



Health care and people who are homeless

Commissioning guidance for London

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About Healthy London Partnership

Healthy London Partnership formed in 2015. Our aim is to make London the healthiest global city by working with partners to improve Londoners' health and wellbeing so everyone can live healthier lives.

Our partners are many and include the NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, Public Health England and London Councils.

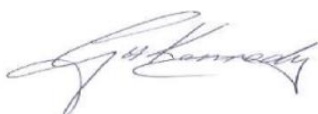
About this document

This Commissioning Guidance has been developed for commissioners of health services for people who are affected by homelessness in London. It outlines ten commitments for improving health outcomes for homeless people. The commitments were developed in consultation with a wide group of stakeholders including the views of people with lived experience of homelessness. Each commitment includes practical suggestions on how to commission high quality, timely and co-ordinated healthcare for people who are experiencing homelessness.

We are pleased to share this guidance, which commissioners can use as guiding principles in their work to improve health services for homeless people in their localities.



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Background

Homelessness can be a consequence as well as a cause of worsening health. People experiencing homelessness have significant needs in relation to physical health, mental health and substance misuse. These needs often go unmet and result in stark health inequalities, with an average age of death of 44 for men and 42 for women who are homeless ([ONS, 2018](#)).

As well as shocking health inequalities, the high prevalence of chronic disease and co-morbidity amongst the homeless population has a significant burden on the system. For example, a [2010 government study](#) on the use of healthcare by single homeless people reported that they are 3.2 times more likely to be admitted to hospital, at an average cost 1.5 times higher than the general population.

In developing this guidance, we engaged with more than 100 NHS and non-NHS organisations across London, including all CCGs and many service providers. Hundreds of previous reports, recommendations and research papers were reviewed and eleven workshops were held with key stakeholders, including CCGs and homeless charities.

The voice of people experiencing homelessness is central to this guidance and each commitment begins with an extract from an extensive, [peer-led consultation with people experiencing homelessness](#) led by Groundswell.

This guidance is intended to support commissioners to improve the health outcomes for homeless people in their localities, to address health inequalities and to deliver more integrated care as set out in the [NHS Long Term Plan](#). It should be used in conjunction with the [Homeless and Inclusion Health standards for commissioners and service providers](#) which sets out clear minimum standards for planning, commissioning and providing health care for this population. Other helpful resources include our [resource pack](#), the London Housing Federation [Atlas of services](#) and the [Homeless Link](#) and [Pavement](#) directories of services.

Commitment 1: People experiencing homelessness receive high quality healthcare

“I think they have got to really start scratching below the surface of people that present [at health services]. People might well present looking a little bit rough and all that sort of thing and a bit incoherent or a bit aggressive or something. There are some issues there. You can’t just take them at surface value. There is reasons why people are in this sort of situation and they need time, empathy, understanding. And actually sometimes just someone to just listen. Let it all out. And it takes time, you know? With me it took time to get through to me to understand what the hell was going on in my life. And then come to my own decision that I wanted to keep it going. Because that was a 50/50 at one point. So, you don’t just look at the guy or the girl that turns up. And make a judgment. There’s a hell of a lot of stuff going on underneath there. An incredibly valuable and sometimes horribly traumatic experience.”

– Groundswell focus group participant

Homeless people experience many barriers to healthcare combined with negative experiences that deter them from accessing services. The greatest impact is typically upon the most vulnerable, excluded groups, such as migrants, people with mental ill health and substance misuse issues.

Specialist homeless health services are highly valued by people experiencing homelessness as they provide flexible appointments and holistic support that is tailored to the needs of homeless people and help to address underlying issues.

Mainstream services can also deliver more compassionate, integrated care that is more personalised and flexible in meeting the needs of people experiencing homelessness and support them in a more holistic way.

1.1 Promote high quality healthcare for the homeless population by addressing health inequality and exclusion at a local level

Identify a Homeless Health Lead in every area, to champion the local homeless health agenda and engage with other areas to deliver a united approach across London. For example, through local networks, regionally through the [Healthy London Partnership](#) and [London Network of Nurses and Midwives](#) and nationally through the [Faculty of Homeless and Inclusion Health](#) and [Queen’s Nursing Institute](#).

1.2 Work in partnership with local stakeholders to build a better understanding of the local homeless population and improve the local evidence base on health needs and outcomes.

