Ending Street Discharge

A delivery paper for national policy makers

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Introduction

> ***"The evidence revealed that with proper discharge planning and care his death would probably have been avoided".***
>
> *Coroner, Prevention of Future Death report.*

In 2024/25, there were more than 10,000 occasions where someone was discharged from hospital to the street – a 17% increase on the previous year[1]. This is an unacceptably dangerous and inhumane way to treat people who are recovering from illness. It is also deeply inefficient. Without a safe place to recover, people's health is put at risk again, perpetuating the cycle of readmission to hospital.

In 2024, 1,611 people died whilst homeless in the UK, an average of four needless deaths every day[2]. Recent research[3] tells us that inadequate discharge arrangements from institutions, including hospitals, were the most commonly cited contributing factor in preventable deaths of people experiencing homelessness identified in coroners' Prevention of Future Death reports.

Against this backdrop, the Government's National Plan to End Homelessness, published in December 2025, marked a crucial and welcome step forward. The Plan recognises the central role that health services must play in preventing and responding to homelessness, reflecting a growing understanding that good health and housing are inseparable. And that, most importantly, when systems fail to work together, people experiencing homelessness face serious, cumulative, and sometimes extreme health harms.

Most significantly in this space, the Ministry of Housing, Communities and Local Government (MHCLG) committed to a target that no one eligible for homelessness assistance is discharged to the street after a hospital stay. Whilst we welcome the Government's recognition that street discharge is a ''deeply harmful outcome'', the task now is to close the substantial gap between this ambition and the reality experienced by thousands of patients every year.

Work to achieve this target will also be crucial to delivering the Government's wider ambition to halve long-term rough sleeping. People with long histories of rough sleeping attend hospital at disproportionately high rates, often because unmet health and support needs have been perpetuated by a lack of effective intervention elsewhere in the system. When done right, an admission to hospital provides a major opportunity to intervene in someone's homelessness and prevent returns to rough sleeping.

This paper is aimed at national policymakers across the MHCLG and the Department of Health and Social Care (DHSC). Delivering the Government's target will require concerted action across both departments, alongside NHS England, local authorities, Integrated Care Boards (ICBs) and Integrated Health Organisations (IHOs).

Drawing on years of evidence and frontline experience from across the sector, this paper sets out the key changes needed to make this commitment a reality. The recommendations combine pragmatic actions that could be implemented within existing system and resource constraints with the longer-term reforms required to fully realise the Government's ambition that no on eligible for homelessness assistance is discharged from hospital to the street. Both are necessary if Government's ambitions are to become a reality. Key pillars include:

- A programme of sustained national leadership and system reform, underpinned by a shared definition and understanding of unsafe discharge;
- Strengthening in-patient care quality and hospital discharge planning with support to implement existing guidance on the frontline. Hospitals seeing high numbers of patients experiencing homelessness should be supported to commission specialist multidisciplinary teams to coordinate care;
- Investing in safe places for patients to be discharged to through the expansion of specialist homelessness intermediate care;
- Removing eligibility barriers that prevent vulnerable patients from accessing safe discharge pathways;
- Strengthening the infrastructure for accountability through improved data collection, routine recording of unsafe discharge, and local and national oversight mechanisms designed to monitor progress and drive improvement.

1. Delivering a national programme to end unsafe discharge

National leadership and sustained system reform

The following chapters set out the core pillars required to deliver the Government's target to end the practice of discharging patients from hospital to the street. However, these interventions will only succeed if they are underpinned by a package of sustained national leadership and system reform.

Historically, support for people experiencing homelessness within health and care systems has too often depended on short-term funding cycles, local champions, and time-limited initiatives. When national direction and dedicated funding are withdrawn, services frequently become unsustainable and are closed down. In financially constrained environments, specialist services are frequently deprioritised or seen as ''nice to have'' by local commissioners, who are managing competing operational pressures.

