Health Services for Homeless People in London
Case for Action
May 2015

Transforming London’s health and care together
# Health Services for Homeless People in London

## Case for Action

Version number: 1.0

First published: 23rd March 2015

Updated: 5th May 2015

Prepared by:

<table>
<thead>
<tr>
<th>Delvir Mehet</th>
<th>Mariko Ollason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Programmes</td>
<td>Project Manager</td>
</tr>
<tr>
<td>Healthy London Partnership</td>
<td>Healthy London Partnership</td>
</tr>
</tbody>
</table>


1 Executive summary

Following the completion of the first stage of stakeholder engagement, the Health Services for Homeless People Programme Board has composed this Case for Action document.

This document forms a Case for Action, and is a precursor to a further paper which will build on the early thinking by describing some key commissioning outcomes, principles and performance indicators. This paper outlines some of the key health issues faced by London’s homeless population (identified in the Better Health for London report), and how, through building a long term programme in collaboration with Clinical Commissioning Groups (CCGs) and other stakeholders, we aim to:

- Ensure the homeless population’s greater health needs (compared with the general population) are addressed and is bespoke for those who are identified as high risk, and
- Improve access to health services for homeless people.

In response to the Better Health for London report, Dr Anne Rainsberry and Dr Marc Rowland, set out a response which will act as a mandate for the programme:

7.11 A significant amount of work is already underway across London to improve services and outcomes for homeless people and rough sleepers. However, more needs to be done to link programmes across London with each other and mainstream services. We therefore welcome the recommendation to develop a multi-agency approach to healthcare for the homeless. We extend our commitment to working with our agency partners to develop dedicated care teams and identify a lead commissioner of these services. The London Commissioning System Design Group is considering the scope of pan-London support to develop a multi-agency approach to healthcare for the homeless to take forward next year.


London has a significant and growing number of homeless people and rough sleepers. CHAIN data from 2010/11-2013/14 shows a 64% rise in numbers of people sleeping rough (up from around 4,000 to 6,500).¹

Our current system of healthcare struggles to meet the needs of homeless people who are facing extreme health inequalities. There are national and (many) local services, but at times they are fragmented, poorly coordinated and often inappropriate for service users’ needs. Patient care can fall through the gaps and boundaries between care settings and services if patients do not meet criteria for treatment. This transformation programme seeks to address this inequity and fragmentation.

Chronic homelessness is an associated but probably non-causative marker for tri-morbidity; physical ill health, mental ill health, and substance use. The chart below shows the ratio of health support needs of homeless people.

¹ CHAIN Annual Report, Street to Home, 1st April 2013 – 31st March 2014, St Mungo’s Broadway
For illustrative purposes, some good practice elements of the existing mainstream and specialist services are described in this paper, however this is not an exhaustive account of the available provision. It also alludes to the debate around the benefits of mainstream services versus specialist services, and the associated costs. For example, homeless people attend A&E five times as much, stay three times as long, and cost between five and eight times as much as the general population. Upon assessment, homeless people are also often two to three times more ill when they attend.

To gain traction and secure continued support from commissioners the initial focus of the programme will be on:

- **designing, piloting and implementing a single lead commissioner model for London**, (pilot phase between October 2015 and March 2016, implementation from April 2016)
- **improving data collection and data sharing** (prototype July-September 2015 followed by implementation)

This approach is not intended to be prescriptive or to replace ongoing work at local levels. In fact, the passionate and dedicated work already being undertaken across London needs to be explored, shared and built upon and will be crucial to the success of this programme.

Further stakeholder engagement will inform a set of proposed commissioning outcomes (without being prescriptive about how they are achieved) and measures by which we will be able to test whether those outcomes are being achieved (see section 5.3).

The initial period of stakeholder engagement has highlighted the following recommendations for the programme to take forward.

A. To address disparity of access and quality of services for the homeless population in London it is recommended that a lead commissioner is appointed. They should then agree with CCGs and service users what outcomes should be commissioned from primary and secondary care and the services that fall between these two distinctions.

B. To support the drive for equity of access across London it is recommended that the lead commissioner works with CCGs to ensure they link closely with their local authority and that these relationships are established maintained to support integrated working between health, social care and housing.

C. Not every borough has the volume of homeless people to justify commissioning the same variety of services as, for example, in Westminster. However, the lead commissioner should support individual CCGs and local authorities in delivering similar outcomes for their homeless populations (for example through joint commissioning and joint working).

---

2 Healthcare for single homeless people, Office of the Chief Analyst, Department of Health, March 2010
D. To address the inequities in care across London, it is recommended that the lead commissioner for homeless health services works with CCGs and service users to build consensus around a London-wide strategy and commissioning plan.

E. To encourage long term planning it is recommended that the lead commissioner for homeless health services in London investigates and supports ways of securing sustainable funding for those services.

F. To help address the barriers faced by primary care and street facing health outreach teams in linking with A&E departments and acute wards, the single lead commissioner for London should support CCGs to build appropriate links with their local acute trusts to improve information sharing and decision making (for instance, using one of the many pockets of excellence in London).

G. It is recommended that the lead commissioner should support all CCGs in commissioning advocacy support to maximise the effectiveness of the other services they commission on behalf of their homeless populations. This can usefully include peers with lived experience of homelessness.

H. It is recommended that, as part of the Homeless Health Services programme, further research should be undertaken to provide stronger evidence around the quality and impact of care, to support future commissioning:
   • establish what value services add to the wider health system,
   • support the case for putting their commissioning on a firmer footing, and
   • help inform the outcomes and key performance indicators against how they could be commissioned.

I. It is recommended that CCGs are supported to commission for one-stop shop type approaches, based on local need, to care for their homeless populations with clear links into other required services (in both health, housing and benefits) either under the same roof or very close by.

J. It is recommended that a new approach is designed to improve the collection and sharing of data for all providers of care to homeless patients to sign up to. This should build upon the work of the Business Intelligence and Interoperability Workstream of the Healthy London Partnership (a collaboration between all London CCGs and NHS England London region to support the delivery of better health in London.)
2 Introduction

Despite affecting a relatively small population, homelessness is a growing and complex problem which reaches right across health, public health, social care and into related areas such as housing and justice. The NHS has an important role in providing specialist services and making mainstream services more accessible and responsive, but recognises that this will only address part of the homeless issue.

This paper outlines some of the key health issues faced by London’s homeless population (identified in the Better Health for London report), and how, through building a long term programme in collaboration with CCG commissioners and other key stakeholders, we aim to:

- Ensure the homeless population’s greater health needs (compared with the general population) are addressed and is bespoke for those who are identified as high risk, and
- Improve access to homeless health services.

To gain traction and secure continued support from commissioners the initial focus of the programme will be on:

- designing, piloting and implementing a single lead commissioner model for London, (pilot phase between October 2015 and March 2016, implementation from April 2016)
- improving data collection and data sharing (prototype July–September 2015 followed by implementation)

The model will operate at a pan-London level to ensure consistency, and will build on the good practice and recommendations identified through engagement with stakeholders across healthcare, government and third sector. **It is not intended to be prescriptive or to replace ongoing work at local levels.** In fact, the passionate and dedicated work already underway across London will be crucial to the success of this programme and should be explored, shared and built upon. The commissioning model will describe the outcomes which should be commissioned for, without being prescriptive on how they should be delivered.

The programme is currently in its scoping phase; the design and lead commissioner for the commissioning model are yet to be determined, as is the data model which will require testing through a prototype during the pilot of the commissioning model.

To inform the scope of the programme and design of the commissioning model, engagement has taken place via 1:1 stakeholder engagement with over 20 individuals from health, third sector and government organisations that provide health-related services. This has helped to identify examples of:

- existing care of London’s homeless and rough sleepers;
- their issues and needs, and
- good practice across specialist and mainstream services

See Appendix 6 for a further breakdown.
In addition, the programme will be driven by the Programme Board whose membership includes representation from CCGs (clinicians and commissioners), Public Health England, NHS England (London region) Local Government, service users and the third sector.

The programme has adopted a definition of ‘homeless’ which encompasses rough sleepers, hostel dwellers, ‘sofa surfers’ and the chronically insecurely housed. Gypsy and traveller communities have not been included within this definition for this phase of the programme (it is envisaged that the scope of the programme will grow over time). However we know that these groups are included within some existing services. Homeless families housed in temporary accommodation have not been included within this definition as the needs and health issues would be arguably different. Commissioners of services for homeless people may include or exclude some of these groups, assuming that their needs are met through a different group or that care is only offered to those who qualify for NHS provision.

The programme’s success will, in part, depend upon its effectiveness in responding to the developing commissioning landscape. For NHS provision this means responding to the co-commissioning agenda as it is implemented throughout London and linking in with different bodies’ responses to the challenges set out in the NHS Five Year Forward View.