Create a local multi-agency homelessness forum/network that includes health and care commissioners, NHS and non-NHS providers and local people with lived

experience of homelessness. This could be chaired by the Homeless Health Lead, be a sub-group of the Health and Wellbeing Board and be used to:

- Regularly assess local homeless health needs – a toolkit can be found [here](#)
- Identify gaps in service delivery and build an evidence base to support commissioning arrangements and plans for future service provision, such as co-commissioning and pooled resources to optimise service delivery
- Steer and coordinate all agencies and staff coherently and reduce organisational boundaries.
- Share best practice and local intelligence, such as data on ambulance callouts to homeless hostels and homeless 'hot spots' in the area
- Review and learn from incidents and deaths of homeless people locally

1.3 Work in partnership with key stakeholders to reduce homelessness as a consequence of social determinants of health (education, employment, housing, financial security and social exclusion)

The needs of the local homeless population should be included in local commissioning arrangements and plans, such as Sustainability and Transformation Plans, Homelessness Strategies, Joint Strategic Needs Assessments, Health and Wellbeing Strategies and Health Inequalities Strategies. For example:

- [The City of London Corporation Homelessness Strategy \(2016-2019\)](#)
- [Brighton & Hove Rough Sleeping Strategy \(2016-2020\)](#)
- [Tower Hamlets Joint Strategic Needs Assessment \(2017\)](#)

The [homeless health needs assessment toolkit](#) has been developed to support this.

1.4 Ensure services provide training for staff on the rights and needs of people who are homeless

Training packages should be co-designed with people who have lived experience of homelessness to raise awareness of the rights of people who are homeless and the challenges they face trying to access healthcare. Training should encourage and empower frontline workers to support homeless people to access healthcare and to advise and signpost to other services and support available to them. For example, our [Training for GP receptionists and practice managers](#)

1.5 Ensure services do not deny access to non-UK nationals when they are entitled to these services.

This is a particular issue in London due to the size of this population, and the high prevalence of homelessness within it. Steps should be taken to ensure that frontline workers can provide homeless non-UK nationals with basic information about their rights to access healthcare, housing, employment, public funds and reconnection services. Adequate provision of interpreting services should be available to prevent

non-UK nationals from being excluded due to communication barriers. This can be a complex area and there are some helpful guidance and examples available online:

- [No Recourse to Public Fund \(NRPF\) Network guidance](#)
- [GSTT resource pack for GPs and other primary care professionals](#)
- [Doctor's of the World – Safe Surgeries Toolkit](#)
- [Kensington, Chelsea and Westminster Homelessness Prevention Initiative](#)
- [Wandsworth Homeless and Asylum Health Team](#)

Commitment 2: People with lived experience of homelessness are proactively included in patient and public engagement activities, and supported to join the future healthcare workforce

“I think peer – the power of peer is phenomenal. It really is. As experience goes, it’s just... It’s the most enlightening and... wonderful experience that sort of takes the burden of shoulders...Makes you recognise that you are not alone. And you can relate to other people. And oh what a relief that is, you know? You can even have a laugh about it sometimes. And then that helps build strength and confidence. And it’s nice to help other people as well and share experience”

– Groundswell focus group participant

Health is one of a number of competing priorities for people experiencing homelessness, but that does not mean people do not want to improve their health. Delivering services in a way that allows people who have experience of homelessness to be involved in making decisions on their own care, and providing more opportunities for input into the way that services are run more generally, will result in better quality care for all.

2.1 Patient & Public Engagement Strategies should specify that people with lived experience of homelessness are included in public consultation

Homeless people are often deemed too ‘hard to reach’ and their voice is rarely heard. Groundswell have carried out extensive [‘peer research’](#) across London and there are some excellent examples of local engagement in partnership with local providers of day centres, hostels and street outreach services. For example through Healthwatch in [Croydon](#), [Kingston](#) and in [Waltham Forest](#)

2.2 Ensure services include people with lived experience of homelessness in workforce planning and encourage them to join the healthcare workforce

This involvement in the workforce could be through voluntary opportunities leading to paid employment and career pathways.

As part of this workforce planning, consideration must be given to the specific needs of this expert group. Accredited standards, training and support must be provided as with any other expert group or profession. Pathway have produced an [involvement handbook](#) for experts by experience of homelessness.