The Out-of-Hospital Care Models Programme (OOHCMP), the most significant Government investment focused on safe discharge for people experiencing homelessness, demonstrated positive outcomes including reductions in street discharge, improved patient experiences, and produced cost savings for the NHS[4]. And yet, once the programme ended, many test sites lacked the resources required to embed successful models within baseline budgets or maintain and expand provision. It demonstrated positive impact, but its longer-term impact was limited by short-term funding cycles and the absence of longer-term policy and system reform.

The experience of the OOHCMP illustrates the need for targeted national intervention. Without sustained political focus, clear national expectations, accountability mechanisms and long-term policy direction, any progress made will be vulnerable to changes in local priorities and funding pressures.

Establishing a shared definition of unsafe discharge

As an initial step towards implementation, MHCLG and DHSC should agree and publish a joint definition of ''unsafe discharge''. While discharge to the street represents the very worst instances, unsafe discharge extends more broadly to situations where people are discharged into inappropriate, unstable, or temporary arrangements that are not conducive

with recovery, such as emergency hotel placements or accommodation that cannot meet a person's care and support needs.

A shared national definition would help establish clearer expectations across local systems, indicating the need to respond to the needs of people facing some of the most extreme health inequalities as a core responsibility. It would also support the consistent recording and reporting of unsafe discharge, as explored further in Chapter 5.

2. Improving in-patient care and appropriate discharge planning

Improving the quality of care that people experiencing homelessness receive from the point of a hospital admission is the first step in ending unsafe discharge to the street. People experiencing homelessness are admitted to hospital at a disproportionate rate when compared to the general population, with an estimated 176,000 homeless hospital admissions in England in one year – more than the number of admissions for stroke in the same year.[5] Assessing new patient referrals as soon as possible after their admission to hospital gives hospital staff the most time possible to build a relationship of trust with the patient, to support and advocate for them in hospital and allows more time for comprehensive care and discharge planning. Too often, housing insecurity is identified too late in a patient's hospital stay, discharge planning is fragmented, and opportunities to coordinate support are missed. Delivering the Government's target will therefore require a more consistent, holistic and multidisciplinary approach to discharge planning for this patient group.

Support to transform capability at the front line and in commissioning

A positive foundation already exists in the form of guidance published by MHCLG and DHSC on *Discharging people at risk of or experiencing homelessness*[6], which Government have committed to implement in order to achieve their target. The guidance provides practical tools, examples of good practice, and step-by-step approaches that can be adopted locally. In particular, it highlights the value of embedding specialist housing officers within Care Transfer Hubs so that housing needs are identified and addressed as part of discharge planning from the outset.

Implementation of this guidance should be supported through a national programme of training and improvement support for NHS trusts, ICBs, IHOs and local authorities. This could include regional training and education roadshows to raise awareness of the guidance and new agreed definition of unsafe discharge, share examples of effective local models and commissioning arrangements, and provide space for systems to work through practical barriers collaboratively. As part of this programme, local areas should also be supported to undertake a structured self-assessment against the guidance to identify gaps, measure progress and strengthen understanding of unsafe discharge. There should be a feedback loop to policy development, with MHCLG, NHSE and DHSC working together to address the common barriers across systems.

Commissioning specialist multidisciplinary hospital teams

The Government's commitment to embedding housing officers within hospital discharge teams represents an important step forward. However, this approach alone stops short of the truly multidisciplinary model recommended by the National Institute for Health and Care Excellence (NICE).

Safe discharge for people experiencing homelessness often requires coordinated responses to multiple and interconnected needs, including physical health, mental health, substance misuse, safeguarding concerns, housing insecurity and access to welfare support. These needs cannot be addressed effectively through housing input alone.

Specialist, clinically-led, multidisciplinary hospital teams working in the Pathway Partnership Programme already model this more effective way of working, showing what is possible when expertise is brought together across agencies and when a patient's housing and support needs are identified from the moment of admission.

