experiencing homelessness with mainstream health services

Accommodation

There are two types of emergency accommodations available to clients at discharge from hospital. These are Private Emergency Accommodation and Supported Temporary Accommodation. The large majority of services are shared facilities with very few single rooms available. All beds are operated on a rolling basis with 24/7 access.

Private Emergency Accommodation (PEA)

These services are run by private operators. There is in-reach support currently offered by visiting support services (see below) and supports in relation to housing are provided by Dublin City Council housing support officers.

Supported Temporary Accommodation (STA)

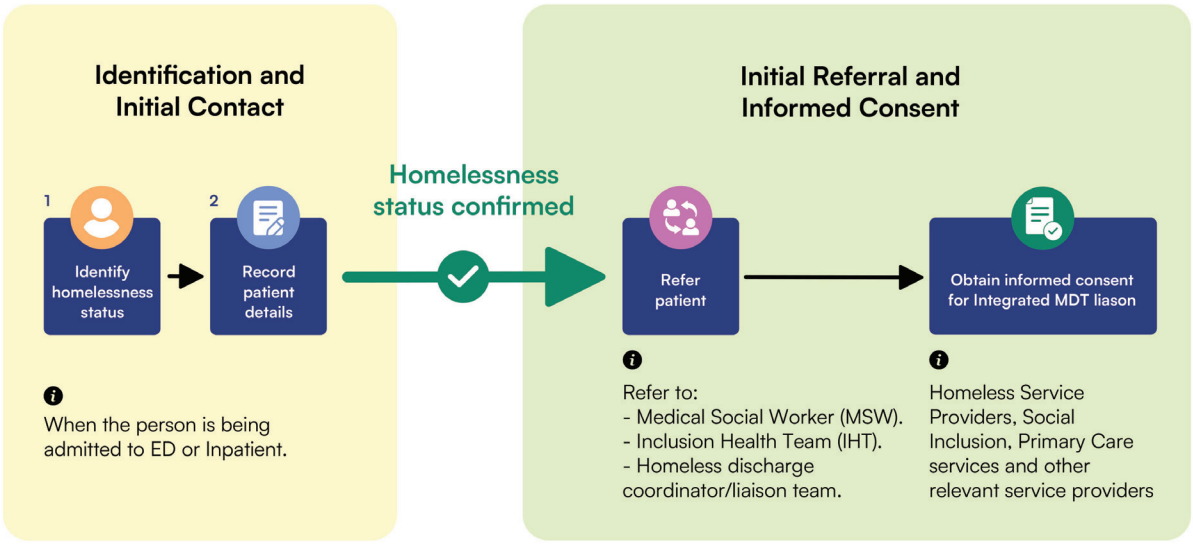
These services are run by Non-Governmental Organisations (NGO). They have 24 hour support staff onsite and clients are assigned a keyworker for support. These services have a service charge attached. We currently engage with 7 NGO services – Novas, Peter McVerry Trust, Dublin Simon, Crosscare, Salvation Army, De Paul and Focus Ireland.