Commitment 3: Healthcare ‘reaches out’ to people experiencing homelessness through inclusive and flexible service delivery models

“I am just talking personally – there are some mornings you wake up and you don’t feel you want to get out of bed, you don’t want to get up and get dressed. You don’t want to even face anyone in the hostel, you don’t even want to step outside. And by having somebody come in, park up there, it would be great”

– Groundswell focus group participant

Basic survival needs like food or managing a substance dependency often take priority over addressing health needs. It is therefore incredibly valuable for services to meet people ‘where they are’ - in day centres, hostels and community centres. In addition to addressing immediate needs, such as preventing conditions getting worse or contagious conditions spreading, they effectively signpost individuals to building-based NHS services.

Consistency in staff and service access is a key factor that can mean people experiencing homelessness build trust and receive more effective interventions. It avoids the need for homeless people to have to ‘explain themselves’ repeatedly, and can help in stabilising an individual’s progress out of homelessness, and into accessing mainstream services.

While frustrations with waiting times, appointments and communication may be common among the general population, they can further compound homeless people’s feelings of exclusion. A proactive approach is needed to involve people in shaping their own care and feeding back on their experiences of care.

3.1 Ensure services have inclusive access policies that specifically address access issues for the homeless population

Access policies should include reduced, removed or different performance targets and indicators for harder-to-reach groups including those experiencing homelessness. For example, the [specialist podiatry service for Homeless and Vulnerable People Healthcare](#) at Central London Community Healthcare Trust.

3.2 Ensure services offer flexible healthcare delivery that includes flexible appointment times, drop-in sessions, in-reach to hostels and day centres and outreach to the street when needed.

Enhanced services or equivalent schemes can incentivise in-reach to local hostels and day centres, and outreach to the street can be an alternative way of providing flexible healthcare. For example, the [Health Inclusion Team](#) in Lambeth, Southwark and Lewisham and the [Homeless Health Team](#) in Central London.

3.3 Ensure that services offer extra support when needed to navigate the healthcare system e.g. registering with a GP, hospital attendance, community follow-up and completing courses of treatment

Support from a [peer advocate](#) or [care navigator](#), particularly with experience of homelessness, can be invaluable in improving access and helping people to gain a sense of control over their health needs. This could be an existing advocacy or care coordination service with an extended role, or a specialist homeless health care navigation service. This can also play a significant role in reducing health inequalities, as set out in the [Saving Lives, Saving Money](#) report.

3.4 Ensure services make ‘every contact count’ by offering holistic assessments of need; covering physical health, mental health, and substance use

Homeless health checks should be on offer that cover the main health concerns affecting the homeless population e.g. skin problems, respiratory illness, blood borne viruses, diabetes, sexual health, oral health, eye checks, mental health and substance misuse. This should also include opportune vaccinations for flu immunisation, hepatitis B, streptococcal and pneumonia.

Healthy living and wellbeing advice should also be on offer including mental health, substance use, alcohol use, smoking cessation, contraception, weight management and healthy eating, oral health, needle exchange, and foot care. The Queen’s Nursing Institute’s [homeless health assessment tool](#) is a helpful resource.

3.5 Ensure services make reasonable adjustments for those with complex needs, including behaviours associated with personality disorders, complex trauma and co-existing substance / alcohol use

People experiencing homelessness can have complex needs and may be unreliable in attending appointments. Life experiences may mean that they have a lack of trust and willingness to engage with professionals and services.

3.6 Ensure services provide and maintain ‘continuity of care’ for people experiencing homelessness, including when they have temporarily moved out of the geographic boundaries of a service, including short stays in prison

This could be achieved by proactively supporting people to take responsibility for their own health and wellbeing through making informed choices about personal data

sharing with other NHS and non-NHS organisations. This would improve partnership working across agencies and enable safe continuity of care across organisational and borough boundaries, to stop people ‘falling through the gaps’.

People with a ‘homeless housing status’ should be asked about a ‘safe address’ to be used as point of contact. This could be a day centre or GP Practice address. They should also be supported to give written consent for information about them to be shared with a ‘trusted person’, this could be a hostel worker, outreach worker or peer support worker.

Homeless Link have produced a helpful [resource for services working with homeless prison leavers](#) in particular.