Evidence shows that of the patients supported by Pathway hospital teams in 2024/25, rough sleeping was reduced by 62% and sofa surfing by 33%[7]. This builds on an earlier randomised control trial showing reductions in street homelessness and improvements in quality of life for patients treated by Pathway teams[8].
Pathway teams are able to deliver these outcomes because they provide holistic, coordinated support that addresses the wider factors impacting safe discharge. Their role typically involves:

- Convening multidisciplinary discharge planning meetings involving housing, Adult Social Care, safeguarding teams, and voluntary sector partners;
- Coordinating referrals into key health and support services, including drug and alcohol treatment;
- Helping patients establish entitlement to benefits and housing assistance;
- Monitoring and reviewing all self-discharges and discharges to the street, recognising these events as serious safeguarding concerns that require follow-up; and
- Training frontline hospital staff to challenge stigma and improve understanding of homelessness and inclusion health.

This level of coordination and clinical oversight cannot be delivered through a single housing worker embedded within a discharge hub alone. Effective discharge planning depends on the development of trusted relationships between patients and hospital staff, enabling a full understanding of an individual's circumstances. Building this trust requires time, continuity and specialist engagement. Without it, patients may be reluctant to disclose the realities of their situation and are more likely to self-discharge before completion of treatment or safe discharge planning.

To support delivery of Government's target, all hospitals should therefore be expected to appoint a homelessness lead nurse alongside embedding a housing worker within Care Transfer Hubs. Hospitals seeing more than 200 patients a year facing homelessness should be expected to commission a specialist, multi-disciplinary team to oversee care co-ordination and safe discharge planning.

To help systems to commission these interventions in proportion to the scale and profile of local needs, local areas should be supported to undertake specialist homelessness health needs assessments. Local commissioners should be encouraged to model their assessment of the number of hospital admissions for people experiencing homelessness on the methodology described by Luchenski et al in their population-based estimation study[9].

Adult social care

People experiencing homelessness frequently present with complex safeguarding and social care needs that must be explicitly addressed within their hospital discharge planning. Just under half of patients seen by hospital teams in the Pathway Partnership Programme in 2024/25 had identified safeguarding needs[10].

If the Government is to meet its ambition of ending hospital discharge to the street, it will need to take steps to strengthen adult social care and local authorities safeguarding responses for people facing homelessness. This should align with commitments made in the National Plan to End Homelessness, including:

- Reviewing and updating relevant sections of the Care Act 2014 statutory guidance in relation to local authorities' safeguarding duties and their application to people at risk of homelessness; and
- Publishing new support guidance to support frontline staff across health, housing and social care to respond effectively to common and recurring challenges in practice.

3. Creating safe places for recovery

The need for specialist intermediate care

The practice of discharging patients to the street persists in part because there has never been sustained investment in safe places where people without homes can recover after a hospital stay.

Mainstream intermediate care services which are designed to focus on physical reablement are often inaccessible to this group, meaning that there currently aren't enough safe places available for people facing homelessness to recover when they are discharged from hospital. Referrals are frequently declined because:

- patients fall outside the intended age profile for services such as care homes, despite people experiencing homelessness developing frailty and age-related conditions much earlier than the general population;
- services may lack the resources or appetite to respond to complex health and social needs; and
- securing appropriate move-on accommodation can be more challenging for this patient group as a result of these complex needs, so patients are refused because of their housing needs.

Specialist step-down accommodation from hospital, often described as specialist homelessness intermediate care, fills this gap by providing safe, supportive accommodation

where people can recover from illness while professionals work to secure longer-term housing and support. Specialist intermediate care has been shown to be cost effective, and deliver improved patient outcomes, when compared to standard discharge arrangements, especially when linked to a homeless hospital discharge team, such as a Pathway team.[11]

While mainstream intermediate care tends to focus on reablement, specialist homelessness intermediate care provides personalised treatment with a focus on recovery. The core components often include medical in-reach support, social support such as attending appointments and making applications for welfare assistance, as well as co-ordinated planning around more permanent housing[12]. The overall purpose is the same as in mainstream contexts – achieving a safe and appropriate discharge and preventing avoidable readmissions.