However, health services for homeless people and populations are also commissioned by local authorities so it will be crucial to liaise with borough Directors of Public Health to learn from and support them in discharging their responsibilities. The programme’s work will also require excellent relationship building to ensure services are as integrated as possible between health, social care and housing, and the Programme Board’s membership has been designed to reflect this.

Finally, the work of this programme, whilst initially focusing on the health aspects of homelessness (including access to services) will be underpinned by an understanding that problems individuals experience with their general wellbeing can be a cause, and consequence, of homelessness. Supporting the whole person as they reintegrate back into mainstream services (as far as is appropriate) will therefore be central to delivering this programme’s ambitions.

“Is recovery about being well enough to be thrown into the world of sharks? Where is the recovery model for the society of sharks?”
Dolly Sen (writer, director, artist, filmmaker, poet, performer, playwright, mental health consultant, music-maker and public speaker).
3  Context

3.1  Why tackle health services for homeless people?

Our current system of healthcare struggles to meet the needs of the homeless population who face extreme health inequalities. There are national and (many) local services, but at times they are fragmented, poorly coordinated and often inappropriate for service users’ needs. Current service provision and examples of good practice which will be incorporated into the commissioning model are described within this document and appendices. More needs to be done to link programmes across London with each other and mainstream services. Some of the organisations involved in commissioning and providing care to London’s homeless population are shown below:

London has a significant and growing number of homeless and rough sleepers. Figures from Department of Communities and Local Government show that while overall numbers for statutory homelessness are down by 2%, we have seen increases in rates of tenancy loss, the numbers of households in temporary accommodation and the numbers of households moved out of their local authority area. 3

Homelessness can be a cause and consequence of physical and mental health problems. The longer and deeper the exposure to homelessness and extreme exclusion, the more profound the likely health harms – both in the short and longer term. Chronic homelessness is an associated but probably non-causative marker for tri-morbidity; physical ill health, mental ill health, and substance use.

- Crisis recently demonstrated a mean age of death of 47 (in men) and 43 (in women) in a large scale analysis of death certificates of people identified as homeless.4
- Homeless people acquire age related functional impairment much earlier than the general population. Often, homeless people find it difficult to manage their own health conditions due to their chaotic lives, low literacy, poor access to services and, the attitude from health professionals.

### Impact on the system
- 70% of homeless people receiving hospital treatment were discharged onto the streets. Homeless people attend A&E five times as much, stay three times as long, and cost up to eight times as much as the general population.12 It should be noted that the hospitals in question do not have a focus on homelessness or work with a Pathway team.
- Of a sample homeless population, half of the total acute care costs were incurred by 10% of people. Financial savings could be made and quality of life improved by earlier intervention.13

---

4 Homelessness: A silent killer, A research briefing on mortality amongst homeless people, Crisis, December 2011
8 A Future. Now, Homeless health matters the case for change, Resolving Chaos CIC and St Mungo’s Broadway, assisted by the Tri-Public Health Intelligence Team, in their 2014 report ‘An analysis of the cost of acute health service use by rough sleepers in London
9 CHAIN Annual Report, Street to Home, 1st April 2013 – 31st March 2014, St Mungo’s Broadway
10 CHAIN Quarterly Report, Greater London, October-December 2014, Greater London Authority
11 Homelessness: A silent killer, A research briefing on mortality amongst homeless people, Crisis, December 2011
12 Healthcare for single homeless people, Office of the Chief Analyst, Department of Health, March 2010
13 An analysis of the cost of acute health service use by rough sleepers in London, Resolving Chaos and St Mungo’s Broadway, 2013
4 The Challenge for London’s commissioners and providers of Homeless Health Services

4.1 Commissioners

4.1.1 Commissioning homeless health services

Homeless people access primary care in several ways:

i. through the local “mainstream” General Practitioner (in the same way as the rest of the general population)

ii. Through mainstream walk in centres

iii. Through mainstream GP practices with additional “locally commissioned service” funding to provide a service, for example, to a nearby hostel

iv. via a General Practice established specifically to meet the needs of the homeless population

v. Via specialist community nursing services, such as the Westminster Homeless Team and the Three Boroughs Team (Lambeth, Southwark and Lewisham)

vi. Occasionally, people access care only via mental health teams or voluntary sector providers, although this is rare.

The ‘mainstream’ GPs are currently commissioned by NHS England, but many areas are moving to a model of co-commissioning where CCGs will jointly commission services with NHS England. The ambition of some CCGs is to move to a model where they are solely responsible for commissioning all general practice for their population.

Specialist GP services are commissioned by a combination of NHS England and CCGs. In London the contracts are either Primary Medical Services or Alternative Primary Medical Services.

Such specialist services have bespoke outcomes and key performance indicators, based on the need of the local homeless population and the wider strategy for primary care.

In the very rare instances where CCGs have come together with councils and housing partnerships to commission services on behalf of their homeless populations (for example, the Joint Homelessness Team in Westminster), feedback is generally positive.

4.1.2 Which populations are homeless health services commissioned for?

Whilst access to walk-in centres and temporary registration with a GP is available anywhere, in terms of ongoing permanent registration, services should ensure clients are registered with GPs, and aim to mainstream people as much as possible. There should be an emphasis on transitioning people into mainstream services to help improve recovery.

However, there are specific rules about the type of care available to people based on their residential status and the type of care required. For instance, according to recent guidance, anyone with an infectious disease (for example, tuberculosis) can seek treatment for it, regardless of their recourse status, but there is a group of people with “no recourse to public funds” who may be charged for secondary care and may not be entitled to non-emergency secondary care. The Public Health Act enshrines free health care for people with HIV and TB disease irrespective of residential status i.e. they cannot be charged for primary/secondary /tertiary health care.
It is important to note that any person can register with a GP (temporary registration is valid for three months) for immediate and necessary treatment, and access emergency secondary care (including maternity).

The table below illustrates how the homeless population also present with a greater level of need than the general population:

<table>
<thead>
<tr>
<th>Condition</th>
<th>% of homeless people</th>
<th>% General population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health difficulty</td>
<td>70</td>
<td>30</td>
</tr>
<tr>
<td>Chronic respiratory illness</td>
<td>36</td>
<td>5</td>
</tr>
<tr>
<td>Illegal drugs or on a methadone programme</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal problems</td>
<td>27</td>
<td>10</td>
</tr>
<tr>
<td>Eye problems</td>
<td>16</td>
<td>1</td>
</tr>
</tbody>
</table>

Brighter futures Academy, 2011  

It should also be noted that the onset of multiple morbidity occurs significantly earlier in the homeless population and consequently some of the areas of specialist expertise they require access to are traditionally the preserve of geriatricians. The Faculty of Homeless and Inclusion Health has begun to define a new sub speciality in medicine for patients with multiple complex needs.

4.1.3 The effectiveness of current commissioning arrangements

The current commissioning arrangements do not deliver equity across London as the homeless population have access to different levels of care in different CCGs. Anecdotal feedback suggests that some areas are wary of commissioning specialist services for homeless people as they fear this would encourage more homeless people to move into their borough. Instead, they seem to assume that mainstream practices should allow registration for these patients.

This approach was described by one stakeholder as a “race to the bottom” and could deny homeless people access to the level of care that the rest of the population enjoys.

The current situation also encourages different approaches to the types of services established, which in turn creates problems for services that wish to refer patients back to the CCG of origin. Nurse practitioners can waste a lot of time speaking to different teams as they seek to find out who will take responsibility for a patient. Sometimes it becomes clear that there is no suitable service available; simply because the patient is homeless.

London’s homeless population require a commissioning model to meet their needs based around their lives which are often mobile and chaotic. Changing the provider of their care based on whichever borough they reside in results in a lack of continuity, the breakdown of relationships and a consequent loss of trust which are all crucial elements of a successful primary care relationship.

Funding is secured by a variety of methods depending on the CCG. Some commission based on a list at a higher cost per patient than for general populations. Others add extra

14 “Rough treatment for rough sleepers – an investigation into the way that medical treatment for homeless people could improve” Brighter futures Academy Research Paper No6 11/09/11
enhanced services or Quality Outcome Framework (QOF) payments to ensure the practices are viable, however there is an argument that using QOF payments should be discouraged, as the homeless population require more engagement work to comply. This second option is particularly useful for those CCGs commissioning their mainstream practices (perhaps those located near hostels) to provide primary care to the homeless population.

4.2 Providers

4.2.1 Who provides services to Homeless populations in London?

4.2.1.1 Primary Care

General practice is the gateway to the rest of the NHS and it offers great opportunity to quickly connect patients with the specialists they need through the referral process. This benefit is unique to the NHS. In other systems, layers of bureaucracy can exist between primary care and dentistry, or primary care and talking therapy services. Therefore it is important to acknowledge the opportunity for GPs to quickly link their homeless patients with appropriate care.

