**What happens if you leave hospital, and you are homeless?** **Two stories**

These true case studies were co-produced by a *Peer Research Advisory Group* of ‘Experts by Experience’, as part of a national [research](https://www.kcl.ac.uk/research/hospital-discharge-and-homelessness) study led by [HSCWRU](https://www.kcl.ac.uk/research/homelessness-research-programme) at King’s College London into people who are homeless being discharged to the street. Permission to share them was given by Group members Mrs A and Mr B (not real names).



**The story of the Gutter Frame Challenge**

**Tuesday**

**0 miles**

Mrs A has been in hospital for nearly three weeks. She is offered a flat many miles from the area she calls home but does not want to take it - her preference is to go to a local hostel where she would have some company and support. Having spent many years living on the streets, Mrs A does not feel ready to have her own place yet. Mrs A is told that the flat is the only option available and that she must leave hospital if she does not take it.

Mrs A is discharged from hospital to the street and told to present at a specialist homeless GP practice at 9am the following morning to organise a methadone prescription. She has had a long wait for her medications to arrive and it is now 7.30pm. She is very upset and crying. It is the middle of winter and cold and wet outside. Following a brutal assault on the street which put her in hospital, Mrs A is unable to walk without a gutter frame. This is heavily ladened with all her worldly possessions in plastic bags. Walking is painful and slow and any unevenness in the pavement causes dangerous instability. Mrs A has no money, and it is a 0.6 mile walk to her usual sleep site: she sleeps in a shop doorway where there are security cameras and where the security guards know and look out for her. She has a panic alarm, but the batteries are dead. The man who assaulted her was never apprehended.

**0.6 miles**

**Wednesday**

Mrs A sets off early to get registered with the GP and to get a methadone prescription. It is a 1.1 mile walk to the surgery and access is on a first come, first served basis. Mrs A gets there in good time but the gate to the disabled access ramp is locked. By the time someone opens it, there is a long queue and Mrs A is now at the back. The surgery is warm and welcoming and caters specifically for people who are homeless. Mrs A is offered a much-needed cup of tea.

**1.7 miles**

At 10.30 am Mrs A is called in to see the nurse. The nurse calls in the GP immediately as she is concerned that Mrs A has been discharged to the street. The GP phones the ward to find out what has happened and is angry that responsibility for this situation has been passed to him. It is agreed that Mrs A’s health needs are such that she should not be on the streets, but that she cannot return to hospital. The only option is an intermediate care bed - these are hostel beds funded by the NHS. There are only two intermediate care beds for women in this borough and they are in exceptionally high demand. The GP does not have ‘referral rights’ into the beds so she tells Mrs A that she must come back to the surgery first thing in the morning to be assessed by the scheme coordinator. Mrs A is advised to go the local homeless day centre to see if she can access emergency accommodation for tonight. The receptionist phones ahead to make the case that Mrs A is a priority. The centre is 0.6 miles from the surgery.

**2.3 miles**

At the homeless day centre, there is no disabled access to the service user reception area so Mrs A must access the building through the entrance reserved for visitors. The message from the Doctor’s surgery has not been received and she must tell her story once more. The worker agrees that Mrs A is vulnerable and rings around to see if she can find her a bed for the night. Good news! There is a bed available in a local women’s hostel. However, the doors do not open until 9.30pm and Mrs A must now kill a significant amount of time as it is only 3.30pm. Mrs A is exhausted and feeling sick. She has been laid-up in a hospital bed for the last three weeks, and today’s exertions are a shock to the system. Just as she is about to leave the day centre, Mrs A thinks to ask if the hostel has disabled access. The worker goes off to check and returns to tell her that there are stairs. Mrs A has now run out of options. The day centre tells Mrs A there is nothing more they can do. It is a 1.4 mile walk back to Mrs A’s sleep site.

**3.7 miles**

**Thursday**

Mrs A is physically exhausted and emotionally drained from yesterday. She does not complain, but there is a grimace on her face when she tries to push the heavily laden gutter frame. She has septic arthritis, and her joints are painful and inflamed. She is still on antibiotics. Before getting back to the Doctor’s surgery for 9.15am, Mrs A must collect her methadone. The GP insists that Mrs A uses a specific chemist which is a 1.1 mile walk from her sleep site. From the chemist, it is a further 1.6 mile walk back to the Doctor’s surgery. The surgery is exceptionally busy. Although advertised as a flexible service, in reality everyone has the same appointment time and late comers are turned away, such is the demand for this service.

**4.8 miles**

At 11.30am Mrs A sees the nurse who assesses people for the intermediate care beds. Mrs A recounts her story once more. The nurse tells Mrs A that these beds are for ‘health and not social reasons’. Hearing this, Mrs A’s heart sinks as she assumes that she will not be eligible. However, the nurse is concerned about Mrs A’s ability to manage her medications: Mrs A has a carrier bag full of pills. The nurse phones through to the intermediate care bed coordinator to try to reserve a bed for Mrs A, but there is no reply. She tells Mrs A to wait for news in the reception area.