The need for specialist intermediate care, and its effectiveness, is very well documented. A snapshot inpatient audit in 2022 found that four in ten patients experiencing homelessness were projected to need short-term intermediate or step-down care following hospital discharge[13]. NICE guidance[14] recommends specialist intermediate care for this group, and evidence suggests it can reduce returns to rough sleeping by around 70%[15]. This is transformative for individuals and can significantly reduce pressure on acute services, as well as contributing to the Government's overall target to halve long term rough sleeping. Evaluation of services commissioned as part of the OOHCMP[16] found a 56% reduction in A&E attendance and a 67% reduction in emergency admissions, generating NHS savings of approximately £47,000 per patient.

Specialist intermediate care is also needed to make the Discharge to Assess (D2A), a key operational model for hospital discharge, work safely and effectively for people experiencing homelessness. Pathway 0 stipulates that patients with no ongoing health or social care needs should be discharged to their usual place of residence. Without the appropriate specialist intermediate care facilities available for this patient group, hospital discharge teams often default to this pathway without consideration of any wider care or support needs for patients without a home to be discharged to, driving unsafe discharges, including to the street.

The evidence about what works in securing safe, timely transfers of care between hospital and home has been synthesised by the Local Government Association in the High Impact Change Model[17]. Specialist intermediate care services should be embedded across D2A pathways 0-3 to provide alternatives for people who cannot safely return home.

Implementing the nine High Impact Changes within these specialist service models, through the Better Care Fund (BCF), is critical to reducing health inequalities and delivering safe, person-centred discharge arrangements for this population[18].

Funding specialist intermediate care

To support delivery of its target to end street discharge, the Government has committed to working with local authorities and Integrated Care Boards (ICBs) to improve how existing funding streams, including the BCF can be used to fund intermediate care services tailored for those experiencing homelessness.

In principle, the BCF is well placed to support this ambition. It is designed to facilitate the delivery of integrated health and social care and is the main policy lever for funding and delivery to support safe and timely hospital discharge. However, in practice, the BCF policy framework has historically been orientated specifically towards older people. Despite the Government's commitment in the National Plan to End Homelessness, the 2026/27 BCF policy framework[19] did not include any explicit reference to homelessness, unsafe discharge, or the need for specialist intermediate care. As in previous years, the framework's success metrics remained focused primarily on reducing delayed discharges and non-elective admissions among people aged 65 and over.

There is a significant opportunity to address this oversight within the current policy context. Health and Wellbeing Boards, ICBs, and local authorities are increasingly being asked to align BCF arrangements with neighbourhood health ambitions and wider strategies for priority populations, including people living with frailty and multiple long-term conditions. People facing homelessness have health profiles that closely mirror these cohorts: research shows that 41% of people facing homelessness experience premature frailty between the ages of 18 and 59[20].

To ensure there are sufficient safe places for recovery available for everyone who needs them, the BCF requires substantial reform. As a first step, Government should ensure that the needs of people facing homelessness are considered in the 27/28 iteration of the BCF policy framework by:

- Reviewing the definition of intermediate care within the BCF framework so that it better reflects the needs of people experiencing homelessness, with a stronger emphasis on recovery.
- Explicitly identifying specialist intermediate care services for people experiencing homelessness as a consideration within the BCF planning arrangements.
- Requiring local areas to assess demand for specialist step-up and step-down pathways for people experiencing homelessness as part of BCF planning and commissioning processes.
- Requiring local systems to evidence how BCF assessments and funded services are supporting delivery of the Government's commitment to end unsafe and inappropriate discharge to the street.
- Supporting local areas to strengthen alignment between BCF planning and their neighbourhood health plans to ensure that the needs of people experiencing homelessness are reflected within integrated service design.

Changes to formal planning requirements and national conditions could also be supported through targeted engagement from regional BCF managers, alongside webinars, guidance, and shared learning resources to strengthen local understanding of the need for intermediate care settings which meet the need of people facing homelessness.

Government should monitor progress against these changes to the BCF policy framework over the first year of implementation and, if gaps in provision persist, introduce minimum ringfenced financial contributions for specialist intermediate care provision which is tailored to meet the needs of people facing homelessness in future iterations.