As noted above, homeless people access primary care services (including dentistry, optometry and podiatry) through mainstream and specialist practices. Individual CCGs decide which of the two models they wish to commission, although it is recommended that there is an emphasis on transitioning people into mainstream services as a move to recovery.

This programme does not intend to influence this decision by recommending a certain approach. Having conducted structured interviews with key stakeholders across homeless services (see Appendix 6) it is clear that the network and quality of care, encompassing pathways which a practice can access has a bigger impact on meeting the needs of homeless patients than the status of a single practice.

There is a clear need, therefore, to provide as many services close to, or co-located with practices with high demand for care from homeless service users.

In the past it has been difficult to make an economic case for the services provided to homeless users due to the extra needs their circumstances create. Service providers we have spoken to attribute their success to allowing longer appointment times and focusing on building long term relationships with their patients. These approaches are inherently expensive, especially when compared to mainstream services.

Part of this is attributable to a higher proportion of homeless people finding it difficult to form attachments and therefore take longer to build trust with clinicians.

The cost of providing effective services to the homeless population is high, but so are the potential rewards.

We know that homeless populations use A&E more frequently, are more likely to be admitted for unplanned care and exhibit a much higher incidence of tri morbidity than the general population.
Homeless people may experience difficulty accessing health care. For them health may be a secondary priority, meaning health problems only get addressed when they become acute.\textsuperscript{16}

Therefore the impact of effective primary care in addressing issues before they become crises, and a mechanism of supporting patients to make the right decisions and access care have a much higher value for the homeless population than the general public.

"The most cost effective way to provide health services is to ensure that health needs are met as soon as they arise. The longer a condition is left untreated, the greater the risk of a poor outcome and the more costly the intervention.\textsuperscript{17}

Another feature of the primary care landscape which particularly affects homeless users is the ability of those who are not registered with a GP to access primary care-type services through A&E departments. This is explored further in section 4.2.1.3, below.

There are pockets of excellent care throughout London indicating the types of models that could be adopted to improve access to health services for the population. However, these are not consistently adopted across the capital so there is a clear opportunity in ensuring the best care offered across London, is offered consistently.

\textbf{A.} To address disparity of access and quality of services for the homeless population in London it is recommended that a lead commissioner is appointed. They should then agree with CCGs and service users what outcomes should be commissioned from primary and secondary care and the services that fall between these two distinctions.

\textbf{B.} To support the drive for equity of access across London it is recommended that the lead commissioner works with CCGs to ensure they link closely with their local authority and that these relationships are established maintained to support integrated working between health, social care and housing.

\subsection*{4.2.1.2 Street Outreach}

Street outreach is often the first step in engaging homeless people in services and involves going out to find people who are sleeping rough or in hostels. The teams build relationships and support homeless people to access the services they require.

\begin{quote}
\textsuperscript{15} The unhealthy state of homelessness, health audit results 2014, Homeless Link
\textsuperscript{16} Royal College of General Practitioners statement referenced in: Rough Treatment for Rough Sleepers, an investigation into the way that medical treatment for homeless people could improve, Brighter Futures Academy research paper, No. 6/11, September 2011
\textsuperscript{17} Rough treatment for rough sleepers – an investigation into the way that medical treatment for homeless people could improve, Brighter futures Academy Research Paper No6 11/09/11
\end{quote}
During the stakeholder engagement for this document we held many valuable discussions with providers of street outreach services from both the public and third sectors. Some of the detail from these conversations (for example, with Great Chapel Street, Joint Homelessness Team, START (a homeless outreach team) and the Dr Hickey Practice) can be found at appendix 8.1.2 and focused on local innovations to improve the services offered to homeless people.

From these discussions, several key innovations and practices emerged as critical for the provision of homeless health services:

- **Peer advocacy**
  The use of former homeless people to engage with and advocate for homeless populations, was widely seen as a crucial part of improving the effectiveness of homeless health services. They have the skills and experience to speak to homeless people frankly to encourage them to engage with health services and they also have the ability to offer a wider perspective on other issues (for instance benefits, housing) which may prevent an individual focusing on their health.
  Such services also provide an excellent pathway for providing experience and employment to former homeless people as they begin reintegrating with mainstream services. Findings from a study by Groundswell and the Young Foundation found support to suggest that Homeless Health Peer Advocacy results in better health outcomes at a reduced cost to the NHS. Attendance at outpatient appointments increased by 130% during the intervention, leading to more engagement, referrals and adherence to courses of treatment. NHS secondary care costs decreased by 42% after the intervention\(^\text{18}\).

- **In terms of completing the course of drugs, the TB Find and Treat model of multidisciplinary teams reports outcomes in line with teams offering the service to the mainstream population.**

- **Reconnection and repatriation services are effective responses for patients discharged from general acute, or acute mental health environments, with no place to stay.** This approach is not without its critics, but if delivered properly can give an individual a better chance of accessing networks and building relationships to prevent them from having to return to the streets. There is a risk that some individuals will be disadvantaged if there is any local authority dispute over criteria or boundaries.

- **There was broad support for facilitating homeless people to move on to mainstream services wherever possible, but an acceptance that for some this would never be possible or appropriate.** To adapt a well-used phrase: homeless people could be asked to engage with general services where possible and specialist services where necessary.

- **Wellbeing is a crucial part of a person’s general health and services should be designed with this expertise in mind (Care Act, 2014).**

- **Many of the services have a health and political impact.** It will be vital for CCG and Local Authority teams to agree on local strategies to ensure that services deliver outcomes in line with the bigger picture.

- **Some services may benefit from being considered through a pan London perspective, for example, the Female Long-term Rough Sleeper project, commissioned by CNWL. These should be commissioned by the lead commissioner for homeless health services.**

- **It is also worth noting one of the limitations of outreach work with nurses who are not NHS nurses. Only NHS nurses have the ability to make referrals and are able to access patient records**

---

Other feedback focused on different issues which should be addressed as part of a pan London commissioning strategy to improve the impact of outreach services.

- Despite their successes in providing services to the homeless population, these outreach services suffer from a general uncertainty around funding. For instance, after being originally funded directly by DH, support for the Find and Treat team was cut four years ago (following the implementation of the Health and Social Care Act). Fortunately it was picked up by the London Levies programme, but even this response has seen its budget frozen.

C. Not every borough has the volume of homeless people to justify commissioning the same variety of services as, for example, in Westminster. However, the lead CCG should support individual CCGs and local authorities in delivering similar outcomes for their homeless populations (for example through joint commissioning and joint working).

D. To address the inequities in care across London, it is recommended that the lead commissioner for homeless health services works with CCGs and service users to build consensus around a London-wide strategy and commissioning plan.

E. To encourage long term planning it is recommended that the lead commissioner for homeless health services in London investigates and supports ways of securing sustainable funding for those services.

4.2.1.3 Acute care
Apart from referrals from primary care, homeless people are treated by acute trusts when they present at A&E. The absence of a single unifying IT system between different departments means that the same patient can present at different A&E departments, under different names over a period of time.

The latest data indicates that the number of A&E visits and hospital admissions per homeless person is four times higher than for the general public.¹⁹

Not only is this expensive, but it results in a disjointed approach towards individuals where treatment can be offered without any reference to previous interventions or the patients' wider strategy.

Also, it can be incredibly difficult for primary care and outreach teams to liaise with different A&E departments due to a lack of consistency in the way they work and the pressures each department face in delivering against their core targets.

Key to the implementation of the NHS’s Five-year Forward View is the establishment of multi-disciplinary community specialist teams. These have been present in selected homeless services for some time. Success within the King’s Health Pathway Team (based on UCLH’s model) has been attributed, in part, to the secondment of a nurse practitioner from the A&E department at St Thomas's to support the linking between primary and secondary care. This has resulted in joint multi-disciplinary team meetings to discuss specific patients and divert them according to an agreed care plan should they present at A&E. In addition, the Health Inclusion Team (HIT) and the Pathway Team sit within the same organisation (GSTT) and have the same commissioner, and crucially now the same senior manager. There has been a joined up organisational commitment to making this work, and there is a commitment to integrate the HIT team and Pathway teams - most recently with the

---

¹⁹ Homeless Link Health Audit Results 2014
introduction of EMIS Web (which is also being installed in the A&Es). Using a care coordination approach in trusts creates a point of contact and focus to improve care for homeless patients.

F. To help address the barriers faced by primary care and street facing health outreach teams in linking with A&E departments and acute wards, the single lead commissioner for London should support CCGs to build appropriate links with their local acute trusts to improve information sharing and decision making (for instance, using one of the many pockets of excellence in London).