Commitment 4: Data recording and sharing is improved to enhance the safety of people experiencing homelessness, enhance best practice and facilitate outcome-based commissioning

“I asked for the letter... for the council, I was under treatment and I was provided that letter by the psychiatrist and ...yes. They talked to me about my housing situation and that I was homeless. They were supportive. The psychiatrist was really supportive. And I appreciate GP as well because he just passed my information to the psychiatrist and the mental health team”

– Groundswell focus group participant

Data collection, recording and sharing is generally seen as a positive, with participants seeing a link between well-informed records accessible across NHS services and service quality. A common rationale is that it means patients do not have to ‘explain themselves’ to medical staff repeatedly, particularly around accommodation and substance misuse. Participants also felt that it was important for people’s accommodation status to be recorded on their NHS records so that medical staff could be aware of this support need at an earlier stage, and therefore plan appropriate treatment, trigger discharge procedures earlier, and increase accountability.

When meeting with patients, healthcare professionals may be privy to personal information about unstable housing even before individuals have engaged with support services. At times of crisis they may also be best placed to support individuals to find relevant support before situations deteriorate further. Medical professionals identifying unstable accommodation status and linking up with local non-medical services, and primary care services offering a ‘social prescription’ to sources of support within the community, can offer an important intervention. One participant explained how “joined up” services, with clear communication between them, led to them being placed in more stable accommodation by the local authority.

4.1 Ensure services record the housing status for all people accessing services at first contact, significant review points and at discharge

[Housing status should be recorded](#) on clinical record systems and be a trigger to activating pathways and services for holistic intervention. Early identification of housing status should lead to early intervention to prevent the development of chronic health conditions and co-morbidity associated with homelessness. This status can change during admission or treatment, so should be updated to ensure health services are well placed to support partnership working.

4.2 Ensure services ask people if their housing status is ‘affecting their health’

This could act as a trigger for a health intervention such as:

- Homeless Health Checks (see 3.4)
- Social prescribing - e.g. housing, financial, legal issues, immigration, reconnection, educational and employment support
- Referral to care navigation / advocacy services (see 3.3)
- Signposting to appropriate support services

4.3 Commissioners should support the collection and analysis of housing status data locally to better understand the needs of the local population, and specifically the health needs of those experiencing homelessness

Collection of an agreed data set across a local health economy will allow commissioners to work in partnership to improve the health of hard-to-reach groups. Data sets could include anonymised data for the purpose of prevalence and benchmarking, and to understand the needs of the local population. This information should be shared with partner agencies locally and across London to support joint working

Commitment 5: Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness

“What I have noticed in London, they haven’t got a lot of information on what to do [when you are homeless]. See like yourself, coming from another country, unless you actually go and meet another homeless person you wouldn’t have a clue where the things are. There is no information, nothing really like. Advertisements sort of thing”

– Groundswell focus group participant

A key issue is the need for information on healthcare and wider support services to be readily available and proactively provided. The limited availability of relevant and helpful information was also held by healthcare and support staff, who could otherwise be in a prime position to direct people to appropriate support. This

highlights the need for better information on healthcare and on homelessness services and for it to be delivered in a way that is clear and easily understood. While information on which services are available and how to access them is key, many people simply do not know their rights around healthcare.

Focus group participants reported dislocation between physical and mental health services and support, including non-NHS services such as social care, housing, and substance misuse. There was also a particular emphasis on the lack of support for people with dual diagnosis (personality disorders and substance misuse).

5.1 Commissioners should work in partnership with Local Authorities and other partners to ensure people experiencing homelessness are able to access timely care and support whilst disputes about responsibility are resolved both locally and across London

This could be taken forward locally by establishing a local Complex Need Forum and Register with membership from local homelessness providers and Safeguarding Lead(s), with an agreed escalation processes and reciprocal arrangements across London for people who wander and move around. The Register could include people:

- With complex co-morbidity
- At high risk of dying within the next 6-12months
- At risk of becoming homeless in the local area due to health problems, or due to leaving institutions such as hospital, care, prison or the armed forces.

People experiencing homelessness should have their needs assessed under relevant legislation and, if eligible, receive care and support, or if not are provided with advice and signposting. Consideration could be given to developing a local [trusted assessment scheme](#) for health, housing and social care assessments on behalf of multiple teams, using agreed criteria and protocols.

5.2 Facilitate and support collaborative multi-agency working and information sharing between local services, including non-NHS providers

Due to the transient nature of people with insecure housing, different ways of sharing clinical data are needed, as current clinical systems across London do not link up. Local information sharing agreements and information governance should be put in place between local NHS and non-NHS Commissioners and Providers that reference people experiencing homelessness.

5.3 Commissioners should work in partnership to agree local health promotion and prevention plans for people experiencing homelessness, and the agencies that work with them

These plans could include Homeless Health Checks and Healthy Living and Wellbeing Awareness Sessions in hostels, day centres and on the streets.