**6.4 miles**

While she is waiting, the nurse advises Mrs A to go to a local chemist to see if she can get the medications put into a dosset box. The nurse says she will have to pull in a favour, as pharmacists usually only handle medication they have dispensed. It is an 0.2 mile walk to the chemist. The pharmacist is concerned by what he sees in the carrier bag that has been dispensed by the hospital and phones the GP to alert her. A plan is hatched to box-up a few days’ supply, and for Mrs A to have a medication review next week. The chemist is busy and asks Mrs A if she can return at 3pm. It is now 12.30pm so she has a long time to wait around in the cold. Mrs A is exhausted and wonders if it just might be easier just to give-up and go back to her sleep site.

**6.6 miles**

After picking-up the dosset box, Mrs A walks the 0.2 miles back to the Doctors’ surgery and takes a seat in reception. After half an hour the receptionist comes over to ask why Mrs A is here. Mrs A explains that she is waiting to hear news about an intermediate care bed. Another receptionist makes some phone calls and returns to say that a bed will be available tomorrow night. She asks Mrs A where she will be sleeping tonight. When she hears that it will on the street, she goes off again and later returns to say that a bed has now been found and that a taxi will be coming to pick her up. Mrs A is very grateful that the receptionist is so kind and has gone the extra mile. Seeing how tired Mrs A is, the receptionist organises the paperwork that Mrs A must sign. This includes a ‘care plan’ outlining the rules by which she must abide. At 3.30pm the taxi arrives. The bed is only short term, but at least Mrs A now has ten day’s grace from the cold and wet.

**6.8 miles**

**Postscript**

In order to access care and support following her discharge from hospital, Mrs A was expected to walk 6.8 miles in winter with her gutter frame and all her worldly possessions. The researchers who helped Mrs A tell this story paid for her to have taxis and hotel accommodation rather than let her sleep on the street. Without this practical assistance this would have been an impossible challenge.

Several years later, Mrs A is in employment, working full time to improve research on homeless social care and health services and to champion ‘lived experience’ voices within research and practice.

**A story about the cycle of A&E attendances, discharges to the street and multiple readmissions**

Mr B visits the GP on 1 May 2019 as his health has worsened. He suffers from COPD, PTSD and bi-polar disorder and recently started to drink heavily to manage his deteriorating mental health. Mr B is referred to the CMHT, but the referral is not accepted. He is a former rough sleeper now living in supported accommodation for veterans but feels unsupported by staff and fellow residents.

**13 – 16 May 2019**

Mr B has severe stomach pains and is taken to A&E and admitted to Hospital 1 for two nights. He is discharged with 20 codeine, but the following day takes an accidental overdose. He has forgotten how much codeine he has already taken due to his drinking. Mr B is re-admitted to A&E but discharged the same evening, after assessment by psychiatric liaison, with no follow-up plan.

**20 May – 2 June 2019**

Mr B has been drinking heavily – he has a violent outburst and damages his accommodation. He is evicted to the street with one hour’s notice. A friend is so concerned about his mental health and substance misuse they take him back to A&E at Hospital 1 where he is admitted to the assessment ward. After two nights Mr B is told he is fit for ‘discharge home’. Mr B does not have a home and his friend reminds staff that they have a ‘duty to refer’ so Mr B’s discharge is delayed. The friend makes a safeguarding referral to adult social care. Meanwhile, Mr B is passed between the psychiatric liaison and medical teams until finally, a case conference is convened. The hospital discharge team start a Care Act 2014 assessment.

**3 - 17 June 2019**

Before the Care Act or any other assessments are complete, Mr B is discharged from Hospital 1 to the local authority housing service with no discharge letter or plan. Mr B is placed in temporary accommodation, but it is inappropriate for his needs. Two days later concerned accommodation staff call the CMHT, who in turn call an ambulance. Mr B is readmitted to Hospital 1 A&E, and from there to the psychiatric unit. After six days on the unit Mr B is discharged to the street because of drinking on the ward. It is 6pm and Mr B is homeless. He travels to the centre of London to sleep rough. The next morning Mr B is found unconscious on the street by police and taken to A&E at Hospital 2. He spends five days on an assessment ward and when a bed becomes available, he is admitted to a psychiatric unit at Hospital 3, in another area of London.

**18 June – 3 July 2019**

Whilst in the psychiatric unit at Hospital 3 Mr B asks that a ‘duty to refer’ notice be sent to the housing service. This is refused, so his friend contacts the housing service to make an appointment. The first available is 4 July. After 11 days in the unit Mr B is discharged to the street with no support, and no inhalers for his COPD. Staff know there are six days until his housing appointment. Having nowhere else to go, Mr B sleeps rough in the hospital garden. Staff take him food but do not act to safeguard him. After five nights Mr B is found collapsed, due to exacerbation of his COPD. He is taken to Hospital 3 A&E but self-discharges to the street as he is made to feel unwelcome by staff.

**4 – 12 July 2019**

It is finally the day of Mr B’s housing appointment, but he is very ill due to exacerbation of his COPD from sleeping rough. Instead of attending the vital appointment, Mr B attends Hospital 4 A&E and is admitted to hospital. After one week, Mr B is ‘signposted’ to the local housing authority where he is at last provided with temporary emergency accommodation. However, the property is a bus ride away and Mr B has no money or directions. Mr B has to sleep rough that night. The following day he moves in. The accommodation is temporary so now Mr B is looking for somewhere to go next…

**Postscript**

Mr B was a valued contributor to a number of research studies that aimed to improving health and social care services for people experiencing multiple exclusion homelessness. He died, in his 40s, in 2021.