4.2.1.4 Mental Health Trusts

Seamless services for homeless patients are supported by specialist community mental health teams such as the Joint Homelessness Team (JHT) in Westminster, START team in Lambeth, Lewisham and Southwark and the Focus team in Camden, and by psychiatric outreach services such as that provided at Great Chapel Street surgery.

The Joint Homelessness Team in Westminster is a combined health and social care model, and has a long established mental health outreach team within it, commissioned by Westminster City Council, West London CCG, Central London CCG and the Sub-Regional Housing Partnerships. Mental health support is delivered (to those who aren’t admitted or who return to the streets) in line with the mental health act and legislation, with the aim of placing people in more stable accommodation and transferring them on to a recovery service for ongoing support. At this point, they would access mainstream care. Support includes medication, social interventions, and encouraging GP registration.

Challenges remain around access to psychological services (IAPT) for the homeless population, which have unwittingly become ‘barriers’ and exclusion criteria. For example, treatment for personality disorders (a specialist area) is difficult to access. Psychological consultant support is available and has been successful in both Dr Hickey’s Surgery (where it has been commissioned for a further year) and Great Chapel Street Practice. This support helps to empower staff, minimise risk and helps access those who need the support by making it available at these well used hubs.

The success of some of these piloted initiatives and services seems to be the link to clarity of outcomes and ‘end points’, such as knowing when to withdraw and conclude treatment; linking with local services to continue the support. For some services, operating on a smaller scale is beneficial, whereas others would benefit from a pan-London remit.

The Gordon Hospital in Westminster provides inpatient mental health services, however one of the challenges is the volume of homeless people in acute crisis who use the hospital as a walk-in inpatient unit. As this is a high end resource and not intended to be accessed in this way, there needs to be an alternative resource and clear pathways to help manage this source of tension for local practitioners.

4.2.2 Who accesses these services and how are they engaged?

The issues faced by homeless people are shared with many socially excluded groups. Therefore to restrict focus to rough sleepers would miss many patients whose needs are also not met through traditional general practice: it should include those in hostels and the chronically insecurely housed too.
For some patients, a successful set of interventions could contribute to their circumstances improving to the extent that they are able to move on to a traditional GP’s list. But for others, success could be very much focused on harm reduction. It is also noted that targets around transferring patients to mainstream practice could have a detrimental effect as they encourage processes to be rushed through.

Geographically speaking, the population used to be concentrated very much in central London but as it becomes more difficult to sleep here, services are noticing a small shift towards the periphery.

It is also difficult to prescribe a single outcome which services for homeless people should deliver. Ideally, specialist primary care providers would discharge their patients to a mainstream GP once their health issues are being managed. But it has already been noted how the attachment processes of homeless people are awry and the required building of trust requires slow engagement. Relationships with patients mean clinicians at specialist centres can convince people to access treatment which otherwise they would not be able to.

4.2.2.1 Community nursing teams

Community nursing teams are significantly sized primary care services that work in partnership with (but are not dependent on) mainstream GP practices. Existing services include the Three Boroughs Primary Health Care team which works across Lambeth, Southwark and Lewisham. The team consists of 16 nurses and 25 staff who go out with outreach workers to hostels and day centres, and provides nurse led primary care and specialist intermediate care for rough sleepers and hostel dwellers.

The Westminster Homeless Health Team is another example of community care. It is commissioned by CCGs (not NHS England) and is a nurse led triage and support service working on an outreach basis, i.e. the equivalent of a District Nursing service for homeless people.

4.2.2.2 Pathway services and Homeless Prevention Initiative (Joint Homelessness Team, Westminster)

These services are sometimes commissioned by CCGs (whereas other provision is not commissioned but solely provider-led such as in UCLH) working in secondary care. They work in direct partnership with their partner services in the borough and would ideally be commissioned together.

4.2.3 How effective are these services?

Prior to 2012, Public Health England undertook a needs assessment and noted the following key reasons why care does not get delivered to people experiencing homelessness.

- Suspicion of clinicians by homeless people
- Mental Health/personality disorder confusion
- Points of access were difficult: people becoming ill out of hours
- Drug and Alcohol service, mental health services and others are confused about who can do the assessment and also who is responsible for the intoxicated.

Another arising challenge where the leadership of a single-commissioner could make a real impact is in enabling access to mental health services for those with a dual diagnosis or co-existing mental health and substance use needs.
Feedback from those specialist practices which are able to offer extended services and rebuild trust with their patients suggest that the patients and the wider system benefit from improved quality and greater efficiencies.

There is also some research which supports the integration of primary and secondary care as an effective method of reducing A&E attendances and unplanned admissions. There is strong evidence from a systematic review of randomised controlled trials that an individualised discharge plan for a hospital inpatient is more effective than routine discharge care that was not tailored to the individual. Re-admissions to hospital were significantly reduced by around 15% for patients allocated to structured individualised discharge planning.20

The Pathway approach introduces GP and nurse led care coordination for homeless patients admitted as an emergency, thus combining integrated care with discharge planning. This approach is primarily intended to improve the quality of care, but it has the additional beneficial effect of reducing bed days associated with admissions of homeless patients by 30%.21 The approach has now been extended into A&E departments, with teams active in University College London Hospitals, Royal London and across Kings Health Partners and teams across the country.

A common theme in our discussions with clinicians was that housing remains a key issue for the sick homeless. Often residential security needs to be supported before other issues can be addressed. One interviewee suggested that secure housing is a crucial aspect of reducing demand for services so should be included in programme plans, even if not an immediate priority.

Equally, helping patients address what matters to them (e.g. resolving benefits issues) provides them with the space which helps them focus on their health.

Investment in a one-stop-shop approach should be beneficial in ensuring patients can access other vital services (housing, benefits advice, job centre plus health needs such as podiatry, dental) under one roof, or at least very closely located.

Inequalities in provision across London mean that homeless people in outlying boroughs are particularly vulnerable due to lack of specialist services and issues with access to mainstream services. Therefore, the proposal for a pan-London approach was seen as beneficial because:

- CCGs would be compelled and supported to provide an equitable service
- Networks could be developed to facilitate the sharing of resources between those CCGs where demand is not high enough to justify local dedicated services.

As noted above it can be difficult to prove efficiency for homeless health services if focusing on cost per patient. Therefore, the conversation should focus on value added by having these services (i.e. cost to the wider system including accident and emergency departments, criminal justice services and local authorities) rather than considering pure cost alone.

One vital aspect which all stakeholders are agreed on is the value added by care/ navigators and peer advocates which improve the effectiveness of services by helping patients attend

---

appointments and navigate the system. They are also invaluable in providing roles and jobs to former homeless people and assisting them in the transition back into mainstream society.

G. It is recommended that the lead commissioner should support all CCGs in commissioning advocacy support to maximise the effectiveness of the other services they commission on behalf of their homeless populations. This can usefully include peers with lived experience of homelessness.

H. It is recommended that, as part of the Homeless Health Services programme, further research should be undertaken to provide stronger evidence around the quality and impact of care, to support future commissioning:
   • establish what value services add to the wider health system,
   • support the case for putting their commissioning on a firmer footing, and
   • help inform the outcomes and key performance indicators against how they could be commissioned.

I. It is recommended that CCGs are supported to commission for one-stop shop type approaches, based on local need, to care for their homeless populations with clear links into other required services (in both health, housing and benefits) either under the same roof or very close by.

4.3 Data

4.3.1 How is data currently collected and collected?

The CHAIN (Combined Homelessness and Information Network) database is commissioned and funded by the Greater London Authority and managed by St Mungo’s Broadway. It captures the history of its client’s engagement with services such as outreach teams, hostels, day centres and resettlement teams. Outreach teams, hostels, day centres and a range of other homelessness services across London access and update the system. It is the main source of data collection for rough sleepers and the wider street population in London.

The CHAIN data sets enable support planning to link people in with available services. It does not contain a huge amount of detail (e.g. around treatment) but provides an excellent resource in terms of statistics from which quarterly reports on homelessness are produced.

Another useful source of data is published by the Department of Communities and Local Government (DCLG) and provides an annual assessment of number of rough sleepers on a specific night.

For Autumn 2014, the homeless statistics headlines were that:
   • London had 742 rough sleepers, which accounted for 27% of the national figure.
   • The number of rough sleepers in London has increased by 37%, compared to an increase of 7% in the rest of England.22

Homeless Link also produce data on the broader incidence and (crucially) responses to homelessness. Of the 26,940 households which asked their council for help with homelessness between April and June 2014, 49% were accepted as homeless and given help to find a home, whereas 51% were turned down.23

4.3.2 What does this data tell us?

In the rough sleeping figures in this report people are grouped into three categories:

- **New rough sleepers**: Those who had not been contacted by outreach teams rough sleeping before the period
- **Living on the streets**: Those who have had a high number of contacts over 3 weeks or more which suggests they are living on the streets
- **Intermittent rough sleepers**: People who were seen rough sleeping before the period began at some point, and contacted in the period - but not regularly enough to be 'living on the streets'

In total during the period October - December 2014 outreach teams recorded 2,565 individuals sleeping rough in the capital. This is a 13% increase on the total figure for October - December 2013.