Supports in Services

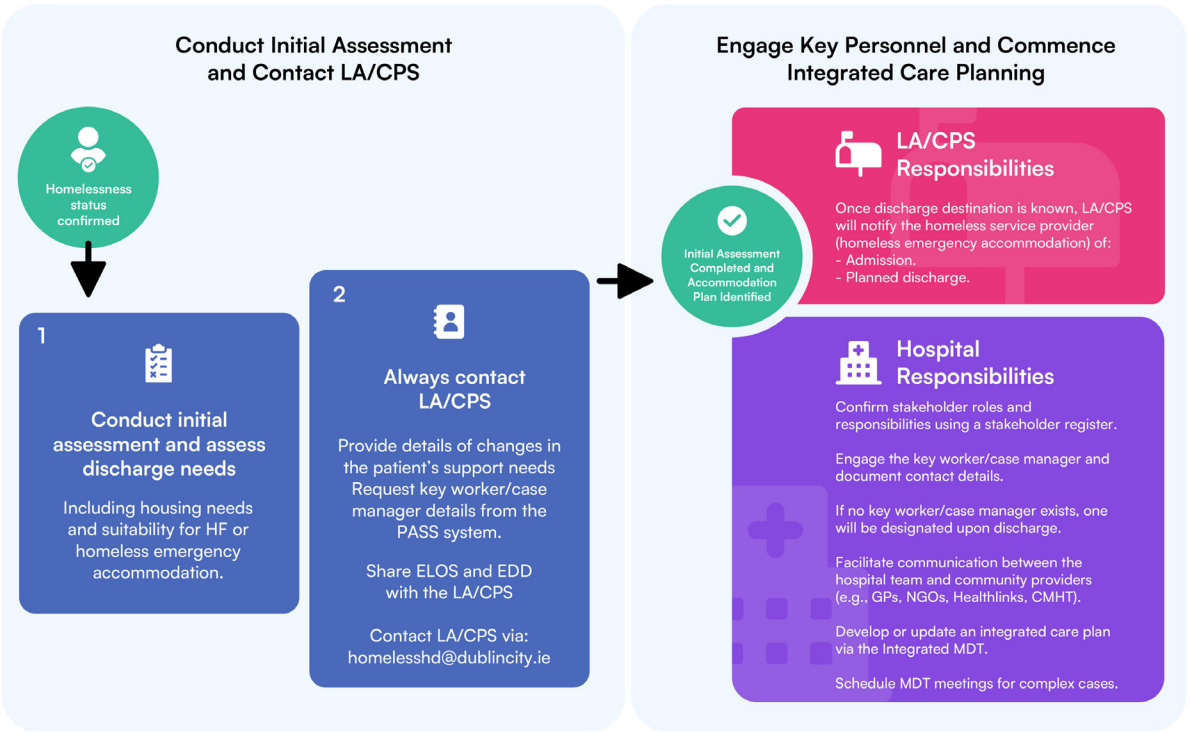
Service Users in STA's receive on-site support from keyworkers. These keyworkers are employed directly by the service provider.

Service users in PEAs receive support either through PACT Team or in some cases Local Authority Housing Support Officers. Service users can also access external supports through Merchants Quay Ireland, Focus Ireland Coffee Shop, Capuchin Centre.

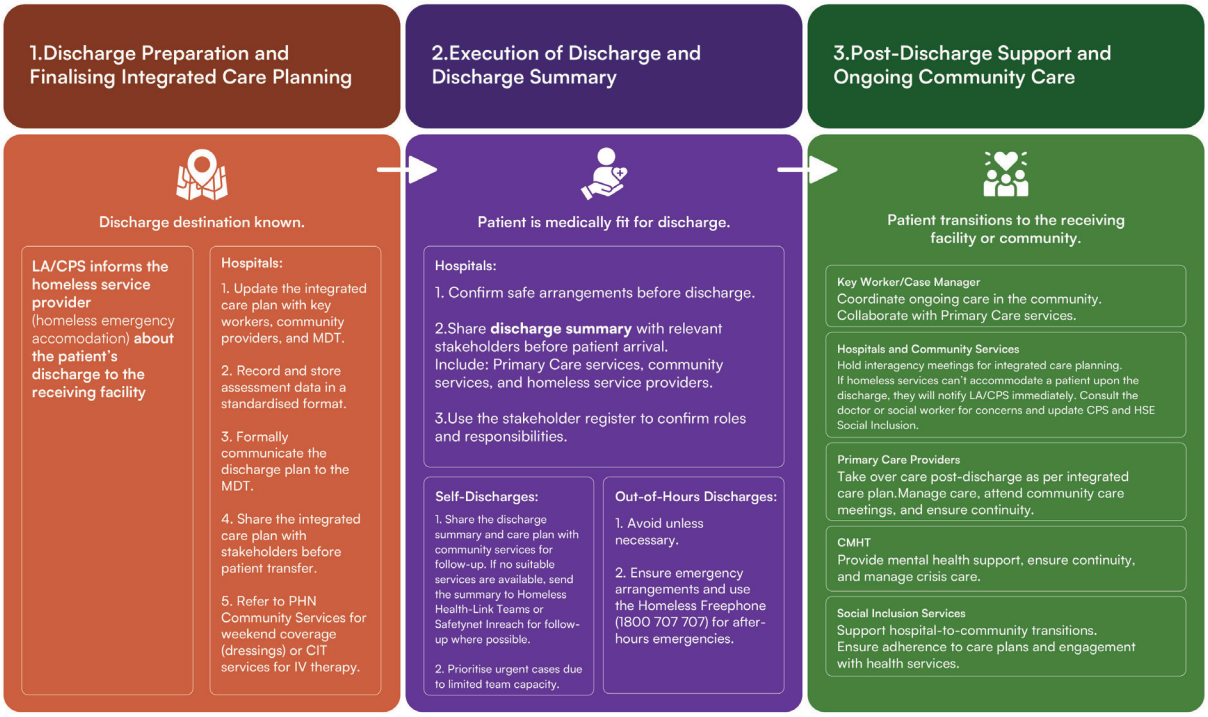
Identification, Initial Referral, and Consent