Reforming the BCF to incentivise local areas to direct resources towards specialist intermediate care for people facing homelessness would be a pragmatic first step that government could take within current resource. However, given the uncertainty around the long-term future of the BCF and the unknown true scale of need (see chapter 5), there is also a strong case for implementation of a longer-term programme underpinned by ringfenced funding. Existing econometric analysis[21] estimates substantial unmet need, with around 32,600 patients experiencing homelessness expected to require specialist intermediate care each year. Investment into a programme of specialist intermediate care is also projected to deliver a positive return on investment, with every £1 invested returning £1.20 in financial savings and generating £4.30 in wider societal value. To support effective planning, government should build its own evidence base on both levels of need and

existing provision through a national mapping exercise to identify services that could be scaled up. These findings should then inform consideration of ringfenced funding for a specialist programme as part of the next Spending Review.

4. Removing eligibility barriers to support

Government's ambitions to end the practice of street discharge will not to be fully realised for as long as restrictive eligibility rules continue to exclude some of the people at greatest risk. Immigration law and the wider immigration policy environment act as a barrier to safe discharge, particularly for people experiencing homelessness who are subject to no recourse to public funds (NRPF) conditions. For example, even where appropriate intermediate care services currently exist, people with insecure or uncertain immigration status are often denied access. Unless they meet the threshold for support under the Care Act 2014, many are excluded from accommodation-based intermediate care despite the serious risks associated with being discharged into homelessness and destitution.

No one should be subjected to unsafe hospital discharge, regardless of their eligibility for homelessness assistance. In the longer term, MHCLG and DHSC should work with partners across Government to remove eligibility criteria from their target to end hospital discharge to the street, ensuring that all patients have a right to somewhere safe to recover after a hospital stay.

In the meantime, Government should act to embed and expand existing good practice. Specialist intermediate care services in areas such as Bradford and North East London already accept referrals for patients with NRPF conditions, demonstrating that it is possible for those who are not eligible for homelessness assistance to experience a safe hospital discharge. In practice, however, access to independent legal advice is often an essential first step in securing intermediate care placements by supporting patients to navigate complex immigration and housing policy, challenging decisions where statutory duties are not being met.

Case Study – Pathway Partnership Programme

Mr A, an elderly man with dementia, diabetes, a history of heart attacks and a stroke, had lived in the UK since 1969 but lacked documentation confirming his immigration status. As a result, he was deemed ineligible for supported housing or care home placement. There

was a pattern of him being discharged to unsuitable hostel accommodation that led to multiple hospital readmissions.

A Pathway team referred Mr A to legal advisers, who gathered evidence to demonstrate that he had settled, lawful status in the UK. As a result of Southwark Law Centre colleagues' efforts, Mr A was eventually referred to a care home and now resides in supported accommodation.

Government should ensure that patients at risk of being discharged into homelessness have access to specialist legal advice to support access to appropriate intermediate care. Government should also ensure that reform of existing funding programmes and new ringfenced funding promotes the scaling up of existing provision which accepts patients subject to the NRPF condition.

5. Building the infrastructure for system accountability

Government's target to end discharges from hospital to the street will only succeed if local systems are able to identify unsafe discharge, record it consistently, and are held accountable for improvement.

Establishing a shared definition of unsafe discharge

As addressed earlier, a shared national definition of unsafe discharge would help establish clearer expectations across local systems, indicating the need to address the needs of people with facing some of the most extreme health inequalities. It would also support recording and monitoring of the problem.

Addressing the data gap and the need for recording

Limitations in data collection means that the true scale of street discharge remains unknown, limiting Government's ability to assess need, allocate resources effectively and, ultimately, track progress made against their commitment. Government's target simply cannot be realised without robust reporting of unsafe discharge, in line with an agreed definition.

It is well established that people in inclusion health groups are often invisible in healthcare data[22]. The consequences are stark; these populations are often overlooked in local needs assessments and service planning, underrepresented in national policy development, and absent from accountability frameworks designed to drive improvements in outcomes.