Of that total:
- New rough sleepers account for 49% of all rough sleepers
- intermittent rough sleepers account for 35% of all those recorded in the period
- 16% of those recorded during the period were living on the streets.

The quarterly report also includes outline figures for those achieving no second night out; nationality; support needs (alcohol, drugs, mental health); institutional (prison and care) and armed forces history accommodation and reconnection outcomes; temporary accommodation.

4.3.3 How can data collection be improved?

There is a genuine need to record how homeless people access health services in order to better understand this group and offer a whole system approach to the population’s and individual’s care.

The key is for data collection and sharing to become aligned across the health and wider system.

The challenges associated with this include:

- Enabling different parts of the system to link to each other
- Ensuring everyone who needs to access information has the appropriate clearance and equipment to do so
- Ensuring appropriate consent can be granted so that patients can be tracked through the system
- Delivering this in a timely manner (which for some services may require information that is updated daily or even hourly)
- Constraints related to information governance which pose potential barriers for seamless sharing of information and data.

J. **It is recommended that a new approach is designed to improve the collection and sharing of data for all providers of care to homeless patients to sign up to. This should build upon the work of the Business Intelligence and Interoperability Workstream of the Healthy London Partnership (a collaboration between all London CCGs and NHS England London region to support the delivery of better health in London.)**

Find and Treat, Pathway and UCL are working to improve NHS data and data matching for this client group.
5 A new commissioning model

5.1 The lead commissioning model

Given the different needs of and existing services offered to homeless people across London, it is not surprising that quality varies considerably. The proposals for a single lead commissioner to lead on commissioning homeless services across London should address this variance and improve the way in which a transient population are cared for by;

- Sharing expertise of what works well
- Coordinating responses (potentially across several CCGs) to ensure services of the highest possible quality can be commissioned, even where demand may be low
- Agreeing the key outcomes which each locally commissioned set of services for homeless people should be commissioned to deliver
- Driving the development of a Pan-London approach to data collection and sharing
- Building on the nascent co commissioning initiatives to ensure homeless health services are commissioned effectively
- Providing a coordinated, pan-London approach so that good homeless services are commissioned consistently.

5.2 Commissioning for outcomes

5.2.1 Joint commissioning

The success of the Joint Homelessness Team is based on joint commissioning between health, housing and social care as this allows for a real integrated services with full referral rights and access into health services, housing provisions and social care funding.

5.2.2 Faculty for Homeless and Inclusion Health commissioning standards

A significant amount of work has already gone into devising commissioning standards for homeless services, principally by Pathway, whose work in this area the Programme Board wish to acknowledge and commend.

These standards are detailed in version 2.0 of “Standards for commissioners and service providers” by the Faculty of Homeless and Inclusion Health. The standards relevant to this work are noted in appendix 5, and is expected that these will form the basis of the work of the lead commissioner model in London.

However, our discussions have noted that it is easier to focus on fewer outcomes than many so prioritisation will be crucial and expected to form part of a multi-year plan for the lead commissioner to implement.

Conversations with stakeholders noted the following key outcomes against which Homeless Health Services could be expected to deliver:

- Where possible the aim should be to integrate homeless people back into mainstream services
- Prevention of homeless and health status worsening is vital. The danger of focusing on health specific outcomes is that we want to stop people becoming homeless, not living on the streets for longer.

• A clear pathway for meeting the needs of the prison population (e.g. those on TB treatment) when they are released to ensure they continue with any required health treatments.
• An understanding of how to measure the health of the homeless population to analyse achievements
• Getting homeless people into accommodation
• Effective and safe discharge to accommodation
• Reducing A&E attendances – evidence of registration with GP practices.
• Reduction in admissions and length of stay where appropriate (noting that it will take longer to set up appropriate discharges).

5.3 Potential commissioning outcomes and measures

Firstly, some difficulties were noted with patient reported outcome measures (PROMs) for this population in that homeless people are good at telling people what they want to hear (due to their vulnerability) and so don’t complain. There are ways around this but they need to be fully thought through. The Adult Social Care Outcomes Framework (ASCOF) and NHS Outcomes Framework (NHSOF) routinely collect data which could be a useful source of information.

Nonetheless our discussion indicated broad support for the following types of outcomes, as long as they are fully consulted on and coordinate with each other:

• Address health inequalities in line with key public health policies and agenda
  o Provide assessment, support and treatment for physical and mental health needs and promote client independence and recovery
  o Drive forward prevention and self-care

Physical health outcomes will be indicated through measures such as increased screening rates, vaccination rates, smoking cessation rates and mortality rates. For services which do not directly measure these, data could be collated on how many appropriate referrals are made for tests and screening.

Those with mental health problems are supported to have a higher level of independence and prevent them deteriorating and being readmitted to hospital, through: building skills to improve self-management. This will be measured through hospital readmission data.

Homeless people diagnosed with established mental health conditions (who are not admitted/ or are discharged) are supported in the interim, until they are eligible to access mainstream support.

• Access to appropriate specialist accommodation for those with mental health problems

• Robust partnership working with service users, statutory and voluntary sectors
  o Which demonstrate good practice in delivering health initiatives
  o Effective pathways into partnership agencies

Service user feedback needs to be captured in a meaningful way and will differ across services (e.g. feedback forms may be used in a GP practice but focus groups and interviews may be more appropriate for other services). Anecdotally, homeless people have been more reluctant to give negative feedback, for fear of negative consequences, so the method of collation will need to be innovative.
• **Specific provision for children and young people and excluded groups**
  o Provide a robust response to safeguarding concerns for the vulnerable.

The service must be able to demonstrate that they have a response to vulnerability (a plan in place to meet the needs of their vulnerable adults), which will differ across services, and report against this.

• **Promote enhanced and easy and equitable access to healthcare**
  o Mainstream patients where possible
  o Encourage GP registration;

This will be indicated through evidence that the services have in place, and are implementing, a robust process to work towards mainstreaming their patients wherever this is possible, perhaps following a period of transition from specialist to mainstream services. Services need to ensure that they are actively seeking the most marginalised people in their population.

• **Enable multiagency working and continuity of care (between primary, secondary and community care)**
  • Enable proactive outreach work; The service must be able to demonstrate that they have robust relationships with the voluntary sector and effective pathways into partnership agencies, for example, such as housing agencies and the voluntary sector (when discharging to accommodation)
  • Enable effective and safe discharge into accommodation and continue care in the community; demonstrated by existence of agreed pathways and discharge and accommodation status data
  • Support with reconnection
  • Peer advocacy support
  • Provide a one-stop shop for advice and support (employment, legal, benefits)

• **Collate and share standard data sets across organisations to support the multiagency approach**
  • Capture specific and relevant information to inform commissioning and address health inequalities
  • Use and share data to enable proactive care planning to meet people’s needs
  • Annual report
  • Accreditation from the Faculty Quality Assessment Framework (a peer review, CQC endorsed process for practices to be accredited against Pathway standards).

• **Promote proactive care planning**

• **Apply innovative approaches to managing total costs**
6  A new model for collecting and sharing data

As set out in section 3.3, current, accurate data is required for the provision of effective health services to homeless users, to both accommodate their chaotic lifestyles and capture evidence of what works best.

In an ideal world this would mean that all providers and commissioners of homeless health services use the same IT system. However, the pressure on health and social services to integrate and become more efficient in the provision of their services means that several transformation programmes across London are experiencing the same difficulties.

This has resulted in London CCGs and NHS England (London Region) establishing a Business Intelligence and Interoperability Transformation Programme to look at how information can be shared across different parts of the system.

The Homeless Health Services programme has already begun discussing its needs with the Business Intelligence and Interoperability Transformation Programme early thoughts on the potential whole system fix is included at Appendix 4.

The key parts of the programme from the perspective of the Homeless Health Services programme include:

- Working with a list of accredited apps to ensure that users of multiple different systems can access centrally held care records for homeless patients (box 2 of the diagram)
- Identity, consent and access controls to ensure access is controlled and will link to the correct record (3, 4 and 5)
- The data access and interoperability environment which will connect those wishing to update or view records to the correct documents and allow them to be updated. (7)
- Interfaces with the local integration services to permit access by appropriate clinicians or professionals.
7 Conclusion

The structured interviews and literature search carried out to inform this document and have helped to reinforce the case for building on existing good practice through the pan-London commissioning model, the challenges ahead and some recommendations for the model. The important role of the NHS in making mainstream services more accessible and responsive and providing specialist services where necessary has also been emphasised.