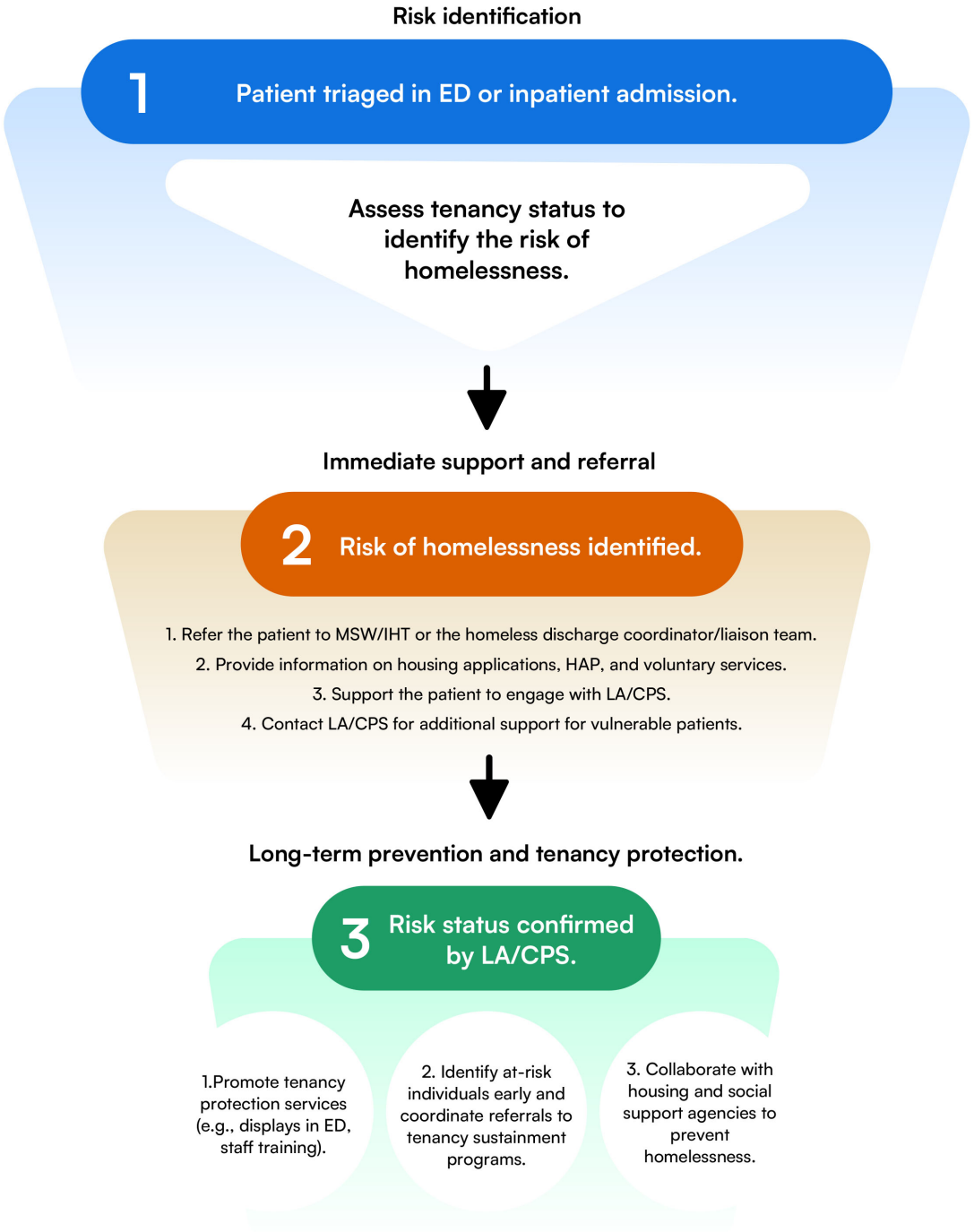
Assessment and Care Planning