Local activities and support groups for short and long-term conditions should also be proactively publicised to people in homelessness services to support preventative homeless health care – e.g. for diabetes and Chronic Obstructive Pulmonary Disease.

5.4 Ensure training and support is provided to non-NHS workers on basic health care screening, advice and raising concerns for homeless people not engaging with healthcare services

Up to date information about local health services should be available at key gateways, such as housing departments, libraries, Citizen Advice Bureau offices, hostels and day centres.

Commitment 6: People experiencing homelessness are supported to access to Primary Care

“You are homeless, you don’t have proof of address, [so] to get a GP you cannot get this done. So when you come to [specialist homeless GP] they must work with you, so they count you as a human. Then you can have a place you can use as an address there as well.”

– Groundswell focus group participant

Many homeless people are unaware of or do not have the confidence to enforce their rights to primary healthcare. They often have difficulty registering with a mainstream GP. Tight appointment slots and short windows for consultations are also key barriers. As a result, many people find it more manageable to use A&E departments.

Where available, specialist homeless GP practices are generally regarded as providing high quality, supportive services that meet the needs of people experiencing homelessness.

In partnership with Healthwatch London and Groundswell, we have produced ‘[My right to access healthcare](#)’ cards and distributed over 70,000 of these to homelessness services in London to help homeless adults register and receive treatment at GP practices.

6.1 Commissioners should ensure all GP Practices register and provide treatment to people experiencing homelessness

As stated in the [Primary Medical Care Policy and Guidance Manual](#), practices should ensure there is equitable access for all patients who wish to register with them and there is no regulatory requirement to prove identity, address, immigration status or

the provision of an NHS number in order to register. A patient does not need to be “ordinarily resident” in the country to be eligible for NHS primary medical care.

Where a GP refers a patient for secondary services (hospital or other community services) they should do so on clinical grounds alone. Eligibility for free care will be assessed by the receiving organisation. General Practices are also under a duty to provide emergency or immediately necessary treatment, where clinically necessary, irrespective of nationality or immigration status. The practice is required to provide 14 days of further cover following provision of immediate and necessary treatment.

The length of time that a patient is intending to reside in an area dictates whether a patient is registered as a temporary or permanent patient. Patients should be offered the option of registering as a temporary resident if they are resident in the practice area for more than 24 hours but less than 3 months.

Where necessary, (e.g. homeless patients), the practice may use the practice address to register them if they wish. If possible, practices should try to ensure they have a way of contacting the patient if they need to (for example with test results).

6.2 GP receptionists and practice staff should be supported and trained to become champions of fair access to healthcare

The Healthy London Partnership and Pathway have developed an e-learning package for staff, available [here](#).

Commitment 7: Mental Health Care Pathways offer timely assessment, treatment and continuity of care for people experiencing homelessness

“Again, my story – mental health and substance misuse went hand in hand. I don’t think I was alone in that one. And the frustration for me was I couldn’t talk to the psychiatrist and stuff until I was sober for at least a year almost. That’s ridiculous. [...] But ... but I could have had other interventions that could have helped me. Like CBT or something. Or just awareness training or basic interventions that could have tried to convince me to build my own motivation up to do something about my situation. When I say situation, I mean housing, homeless, drinking, everything. And self-esteem, confidence the lot.”

– Groundswell focus group participant

People with mental health conditions are more likely to be homeless and there is a high prevalence of mental health needs within the homeless population. Access to mental health support is made significantly more difficult by the chronic impact homelessness has on the individual and can be further complicated by issues such as substance dependency.

Difficulties and delay in securing funding and fulfilling access criteria frequently result in people not getting the support they need or relapsing. For many, an earlier intervention would have avoided a further decline in mental health, and would have prevented further development of substance misuse issues.

People experiencing homelessness alongside mental health problems can be reluctant to engage with services. Psychosis, delusional disorders and paranoia lead people to mistrust street outreach workers and other professionals. Street outreach workers are unable to engage properly with people sleeping rough for months or years due to mental health problems. Negative symptoms of schizophrenia, depression and post-traumatic stress disorder can contribute to a lack of motivation and sense of hopelessness.

7.1 Ensure community mental health services have working agreements in place for people experiencing homelessness, and the agencies that support them

This should cover the full range of service models including for older adults, early intervention in psychosis, assertive outreach, in-reach counselling, resilience training, drop-in sessions or pre-treatment interventions to day centres, hostels or specialist GP Practices.