Health services cannot address homelessness on their own but they can contribute to a wider solution. However, it is important to recognise that the initial conversations to arrive at referral agreements to enable reconnections are made within health services, and many homeless health teams do currently broker reconnections. Some individuals (for example the Eastern European homeless population in London) are highly unlikely to access support services such as addictions treatment or be able to go back into employment without returning home.

There is variation in the provision of services, which causes inequalities in care. Some of this is related to the size of homeless populations, which differs across boroughs, and therefore impacts the need for these services locally. In addition, patient care is also impacted by the ‘boundaries’ between care settings and care services; where a patient may not meet the criteria to access treatment from a particular service. This programme seeks to address such inequalities and gaps and provide a consistent and equitable approach across London through the pan-London commissioning model.

By coordinating the commissioning of homeless health services through a single lead commissioner we can strive for consistently good provision and offer support to services to continually improve.

Key drivers of this will include the closer integration of health and social care, and the development and implementation of a better way of collecting and sharing data.

It is the programme board’s belief that both of these ambitions will be driven forward by the recommendations set out in this document, and that the homeless population of London is long overdue a coordinated response to their needs:

“To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.”

8 Appendices

8.1 Appendix 1 - Current service provision

**Health E1**, (Interview held with: Peter Buchman), Penny Louch and colleagues

Health E1 is a dedicated practice set up to offer primary care to homeless service users.

They also provide the Pathway care coordination service to the Royal London. This initiative was borne of a randomised control trial to explore how homeless could be provided with better health services and there are a number of synergies with substance misuse.

Most of the services are funded through the usual contractual routes. However, some services (e.g. the 2 x nurses who support the circa 150 patients on drug addiction, funded via the local Drug and Alcohol Team) are not something a mainstream practice would offer.

**Great Chapel Street Practice, Soho**, interview held with Dr Philip Reid, Maxine Radcliffe and colleagues

Multi disciplinary team meetings are held weekly to identify patients in need of extra support from the many services offered at great chapel street. These include mental health outreach, HIV clinic, dentistry and drug and alcohol teams.

This multi agency approach is crucial in allowing a patients (for example) methadone, HIV and iron needs to be monitored and addressed.

Clinicians also work with outreach workers to locate patients in difficult or dangerous situations which are too risky for the street rescue team to approach.
**Dr Hickey’ Surgery, Victoria**, Dr Paul O'Reilly and Dr Hickey  
2x fulltime GPs are complemented by many GP and nurse doing odd sessions, highlighting  
1. The homeless population is a difficult one for clinicians to focus on full time due to funding challenges, but more positively:  
2. The overwhelming amount of goodwill of clinicians and professionals involved in providing services to this population  

This surgery noted that for their patients, the major problems from secondary care are almost all alcohol related.  

70% of all non elective admissions were alcohol related: half from one 36 bed hostel.  

Much of the problem was due to people not taking medicine, so a nurse was placed in the hostel 4 mornings a week and the non elective admission rate was halved.  

Benefit in financial terms was greater than cost of the whole surgery.  

---  

**Project London and the Pavillion**  

Other specialist service provision includes Project London and the Pavillion in Brixton, whose work is focused primarily on refugees and migrants, many of whom are themselves homeless. Project London is voluntarily funded (not commissioned), and exists because some homeless people cannot get registered without advocacy. Clients of the Pavillion and Project London have been disenfranchised from all other access. The Pavillion’s primary outcome is to mainstream care in an integrated context by working with housing.
8.2 Appendix 2 - Outreach teams

There are many examples of excellent work by outreach teams in London which can capture people unknown to primary care to support meeting health needs as soon as they arise, and potentially provide a referral pathway for specific groups of patients.

Find and treat team, Dr Alistair Story

Find & Treat are a specialist outreach team that commission services for a range of populations, including homeless people. They work alongside over 200 NHS and third sector front-line services to tackle tuberculosis (TB) among homeless people, drug or alcohol users, vulnerable migrants and people who have been in prison.

The model reaches out to c10,000 people per year and focuses on identifying those with infections, providing a care pathway and support to continue with treatment.

Initially established as a screening unit in 2005 it was noted that 53% of patients were originally lost to follow up. To address this, a truly multi-disciplinary team has been recruited to include reporting radiographer (Clinical Lead) and Driver/Technical support. Half of the team are former patients (as peer educators).

TB treatment is a 6-24 month programme which presents obvious challenges to teams working with populations with less settled lifestyles. Nonetheless Find and Treat report the same completion rate for TB treatment as those teams offering services to the general national population.

They also report a drop in DNAs from 60% to 6% by using peer advocacy approach.

Innovative engagement with of patients to manage their own care and use smartphones to engage.
- data deal is valued by people
- Cost is same as observing 3 doses.
- Triages out those who do need observing

Despite their successes in providing services to the homeless population, these outreach services suffer from a general insecurity around funding. For instance, after being originally funded directly by DH support for the find and treat team was cut four 4 years ago (following the implementation of the Health and Social Care Act). Fortunately it was picked up by the London Levies programme, but even this response has seen budget frozen.
StreetMed, St Mungo's Broadway, Andrew Casey

StreetMed is a nurse-led outreach and intensive case management service. StreetMed aims to provide 'whole person care', addressing health and social care as well as housing and other issues by using action plans and advocacy based on individual assessments to support those with complex needs to meet their needs, access other services or be safeguarded against harm. Referrals to the services come from various other providers and agencies such as outreach teams, hospitals and hostels for homeless people. This is now restricted to accepting referrals from Hackney, Waltham Forest, Ealing and Hounslow. It is clear that the service is making a real difference in reducing pressure on A&Es by enabling people to access planned and more appropriate healthcare.

St Mungo's Broadway, Anna Page, Elin Jones and Andrew Casey

St Mungo’s Broadway Provide 2,500 beds, mainly in London, and 250 further services (mainly housing-related). They advocate an approach focused on recovery and recognise that the health of their clients is a crucial part of this. Whilst the principle that homeless people should access mainstream services is supported St Mungo’s Broadway recognise that this is often impossible. For instance Mental health Services often exclude those with addictions. Therefore they offer their own services (e.g. psychotherapy) paid for through fundraising via statutory grants.

There is a strong focus on tri morbidities, and they currently provide step down support in Camden and Hackney. Other initiatives include:

- Streetmed services (shifting people from using emergency services to planned care via better engagement)
- Substance misuse for individual clients
- Health and wellbeing centres: a health focus day service
- Dedicated Eastern European worker and Horn of Africa worker.
- Support groups
- End of life care worker who leads across St Mungo’s Broadway (London)

Crucially, St Mungo’s Broadway also manage the CHAIN database, commissioned by the Mayor’s office and which provides data on the number of rough sleepers and the wider rough sleeping population in London.

Community Nurse Teams

Three Boroughs Primary Health Care Team

The Three Boroughs PHCT provides nurse-led primary health care and health promotion to homeless people, refugees and asylum seekers, people with tuberculosis, and people with drug and alcohol problems. The service operates in Lambeth, Lewisham and Southwark and aims to reducing health inequalities, discrimination and social exclusion. The service has the following teams: The Drug and Alcohol Team, the Refugee and Asylum Seeker team, the Homeless Team Community Tuberculosis Team and the HIV Community Nursing Team.
Integrated health and social care services

**Joint Homelessness Team (JHT), Westminster** (a multi-disciplinary community mental health service).

Westminster City Council (WCC), West London Clinical Commissioning Group (WLCCG), Central London Clinical Commissioning Group (CLCCG) and the Sub-Regional Housing Partnerships commission the *Joint Homelessness Team* to deliver four specialist integrated homelessness services:

**JHT Outreach**
A multi-disciplinary team who carry out street facing mental health, housing and social care needs assessments and then provide intensive care co-ordination and case management for those assessed to have eligible needs. The team offers a personalised recovery-focused care pathway from the street to stable accommodation. The team has access to crisis beds and gate-keeping responsibility for a number of supporting people placements for mentally ill verified rough sleepers.

**Joint Assessment Service (JAS)**
A social work team who carry out Assessments of Vulnerability under housing legislation for people who present at the Westminster Housing Options Service. The team provides housing support until the person is settled in permanent accommodation.

**Homelessness Prevention Initiative (HPI)**
A team of social workers and peer support workers who provide a personalised recovery focused rapid response for those admitted to mental health hospitals in KCW. The team identify all service users who are homeless or have a tenancy-at-risk within 24hrs of admission and undertake a face-to-face initial assessment within 48 hrs. The team work in partnership with the service user to complete a health, social care and housing needs assessments and a housing discharge plan. For those with no recourse to public funds or social capital in the boroughs an assisted reconnection is offered. The team have access to a step-down bed and referral rights to a number of housing pathways. The team remain involved for up to 3-weeks post discharge.