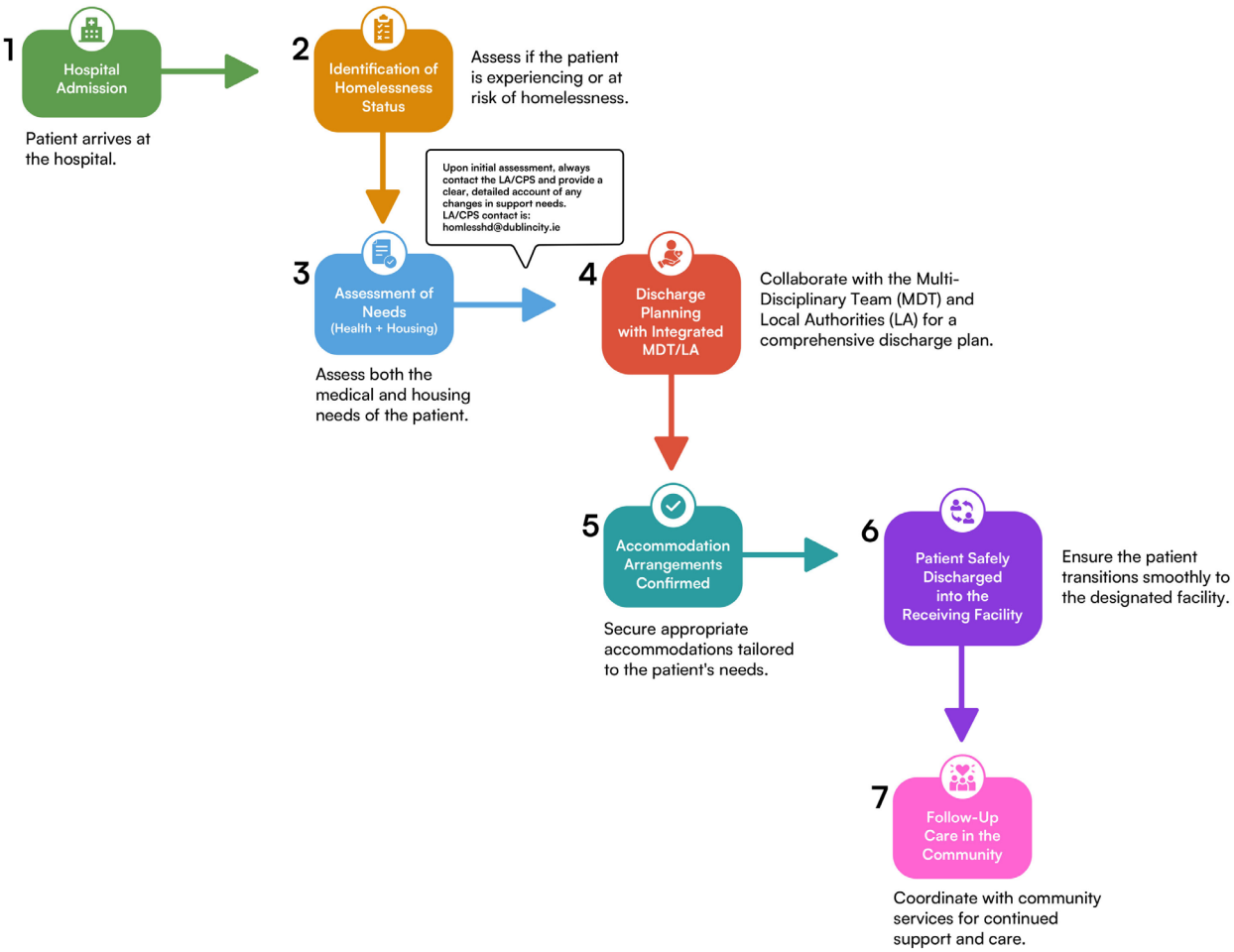
Discharge Preparation, Execution, and Follow-Up