Where there are high levels of rough sleepers or homeless hostel beds commissioners should consider specialist mental health provision, as set out in section 2.32 of the [NHS Long Term Plan](#). Some good examples include homeless outreach teams in [Lambeth and Southwark](#) and in [Camden and Islington](#), as well as the citywide [Enabling Assessment Service London](#).

7.2 Local personality disorder services have service delivery models that are accessible and responsive to the homeless population, and the agencies that support them

Personality disorder has been recognised as a ‘[diagnosis of exclusion](#)’ because people with that diagnosis were frequently unable to access the care that they needed. There is a high prevalence of complex trauma and personality disorder within the homeless population, with up to [60% of people who experience homelessness having personality disorders](#).

7.3 Work in partnership with Local Authorities to ensure the homeless population receive assessments under the Care Act (2014) and the Mental Health Act (1983) and, for those assessed as having eligible needs (including Section 117 aftercare), care and support is provided

This could be through ‘Section 75’ agreements for integrated teams or joint working agreements for others. Pathway have produced some helpful resources available [here](#).

7.4 Work in partnership with Local Authorities and the Police to ensure that people experiencing homelessness in Mental Health Crisis receive the same response as the housed population

Homeless people in mental health crisis should be ‘kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first’ - [Mental Health Crisis Care Concordat](#).

Commissioners should be focused on providing accessible and available help, care and support for all those who require it at the time they need it, as set out in the [London mental health crisis commissioning standards and recommendations](#).

They should engage with partners to foster strong relationships and to find innovative approaches to improve the experience of those in crisis.

Crisis care should include alternative intermediate care options to prevent admissions based on social/housing crisis or as an option for home treatment/crisis resolution.

7.5 Ensure mental health services and Local Authority commissioned substance misuse and alcohol services have multi-disciplinary dual diagnosis partnership working agreements in place for people experiencing homelessness and the agencies that support them

Shelter have produced a helpful [briefing](#) on supporting people with ‘dual diagnosis’ - the co-existence of a broad range of mental health and substance use problems.

Commitment 8: People experiencing homelessness are discharged from hospital to suitable accommodation

“My last experience of the hospital was really beneficial. Really beneficial, because they were able to...took a lot of the burden and expectation that they had in dealing with homeless clients, like myself so to speak. They had a homeless team based on site. And it was only through that that all that madness stopped. And that’s when it stopped. At that weekend, at that time, I have never been in-patient since. What stopped it was ... again it was the homeless team who actually helped me – they actually facilitated all of it –was the discharge from hospital to [hostel]. So that’s what made the difference. Them having the expertise and... knowing what to do. And that’s three years ago and I haven’t been an inpatient since.”

– Groundswell focus group participant

Negative experiences of hospital discharge processes are widespread among the homeless population, with many having been previously discharged to the street without any signposting to relevant services. This is particularly so with ‘frequent flyers’ who, due to their regular attendance can sometimes have their medical needs overlooked by staff at the hospital.

This leads to unsafe, inequitable experiences, worsening health problems, increased use of emergency departments and repeated hospital readmission. This ‘revolving door’ scenario illustrates the missed opportunity to capture and build on the benefits of a hospital stay, to address underlying problems and to support the wider reduction of homelessness.

A decisive intervention, on the other hand, can help people to access secure, appropriate accommodation and to turn their lives around. Whether this is through facilitating bed spaces, effectively signposting, or adding medical ‘weight’ to applications for accommodation with the local authority - healthcare staff can play an important role in improving access to appropriate support. Guidance on safe and effective discharge of homeless hospital patients in London can be found [here](#).

8.1 Ensure that hospitals (including mental health facilities) have protocols for admission and discharge planning that specifically address the needs of people experiencing homelessness

As outlined in reports from [Healthwatch](#), the [Queen’s Nursing Institute](#) and the National Institute of Healthcare Research, one of the main challenges is the ‘transition of care’ between hospital and the community. It is crucial therefore to work in partnership across health, social care, housing and the voluntary sector in order to best support homeless patients and ensure, once medically fit, they are safely discharged to an appropriate setting where they can be supported back into healthy, independent and economically active life. In Richmond, partners have come together and signed up to a [Homelessness Prevention and Hospital Discharge Protocol](#).