**Pan-Female Entrenched Rough Sleep Project**
A nurse working with a cohort of 50 female entrenched rough sleepers, mostly older females who wander across the boroughs of London, rarely bedding down or engaging with services. The project provides a specific lead practitioner who supports multi-agency case management with good joint working across borough boundaries to achieve positive outcomes for these women.
Great Chapel Street Surgery, Dr Philip Reid and Maxine Clifford

Great Chapel Street Surgery is a specialist primary care service, offering an integrated model of care with a full multi-disciplinary team. This includes, GP, nursing, psychiatry, substance use, dentistry, counselling and social care services, and liaison and referrals to other specialist services. Outreach clinics are also run (a nurse-led targeted outreach service (difficult-to-engage people) working in conjunction with Westminster Outreach Teams and a Winter Enhanced Outreach service where a team of a Nurse and a Advisor offers health assessments and advice at Cold Weather Shelters and on the streets, targeting people with complex needs and hard to engage. The outreach team also closely liaises with A&E departments and provides training to other organisations (staff) in the areas of health and social care (entitlements) for homeless people.

Thames Reach

Thames Reach, Jeremy Swain and Bill Tidnam

Thames Reach is not a health service, but have been working alongside SLAM. Thames Reach provide a service based upon three stages of support:

i. prevention of homelessness,

ii. stabilisations (preventing things getting worse and getting on with lives), and

iii. recovery (moving on).

Their population lives chaotic lifestyles and the public sector finds it difficult to engage with them so Thames Reach aims to help people better manage their conditions.

Some will have traditional homelessness background, some not so Thames Reach tend to shy away from using residential status as a definition. Provision includes:

- Contracts to provide services for hostels etc.
- Drug and alcohol programmes
- Training programmes for people in recovery
- London Street rescue (x4 teams).

Thames Reach also work with Providence Row on homeless central and east European workers so they can be discharged effectively to their country of origin where they have stronger networks of support. Strong relationships are key for this and the approach is not without critics so Thames Reach work to ensure clients have the support they need to link back in with mainstream society when they return.
Appendix 3 - Map to show London’s specialist GP practices which are directly commissioned by NHS England
8.4 Appendix 4 - Data: proposed fix from Business Interoperability Workstream

Logical Design – Citizen-centric information exchange

1. Navigation: Citizens should be able to navigate to any NHS service via the GOV service.

2. Citizen apps: Apps should be able to send to and receive from the NHS key information and preferences. The NHS should remember the citizen.

3. Identity Management: Citizens should be able to confirm their identity (once) – potentially via ODS.

4. Consent: Citizens should be able to oversee and manage the flow of information (for both primary and secondary uses) that is held in their various records via an accredited channel of their choice including third-party apps.

5 (a) Proxy users: Citizens should be able to nominate a carer of their choice to act on their behalf.

5 (b) Authorisation: Third party applications should only be able to access patient data utilising information provided by identity management and consent services.

5 (c) Access Controls: Citizens should be able to control the flow of information between organisations (based on organisation name and/or role type).

5 (d) Single sign-on: Authorised citizens and clinical users should be able to log in (once) to multiple systems.

6. Content Management: Citizens should expect to exchange data that is contextually logical.

7. Data access and Interoperability: Authorised citizens and clinical users should be able to locate and navigate to data held in different instances of a record using a variety of channels, to subscribe to receive alerts driven by key events and view details of the people who have subscribed to receive alerts and/or accessed different instances of their record.

8. Standards: Standards-based information exchange should be based on defined services that are enabled via the consent service so that citizens are able to provide informed consent.
Appendix 5 - Faculty for Homeless and Inclusion Health

Standards for commissioning Homeless Health Services

1.1 In line with their statutory duties, commissioning organisations must understand and address health inequalities as part of their core responsibilities (rather than as a marginal agenda); consider synergies with other key policy agendas, e.g. NHS Improving Quality (http://www.nhsiq.nhs.uk/).

1.2 The accountable officer for Inclusion Health (whether in a CCG or NHS England local area team) should be at Director level or above.

1.3 The Faculty recommends that responding to the health inequalities duty should require collaboration with a Public Health led Inclusion Health Network, which must include partnership working with statutory and voluntary sectors and service users.

1.4 Standard data sets concerning numbers of homeless people, vulnerable migrants, sex workers and Gypsies and Travellers, their health and associated expenditure in primary and community care and secondary care, as well as offender health care should be collated, and inform commissioning to address health inequalities. Data should be collated in such a way that targets do not distort outcomes. The Public Health England Data and Knowledge Gateway (http://datagateway.phe.org.uk/) provides a single point of access to data and analysis tools, and via a health inequalities category, has links to a health inequalities gap measurement tool, health inequalities intervention toolkit, health inequality indicators, and life expectancy calculator (at local authority and ward level).

1.5 Means of enhanced/easy access to health care for homeless people, vulnerable migrants (including those without documentation), sex workers and Gypsies and Travellers (including those living on unauthorised encampments) should be described, publicised and promoted in an accessible format, and made available to the respective excluded communities for each area – specialist services are not the only solution, enhanced access and outreach services from mainstream providers are also important. All primary care providers should be routinely tested for their willingness to register patients from these groups and refusal of access should be robustly contested.

1.6 Appropriate service responses to Inclusion Health patients – to these standards - must be commissioned, publicised in an accessible format and performance managed for community health care, specialist primary care, mainstream primary care, dental care, mental health care and secondary care.

1.7 It cannot be assumed that the health needs of Gypsies and Travellers are met by existing policy in relation to other ethnic minorities and socially disadvantaged groups; cultural beliefs strongly influence health and health-seeking behaviour – targeted culturally-appropriate services or specialist liaison workers may be needed.

1.8 Collaborative commissioning will be required since primary care is commissioned by NHS England while community care and locally enhanced services are commissioned by CCGs, and public health services are commissioned by Public Health England and local authorities, but service delivery needs to be seamless.

1.9 Commissioners should require proactive care planning, so encouraging a move away from gate keeping (spending time assessing and rationing entitlement) towards proactively planning to meet people’s needs.

1.10 Commissioners should require horizontal, patient-centred integration. By this we mean care planning and continuity across community settings and service provider boundaries, so that people can continue to receive continuity of care even if they lose the address that originally gave access to that care.

1.11 Commissioners should require vertical integration. By this we mean care planning, multiagency working and continuity of care into secondary care and back into the community. A clear expectation of compassion, communication and continuity of care between secondary, primary and community care.

1.12 Measures of success should be shared across multiple agencies, such as reductions in rough sleeping, antisocial behaviour, unscheduled re-admission within 30 days, and unplanned A&E re-attendance within 7 days. Innovative approaches to managing total costs over a 12 month period used for long term conditions might also be applied for some excluded groups.

1.13 There should be specific commissioning plans for children and young people of excluded groups, as their care pathways and service requirements may differ; this particularly applies to commissioning of immunisation, where special attention needs to be given to the needs of excluded groups.

1.14 Immunisation: vaccination programmes have been shown to reduce health inequality worldwide. However, differences in vaccine uptake persist in England and are associated with a range of social, demographic, maternal- and infant-related factors. The 2009 NICE guidance on reducing the differences in immunisation uptake identified a number of groups at increased risk of not completing routine immunisations in England and Wales, including: those not registered with a GP, looked-after children, younger children from large families, those from some minority ethnic groups, those from non-English speaking families, and vulnerable children, such as those whose families are asylum seekers or are homeless.

1.15 Low vaccination coverage and frequent movement of Traveller communities presents a particular challenge for measles elimination in Europe, and underserved minorities have repeatedly been involved in vaccine-preventable disease outbreaks within the UK and across Europe. Indiscriminate population based interventions that aim to improve overall uptake of vaccination are unlikely to reduce social inequalities in uptake. Evidence suggests that social inequalities in immunisation only start to narrow when uptake of the most affluent groups is very high. While coverage for primary vaccination is now approaching or above 95% in most English regions outside of London, concerted efforts need to be made to reach excluded groups - with specific approaches to improve coverage – in routine vaccination programmes, e.g. Specialist Health Visitor for Travellers.

1.16 A number of cross-European resources are available which may be useful for those planning and delivering immunisation programmes, including: a review of the evidence for effective national immunisation schedule promotional communications; a communication action guide for health care providers in relation to childhood immunisation (see ‘Section 4: A so-called ‘hard-to-reach’ population perspective’); a guide on building trust in communication re: immunisation programmes, and a communication guide in relation to MMR specifically45. Additional examples of promising practice for improving immunisation uptake among underserved groups across the EU (with specific examples for the Roma population) can be found on the website of an ECDC meeting on Immunisation in Underserved Populations.
1.17 Commissioning of more innovative partnership working with third sector agencies, which already demonstrate good practice in delivering health initiatives, e.g. the Traveller Movement in Britain and Royal Free NHS Trust Maternity Services project, under the DH-funded Pacesetters programme.