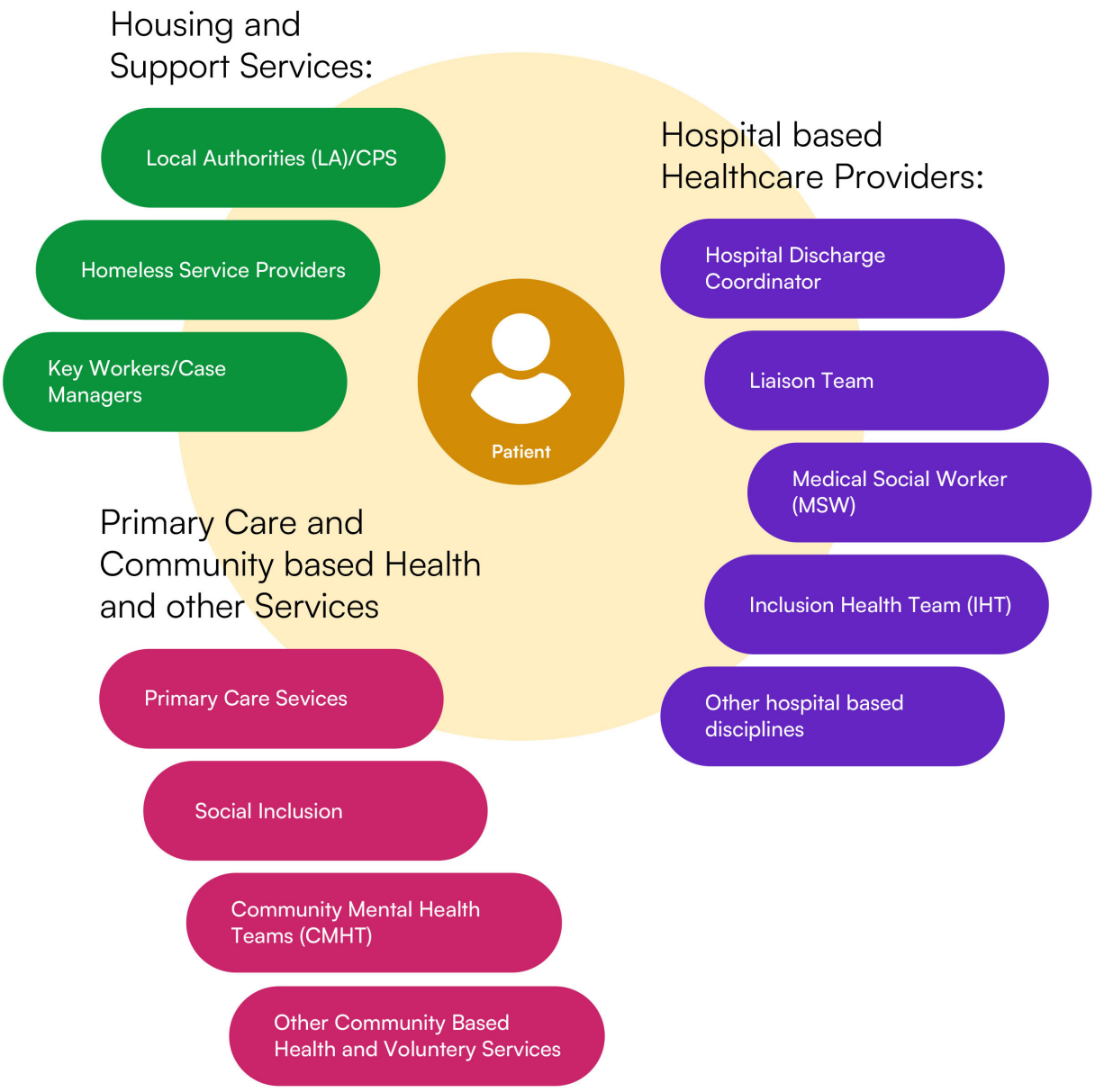
Early Identification & Risk Management for Those at Risk of Homlessness