This challenge is particularly acute in relation to hospital discharge. In the absence of a standardised indictor for homelessness across the NHS, there is currently no systematic way to accurately record or identify patients who are discharged from hospital into homelessness. Existing national datasets provide only partial or secondary insight:

- **Hospital Episode Statistics (HES)** allow us to identify patients recorded as having No Fixed Abode (NFA) at the point of admission. However, while HES includes a discharge destination field, it does not contain a category that captures discharge into homelessness or the street. NFA is also an imperfect proxy. It may include individuals who are not experiencing homelessness (for example, some nomadic groups or people living on boats), while excluding many who are, such as those in temporary accommodation or sofa surfing who can provide an address. As such, it is likely to significantly underestimate the true scale of homelessness in hospital episodes.

- The **Acute Discharge Situation Report** captures overall discharge activity and some information on discharge destinations. However, it does not include detailed housing outcomes. While homelessness may be recorded as a reason for delayed discharge, the dataset does not track where these patients are ultimately discharged to.

Data collected by the MHCLG offers additional but still incomplete insight into the interface between hospital discharge and homelessness:

- The **Rough Sleeping Management Information** dataset provides estimates of people sleeping rough who have left an institution (including hospitals) within the previous 85 days. It captures only rough sleeping, not the broader definition of homelessness, meaning it does not account for individuals who experience unsafe or inappropriate discharge without returning to rough sleeping. This measure is based on snapshot estimates from a single night, partially relying on self-reporting, limiting its robustness.

- The **Homelessness Case Level Information Collection (H-CLIC**) records local authority activity under statutory homelessness duties, including referrals from hospitals. While it can indicate the number of referrals made on behalf of patients identified as being at risk of homelessness, it does not capture the housing outcomes of those individuals. In addition, evidence suggests that referrals are not consistently completed, despite the statutory duty to do so[23].

There has already been some progress made in this area. Co-produced housing status codes have been incorporated into the NHS Data Dictionary, with categories such as ‘’rough sleeper’’, ‘’temporary accommodation’’, and ‘’night shelter’’ now available within datasets such as the Mental Health Service Data Set (MHSDS) and the Emergency Care Data Set (ECDS). The need to record housing status is also now recognised in NHS England’s statement on information on health inequalities[24], which sets out expectations on healthcare bodies to record and gather data for the purposes of addressing health inequalities.

However, use of these fields remains inconsistent and non-mandatory. As of February 2024, the housing status field in MHSDS had a completion rate of just 21%[25]. This reflects, in part, a lack of confidence and clarity among frontline staff about how to ask patients about their housing situation. Equipping the workforce with the guidance, training and confidence to ask appropriate questions, and record responses in line with NHS England’s guidance, will be an important first step in addressing the data gap.

In the longer term, Government should mandate the routine recording of housing fields across all health datasets, building on existing standards established within MHSDS and ECDS, driven by existing detailed implementation plans[26]. This would be a high impact intervention that would drive a measurable difference across the extreme health inequalities faced by people in inclusion health groups.

However, the scale of invisibility of this issue means that more immediate action is also required. Government should develop a near-term mechanism for the routine recording and reporting of unsafe hospital discharge for people experiencing homelessness, aligned to the agreed national definition, either through amendments to existing datasets such as the Acute Discharge Situation Report or through the development of a dedicated reporting mechanism.

Monitoring and performance oversight

Improved data collection must be accompanied by meaningful accountability mechanisms. Without clear oversight arrangements, unsafe discharge is likely to persist despite Government's ambitions.

Strengthening local accountability

Local homelessness action plans should include explicit plans relating to safe hospital discharge, agreed jointly between local authorities, NHS trusts and ICBs.

These plans should be signed off by director-level representatives within relevant NHS trusts and ICBs and should:

- Identify named leads responsible for safe hospital discharge at both trust and ICB level;
- Outline how partners will coordinate discharge planning across health, housing and social care systems;
- Demonstrate alignment with neighbourhood health planning and BCF planning processes; and
- Include clear local objectives and performance measures relating to unsafe discharge.