1.18 Offender healthcare: Prison Health Performance and Quality Indicators (PHPQIs) are available to guide Strategic Health Authorities (SHAs), Clinical Commissioning Groups (CCGs) and prisons in judging their own performance in commissioning, and where relevant, delivering healthcare services to prisoners. There is a need to include the monitoring of excluded groups in PHPQIs. The Health Protection Agency (now Public Health England) has previously outlined the standards that it should meet in supporting the delivery of specific health protection PHPQIs in prisons that are part of the prison estate under control of HM Prison Service. Private prisons (contracted out prison estate) have separate performance arrangements but are expected to meet similar levels of healthcare service provision.
## 8.6 Appendix 6 – Stakeholder engagement to inform the Case for Action

The programme wishes to thank the following individuals for their contributions to this document.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Programme Board member</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth CCG</td>
<td>Dr Adrian McLachlan</td>
<td>Chair, Clinical SRO and Chair of Lambeth CCG</td>
</tr>
<tr>
<td>NHS England London Region</td>
<td>Caroline Alexander</td>
<td>SRO and Nurse Director</td>
</tr>
<tr>
<td>Office of London CCGs</td>
<td>Barbara O’Connor</td>
<td>Associate Director</td>
</tr>
<tr>
<td>Public Health England (London)</td>
<td>Dr Nike Arowobusoye</td>
<td>Consultant in Public Health</td>
</tr>
<tr>
<td>Central London CCG</td>
<td>Matthew Bazeley</td>
<td>MD, Central London CCG and Programme SRO</td>
</tr>
<tr>
<td></td>
<td>Roz King</td>
<td>Director of Health Outcomes</td>
</tr>
<tr>
<td>Kings Health Partners Pathway Homeless Team</td>
<td>Sam Dorney-Smith</td>
<td>Lead Practice Nurse and Integration Lead</td>
</tr>
<tr>
<td>Balham Health Centre</td>
<td>Malachy O’Hagan</td>
<td>Specialist Nurse Practitioner, Team Lead</td>
</tr>
<tr>
<td>Pathway</td>
<td>Alex Bax</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>NHS England (London Region)</td>
<td>Attracta Asika</td>
<td>Assistant Head of Primary Care Commissioning</td>
</tr>
<tr>
<td>London Boroughs of Camden and Islington</td>
<td>Julie Billet</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>Groundswell</td>
<td>Gerry Dickson</td>
<td>Service User</td>
</tr>
<tr>
<td>City of London</td>
<td>Davina Lilley</td>
<td>Local Government Lead</td>
</tr>
<tr>
<td>Greater London Assembly</td>
<td>Dr Helen Walters</td>
<td>Head of Health</td>
</tr>
<tr>
<td>Homeless Link</td>
<td>Helen Mathie</td>
<td>Head of Policy</td>
</tr>
<tr>
<td>CNWL Foundation Trust</td>
<td>Tristy Robinson</td>
<td>Team Manager, Joint Homelessness Team</td>
</tr>
<tr>
<td>Organisation</td>
<td>Name</td>
<td>Title</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>GLA</td>
<td>Deborah Halling</td>
<td>Senior Policy Officer Housing Policy, Strategy &amp; Services and Contact for the Mayor’s Rough Sleeping Group</td>
</tr>
<tr>
<td>St Mungo’s Broadway</td>
<td>Anna Page</td>
<td>Policy, Public Affairs and Research Manager</td>
</tr>
<tr>
<td>St Mungo’s Broadway</td>
<td>Andrew Casey</td>
<td>Director</td>
</tr>
<tr>
<td>St Mungo’s Broadway</td>
<td>Elin Jones</td>
<td>Manager Homeless Health Care</td>
</tr>
<tr>
<td>Thames Reach</td>
<td>Jeremy Swain</td>
<td>CEO</td>
</tr>
<tr>
<td></td>
<td>Bill Tidnam</td>
<td>Director of Operations</td>
</tr>
<tr>
<td>Groundswell</td>
<td>Athol Halle</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Greenhouse Practice, Hackney</td>
<td>Angela Burnett</td>
<td>GP</td>
</tr>
<tr>
<td>UCL</td>
<td>Alistair Story</td>
<td>Lead, Find and Treat Team</td>
</tr>
<tr>
<td>Public Health England</td>
<td>Gill Leng</td>
<td>National Housing and Health Lead (Public Health England)</td>
</tr>
<tr>
<td>Public Health England</td>
<td>Dr Paul Plant</td>
<td>Deputy Regional Director – Health Improvement</td>
</tr>
<tr>
<td>Great Chapel Street Medical Centre</td>
<td>Dr Philip Reid</td>
<td>GP</td>
</tr>
<tr>
<td>Dr Hickey Surgery</td>
<td>Dr Paul O’Reilly</td>
<td>GP</td>
</tr>
<tr>
<td>Dr Hickey Surgery</td>
<td>Dr Hickey</td>
<td>GP</td>
</tr>
<tr>
<td>Central London Community Healthcare NHS Trust</td>
<td>Mark McDonagh</td>
<td>Clinical Business Unit Manager Tuberculosis Nursing Service, Homeless Health Service, Primary Care Psychological Health</td>
</tr>
<tr>
<td>Homelessness Group of the London Network of Nurses and Midwives</td>
<td>Maxine Radcliffe</td>
<td>Chair LNNM Homeless Group Nurse Practitioner and Outreach Lead, Great Chapel St Medical Centre</td>
</tr>
<tr>
<td>Health E1</td>
<td>Peter Buchman</td>
<td>GP</td>
</tr>
<tr>
<td>Pathway</td>
<td>Dr Nigel Hewett</td>
<td>Medical Director, Pathway and secretary to the Faculty of Homeless and Inclusion Health</td>
</tr>
<tr>
<td>Dellow Day Centre, Providence Row charity</td>
<td>Pam Orchard</td>
<td>CEO</td>
</tr>
<tr>
<td>Organization</td>
<td>Name</td>
<td>Position</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>NHSE</td>
<td>Hong Tan</td>
<td>Head of Health in the Justice System</td>
</tr>
<tr>
<td>Mental Health Trust</td>
<td>Jacqui Van Rossum</td>
<td>Medical Director (ONEL)</td>
</tr>
<tr>
<td>Medical Director (ONEL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UCLH</td>
<td>Andrew Hayward</td>
<td>Professor of Infectious Disease Epidemiology and Inclusion Health Research</td>
</tr>
<tr>
<td>UCLH</td>
<td>Rob Aldridge</td>
<td>Epidemiology &amp; Public Health Academic Clinical Fellow - 2012</td>
</tr>
<tr>
<td>Westminster</td>
<td>Alison Danks</td>
<td>Former Service Manager for homeless health services in Westminster</td>
</tr>
<tr>
<td>Westminster</td>
<td>MaryCate MacLennan</td>
<td>Former Homeless Health Service Development Manager in Westminster</td>
</tr>
<tr>
<td>East London NHS Foundation Trust</td>
<td>Dr Lucja Kolkiewicz</td>
<td>Consultant Psychiatrist &amp; Associate Medical Director for Recovery and Well-Being, Resettlement Team</td>
</tr>
<tr>
<td>Westminster Mental Health Services</td>
<td>Dr Jo Emmanuel</td>
<td>Consultant Psychiatrist and Clinical Director Consultant</td>
</tr>
<tr>
<td>Brighton &amp; Hove City Council</td>
<td>Alistair Hill</td>
<td>Consultant in Public Health</td>
</tr>
<tr>
<td></td>
<td>Sue Forrest</td>
<td>Commissioning Officer for rough sleepers and single homeless people</td>
</tr>
<tr>
<td>Brighton &amp; Hove CCG</td>
<td>Linda Harrington</td>
<td>Commissioning Lead, Homeless programme</td>
</tr>
<tr>
<td>Public Health, East Sussex County</td>
<td>Martina Pickin</td>
<td>Consultant in Public Health</td>
</tr>
<tr>
<td>NHS England</td>
<td>Lynn Altass</td>
<td>National TB Strategy Implementation Manager</td>
</tr>
<tr>
<td>London Borough of Lambeth</td>
<td>David Orekoya</td>
<td>Lead Commissioner Health Improvement, Integrated Commissioning</td>
</tr>
<tr>
<td>London Ambulance Service</td>
<td>Alan Taylor</td>
<td>Head of Safeguarding London Ambulance Service NHS Trust</td>
</tr>
<tr>
<td>London Borough of Haringey</td>
<td>Sarah Hart</td>
<td>Senior Public Health Commissioner</td>
</tr>
<tr>
<td>Westminster City Council</td>
<td>Victoria Aseervatham</td>
<td>Rough Sleeping Commissioner</td>
</tr>
</tbody>
</table>