Patient Journey: From Admission to Discharge



Integrated Multi-Disciplinary Team (MDT) Structure



Roles and Responsibilities of Stakeholders

Hospitals: Discharge planning, needs assessment, communication.

1. Discharge Planning:	- Homeless Discharge Coordinator/liaison team/MSW/IHT oversees planning and works with local authorities/CPS, community services, and healthcare providers to arrange suitable accommodation. - Notify CPS of admission for housing-related needs and confirm safe arrangements before discharge.
2. Needs Assessment:	- Assess housing and health needs within 24 hours of referral.
3. Documentation and Consent:	- Document housing status, obtain consent for information sharing, and share discharge summaries.
4. Emergency Department (ED) Role:	- Identify and flag homeless patients for support; also communicate with accommodation providers and assist with transport arrangements where possible.
5. MDT Involvement:	- Represent patients in hospital MDTs to ensure integrated care plans.
6. Integrated MDT Involvement:	- The team in the hospital works closely with the key stakeholders in the community (e.g., key worker/case manager, HSE Social Inclusion staff, homeless service provider, local authority, etc.) to ensure integrated care plans and manage complex discharges. Meetings are held for complex cases to ensure community care providers are involved, and a follow-up care plan is established and implemented.
7. Advocacy for At-Risk Patients:	- Assist in accessing housing-related services and tenancy protection.
8. Care Packages:	- Arrange home care packages and liaise with PHNs for equipment needs

Roles and Responsibilities of Stakeholders (continued)

Local Authorities: Secure accommodation and follow-up support.

1. Collaboration:	- Engage early with hospital teams to secure accommodation pre-discharge.
2. Waiting List Management:	- Maintain discharge waiting lists and prioritize supported accommodation.
3. Coordination with Hospital Teams and Homeless Service providers:	- Local authority/CPS works closely with homeless discharge coordinators/liaison teams/IHT to secure suitable accommodations. Once a discharge destination is confirmed, the local authority/CPS notifies the homeless service provider of the expected length of stay (ELOS) and estimated discharge date (EDD). At least 24 hours before discharge, CPS confirms the patient's care arrangements with the homeless service provider to ensure readiness for their arrival.
4. Dedicated Liaison:	- Provide a liaison officer to support discharge cases.
5. Participation:	- Attend Integrated MDT meetings to assist with complex discharges.
6. Emergency Support:	- Continue accommodation efforts for unresolved cases and follow up on self-discharges.

Homeless Service Providers: Readiness checks, integrated care plan execution.

1. Discharge Planning:	- Notified by CPS and involved in planning with ELOS/EDD updates.
2. Communication:	- Confirm care readiness 24 hours before discharge.
3. Integrated MDT Participation:	- Attend MDTs for complex cases or share concerns in their absence.
4. Accommodation:	- Notify CPS immediately if unable to accommodate; consult with doctors or social workers as needed.
5. Discharge Summaries:	- Receive summaries (with consent) before discharge.
6. Support Coordinator:	- Collaborate to arrange care packages for high-need patients.