Embedding these requirements within local homelessness action plans would help ensure that safe discharge is treated as shared system responsibility.

National performance oversight

At a national level, Government should establish a joint MHCLG-DHSC improvement and oversight programme focused on areas experiencing persistent challenges with street and unsafe discharge. This programme should work with areas where reporting indicates high levels of unsafe discharge and where local performance metrics, as outlined in homelessness action plans, are not being met.

The support programme should be jointly led by MHCLG and DHSC and involve expertise from across local government, the NHS, adult social care, homelessness services and BCF leadership. Its role would include identifying barriers to local implementation and supporting local systems to improve discharge pathways in line with Governments ambitions.

Recommendations for delivery

1. Delivering a national programme to end unsafe discharge

- MHCLG and DHSC should publish a joint definition of ''unsafe discharge'' to help generate the impetus needed to deliver their target, establish clearer expectations of local systems, and to support recording and monitoring.

2. Appropriate and timely discharge planning

- Implementation of the *Discharging people at risk of or experiencing guidance* should be supported through a national programme of training and improvement support for NHS trusts, ICBs, IHOs and local authorities. As part of this programme, local areas should be supported to undertake a structured self-assessment against the guidance to identify gaps, measure progress and strengthen understanding of unsafe discharge in line with the agreed definition.

- All hospitals should be expected to appoint a homelessness lead nurse alongside embedding a housing worker within Care Transfer Hubs. Hospitals seeing more than 200 patients a year facing homelessness should be expected to commission a specialist, multi-disciplinary team to oversee care co-ordination and safe discharge planning.

- To help systems to commission these interventions in proportion to the scale and profile of local needs, local areas should be supported to undertake specialist homelessness health needs assessments.

3. Creating safe places for recovery

- Government should ensure that the needs of people facing homelessness are explicitly reflected within the 27/28 iteration of the BCF policy framework.

- Changes to formal BCF planning requirements should be supported through targeted engagement from regional BCF managers, alongside webinars, guidance, and

shared learning resources to strengthen local understanding of the need for intermediate care settings which meet the need of people facing homelessness.

- If gaps in provision persist, Government should introduce minimum ringfenced financial contributions for specialist intermediate care provision which is tailored to meet the needs of people facing homelessness in future iterations of the BCF framework.

- Government should build its own evidence base on levels of need for specialist intermediate care and existing provision through a national mapping exercise to identify services that could be scaled up. These findings should then inform consideration of ringfenced funding for a specialist programme as part of the next Spending Review.

4. Removing eligibility barriers to support

- MHCLG and DHSC should work with partners across Government to remove eligibility criteria from their target to end hospital discharge to the street, ensuring that all patients have a right to somewhere safe to recover after a hospital stay.

- Government should ensure that patients at risk of being discharged into homelessness have access to specialist legal advice to support access to appropriate intermediate care.

- Government should ensure that reform of existing funding programmes and new ringfenced funding promotes the scaling up of existing provision which accepts patients subject to the NRPF condition.

5. Building the infrastructure for system accountability

- In the longer term, Government should mandate the routine recording of housing fields across all health datasets, building on existing standards established within MHSDS and ECDS, driven by existing detailed implementation plans.

- In the meantime, Government should develop a near-term mechanism for the routine recording and reporting of unsafe hospital discharge for people experiencing homelessness, aligned to the agreed national definition, either through amendments to existing datasets such as the Acute Discharge Situation Report or through the development of a dedicated reporting mechanism.

- Local homelessness action plans should be required to include explicit plans relating to safe hospital discharge, agreed jointly between local authorities, NHS trusts and ICBs. These plans should be signed off by director-level representatives within relevant NHS trusts and ICBs, identifying named leads responsible for safe hospital discharge in their local area.

- At a national level, Government should establish a joint MHCLG-DHSC improvement and oversight programme focused on areas experiencing persistent challenges with street and unsafe discharge.

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