The [Homelessness Reduction Act 2017](#) places a duty on hospital trusts, emergency departments and urgent treatment centres to refer people who are homeless, or at risk of becoming homeless within 56 days, to their local authority. This came into effect in October 2018 and requires as a minimum that the individual’s contact details are passed to an agreed local housing authority, subject to the individual’s consent. The Department of Health and Social Care and Pathway have produced [guidance and resources to support trusts in meeting this duty](#), including a template, contact details for every local authority and a checklist. Wherever possible, this should involve joint working with the local authority and agreed protocols, rather than a passive referral. Identification of a patient’s housing status and referral to the local authority should happen as early as possible on admission.

8.2 Ensure that hospitals (including mental health facilities) have Homeless Health Care Pathway arrangements in place for people who are identified as homeless on admission, to maximise benefits of admission and to support timely discharge planning

Homeless Health Care Pathways should be integrated and have multi-agency and multi-disciplinary planning to support ‘transition of care’ points, between hospital and the community.

Where a hospital has a high number of homeless inpatients there should be consideration for a dedicated homeless health team / worker to support homeless hospital patients and to coordinate their discharge arrangements. For example, the University College London Hospitals specialist '[Pathway](#)' team, highlighted in section 2.32 of the [NHS Long Term Plan](#),

8.3 Ensure that hospitals (including mental health facilities) have intermediate care options available when a person is medically or psychiatrically fit for discharge but needs a secure place to receive home treatment or respite

Delivering [homeless medical respite](#) or mainstream intermediate care provides an important opportunity for homeless patients to stabilise and recuperate, while assessments and longer term arrangements are put in place. This is particularly important for those who are 'entrenched' and unwilling to move off the street, or people who live more chaotic lives and are unable to sustain accommodation.

8.4 Ensure that hospitals (including mental health facilities) have timely and informative discharge summaries sent to primary care even when the person self-discharges

This should include a flag if the person has a 'Homeless Housing Status'. NHS England requires hospitals to send inpatient and day case discharge summaries to GP practices electronically – guidance can be found [here](#).

Arrangements should also be in place for safe discharge of people not registered with a GP, such as a referral to a Care Navigator, a hand-held record given to the individual or 'consent' obtained for discharge summaries to be sent to a 'trusted person'.

Commitment 9: Homeless Health advice and signposting is available within Urgent and Emergency Care Pathways and Settings

"I was starting to be recognised at the local A&E department on a first name basis, even the consultant knew who I was because of the number of times I would present myself. With trips in the ambulance or by the police this felt like my own private cab company at times. But the main reason was that I knew I would get all the help I needed at one place and fast.

On one visit I was lying in bed hooked up to the ECG machine because of my heart palpitations. The consultant, let's call her Tina, came and had a chat with me. Tina took time out of her busy schedule and made a connection on a personal level with me. She came and shared some of her own life story and told me of times when things weren't going too well for her. She also helped me to believe that my life was far from over. At the age of 36 I just need to get the help that a hospital can't deliver

or provide. She talked me through some steps I could take to keep myself safe, and signposted me to the local drug prescriber to get myself stabilised. It was this that allowed me to begin to tackle the underlying mental health issues and the substance misuse problem that I had that was affecting every aspect of my life.

I know how busy the A&E is but the fact that I felt that I was receiving truly personal care was life changing for me. I felt valued and important for the first time in ages and I am not entirely sure where the motivation came from but that was the catalyst to changing my life. Maybe I wanted to go back one day and show to Tina that I had changed. Or it was just the right information at the right time. I may never know but being able to do more than just health is the best way to help with health. It sounds mad but it has to be joined up thinking to win the war on homelessness health.”

– Groundswell focus group participant

The open access nature and the opportunity to have multiple health needs attended to in an immediate fashion, as well as issues accessing primary care, mean that many homeless people rely on emergency care to address their health needs. They are often high frequency users of A&E departments, across multiple boroughs.

When an individual accesses emergency care it offers an opportunity to tackle issues beyond immediate health needs and provide a more holistic intervention. While the individual accessing emergency care might be presenting with a specific ailment, it could be the route towards a life changing intervention.

The Royal College of Emergency Medicine (RCEM) highlighted the importance of providing advice and information to homeless patients in their [inclusion health clinical audit](#):

“Homeless people represent some of the most vulnerable individuals in our society. It is surely a marker of a civilised society that care and concern for these people is reflected in the provision of appropriate healthcare services.”