Roles and Responsibilities of Stakeholders (continued)

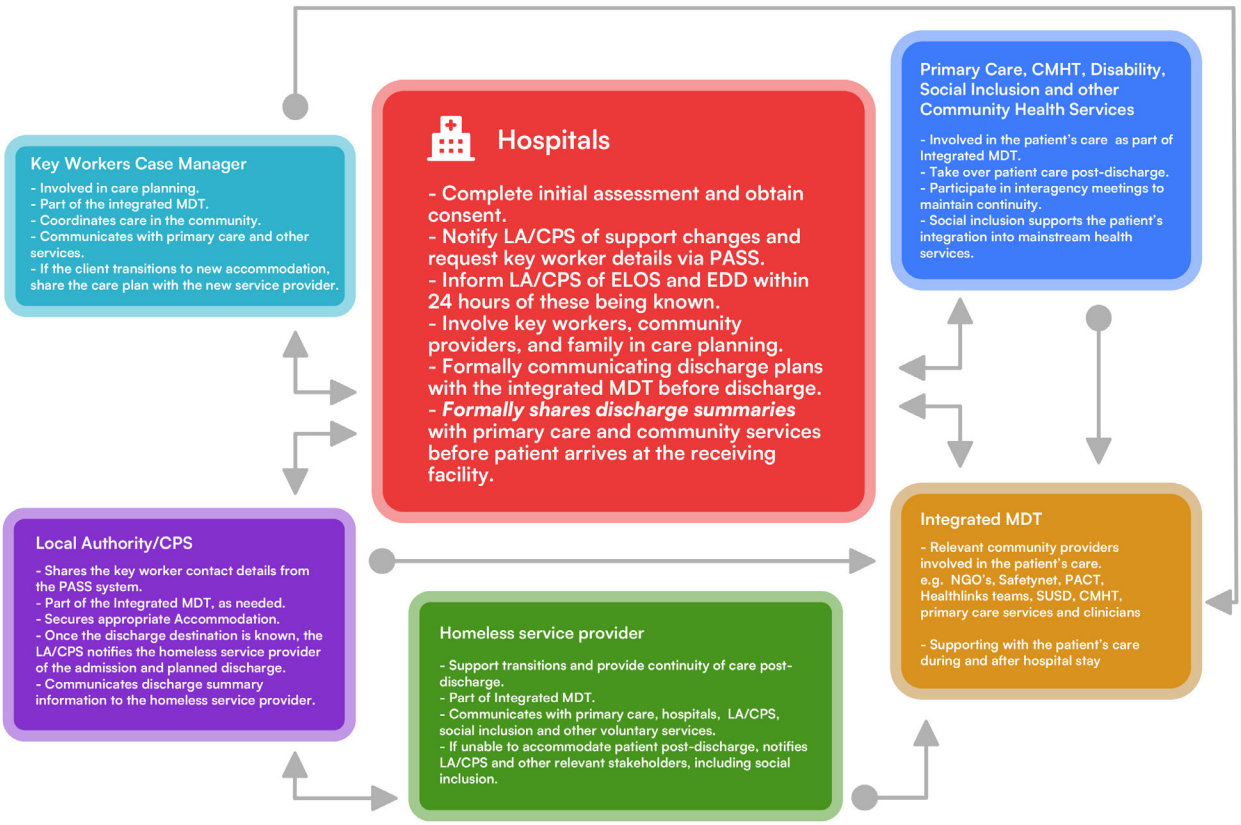
Primary Care/Community Services: Follow-up medical needs, ongoing care.

1. Primary Care and Public Health Nurses (PHNs):	- Manage post-discharge care, attend MDTs, and make referrals to other services. - Patients must have a GP and Medical Card for required equipment
2. Community Mental Health Teams (CMHT):	- Support mental health needs during and post-discharge. - Facilitate continuity of care if clients relocate. - Provide crisis contacts and ensure follow-ups.
3. Social Inclusion Services:	- Support transitions from hospital to community care. - Engage with key workers to address issues during recovery. - Promote mainstream service access for homeless individuals.

Key Workers/Case Managers: Care coordination, advocacy, continuity post-discharge.

1. Primary Contact:	- Serve as the main support throughout discharge.
2. Care Coordination:	- Collaborate with hospital teams to create and update care plans.
3. Continuity of Care:	- Support follow-ups, including outpatient appointments and medical card arrangements.
4. Local Knowledge:	- Refer patients to local health and housing resources.
5. Patient Advocacy:	- Assess and address urgent physical, mental health, or substance use needs.
6. Medication Adherence:	- Ensure prescriptions are current and appointments are kept.
7. MDT Participation:	- Represent patients in MDTs to align care plans with their needs.

Communication and Information Flow



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