- Dr Cliff Mann, President, RCEM

9.1 Ensure providers of Urgent and Emergency Care (including 111, ambulance services, urgent care centres and A&E departments) identify people experiencing homelessness by asking and recording ‘Housing Status’ and ‘GP Status’ as part of the triage process

This is essential in meeting the [Homelessness Reduction Act 2017](#) duty on hospital trusts, emergency departments and urgent treatment centres, to refer people who are homeless, or at risk of becoming homeless within 56 days, to their local authority. This requires as a minimum that the individual’s contact details are passed to an agreed local housing authority, subject to the individual’s consent. (See guidance in 8.1 above.)

9.2 Ensure providers of Urgent and Emergency Care (including 111, ambulance services, urgent care centres and A&E departments) have protocols in place that include the provision of advice and signposting for those identified as being at risk of or experiencing homelessness

In addition to the legal duty to refer to the local housing authority set out in 9.1, this should involve joint working with the local authority and agreed protocols. Advice could take the form of a leaflet detailing local homeless services or, where relevant, a referral to an onsite homeless health team.

In addition to borough based homelessness services, the Mayor provides a range of [services for rough sleepers](#) in London, which can be referred to via [Streetlink](#).

Commitment 10: People experiencing homelessness receive high quality, timely and co-ordinated end of life care

“We have lost four people in this one year, in this place [Hostel]. Just this year in the first five months. A lot of people have died here and other residents have been close with those people, close friends. And I have seen those people really, really down and I have said to staff and it’s like have a chat with so and so because he looks a bit blah blah.”

– Groundswell focus group participant

“If people come to the end of their lives and they are still homeless, I think there is a good calling for a support service for those people because a lot of them, I am sure the majority of them will have more or less no family, not many friends. But yeah I think people coming to the end of their lives definitely need a support services because you probably find that they don’t have a lot of support coming from anywhere else.”

– Groundswell focus group participant

Homelessness involves elements of isolation and social exclusion, with support networks tending to be fragmented or unavailable. This isolation means that extra support for people in their final days (as well as those around them) is needed. Whether this is through a mainstream or specialist palliative care service, the key is that people are given the choice to make decisions about where they pass away and how they are supported to do so with dignity and respect.

Some people who have been homeless for a long time and not in contact with mainstream services can have complex chronic health conditions but no formal diagnosis, which can itself become a barrier to accessing palliative care as referrals from non-NHS services are not accepted within formal diagnoses from a medical professional.

It is common to have had experiences where fellow residents in homelessness support services had passed away, either as an unexpected incident or following a protracted bout of illness. Staff at hostels are often unprepared (or unable) to offer emotional support to the individual who is passing away, or to the other residents in the hostel.

10.1 Ensure providers of end of life and palliative care have multi-agency and multi-disciplinary partnership working arrangements in place for those people experiencing homelessness in the local area

This should include the ability for palliative care services to be able to in-reach to hostels and outreach to the streets when needed. They should also include a regular multi-disciplinary and multi-agency interface to support personalised care planning. Care pathways should support those with chronic health conditions and co-morbidity, e.g. mental health, brain injury, learning disabilities, substance use and alcohol.

10.2 Ensure providers of end of life and palliative care have care pathways and resources in place that enable people to die in their preferred place of death

This could be in a hostel or on the street, dependent on the individual patient's circumstances and wishes. Medication management protocols for hostels should enable controlled drugs to be safely held there and in other accommodation where the person is choosing to die.

10.3 Ensure providers of palliative care proactively work with local multi-agency partners to identify people with chronic health conditions, in hospital or in the community, who may be approaching the end of life

Consideration should be given to providing, in partnership with the Local Authority, a local end of life care coordinator specific for people who are homeless. This would focus on homeless and marginalised groups and support personalised emergency care planning. For example through fast-track referrals and Continuing Care Assessments between NHS and non-NHS providers for those people who remain homeless through choice when they deteriorate unexpectedly and suddenly.

10.4 Non-NHS staff working within hostels, day centres and street outreach should be supported with training to enable them to provide appropriate advice, care and support to people with deteriorating chronic health conditions who may not be accessing regular healthcare but have health related care needs

Reciprocal arrangements could be in place for training to be available for hospice, palliative care and end of life care workers on how to work with people who have a history of homelessness and may still be homeless. This training should include what is an acceptable and safe environment to discharge someone to and how to accept

someone's choices, however unwise they might be and how to plan care around their choices.

A free, [online toolkit](#) has been developed to help hostel staff identify and support homeless people with advanced ill-health.