



A Future. Now
Homeless Health Matters: the case for change
October 2014



**St Mungo's
Broadway**
Rebuilding lives, day by day

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Executive summary

Homeless Health Matters: the case for change is aimed at Health and Wellbeing Boards and their constituent members. It shows how health and housing services can be better designed to meet the health needs of homeless people.

People who are homeless have worse health than most, yet they find it harder to get help. While there are some services which are effective in addressing the health needs of homeless people, this is not yet consistent across the country. There is an urgent need for change. We are calling on Health and Wellbeing Boards to take action to improve homeless health.

Why?

1. Homelessness hurts:

People who are homeless often have multiple and complex health needs.

- **73%** of homeless people report a physical health problem¹
- **80%** report a mental health problem²
- The average age of people who die while homeless is **47**; for women it is only **43**.³

Despite this, people who are homeless often struggle to access healthcare.⁴ Changes to how health and housing support is provided can make a significant difference.

2. The financial cost:

The annual cost of hospital treatment for homeless people is at least **£85m a year**.⁵ Failure to support homeless people to get the healthcare they need when they need it, before they require urgent hospital treatment, comes at great cost to the health sector, and for homeless people themselves. There is mounting evidence of a number of health interventions that can bring significant financial savings.⁶

3. Health inequalities:

Health and Wellbeing Boards must act to **improve the health** of all local people. Clinical commissioning groups have a **duty to reduce inequalities in health outcomes and access to health services**. These responsibilities will not be met unless action is taken to improve the poor health experienced by people who are homeless.

¹ Homeless Link (2014) *The unhealthy state of homelessness: health audit results 2014*

² As above

³ Based on analysis of CHAIN (Combined Homelessness and Information Network) data, which suggests that between 2009 and 2014, 307 people who had slept rough in London died. The mean average age of death for men was 47, and for women, 43. This aligns with previously published research which used a larger sample: Thomas, B (2011) *Homelessness is a silent killer* Crisis. CHAIN is a multi-agency database recording information about rough sleepers and the wider street population in London, commissioned and funded by the Mayor of London and managed by St Mungo's Broadway

⁴ McCormick, B, (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health

⁵ As above

⁶ Hendry, C (2009) *Economic Evaluation of the Homeless Intermediate Care Pilot Project*; Hewitt, N (2010) *Evaluation of the London Pathway for Homeless Patients* University College London Hospitals

So how do we change this?

Homelessness is a social determinant of health: it can both cause and exacerbate health problems. Poor health can also make it more difficult to recover from homelessness.

Integrating housing and health commissioning can help ensure people who are homeless get the support they need to improve their health and move on from homelessness.

There are different ways of achieving this integration. Key commissioning principles are ensuring parity of esteem between physical and mental health, training for both health and homelessness staff, cross boundary commissioning, and advocacy.

Summary of recommendations:

Homeless Health Matters: the case for change explores how services can be designed to overcome the many barriers to care experienced by people who are homeless. To achieve this, we are calling on Health and Wellbeing Boards to take the following actions:

1. Identify need:

Knowledge of local health needs is a prerequisite for designing effective services. Health and Wellbeing Boards have a central role in collating this knowledge in Joint Strategic Needs Assessments (JSNAs). Research by St Mungo's Broadway and Homeless Link found that only 36% of JSNAs currently make reference to single homelessness, and only a quarter include detailed information.⁷

- The health needs of single homeless people should be included in each JSNA
- Health and Wellbeing Boards should work with homelessness agencies to collect this data

- People with experience of homelessness should be involved in developing this knowledge.

2. Provide leadership:

Without strong leadership to drive improvements to homeless health and wellbeing, the needs of single homeless people are more likely to be overlooked.

- Directors of Public Health should provide this leadership
- Health and Wellbeing Boards should regularly consider homeless health
- Clinical commissioning groups should ensure they respond to the health needs of local people who are homeless.

This leadership must ensure vulnerable individuals do not fall into the gaps between services.

3. Commission for inclusion:

Commissioners of health and homelessness services should ensure that services meet the health needs of people who are homeless, and that they are welcoming and easily accessible. There is no one size fits all solution, but *Homeless Health Matters: the case for change* sets out a range of approaches for making services more accessible.

We are asking Health and Wellbeing Boards to sign up to the *Charter for Homeless Health*, committing to identify need, provide leadership and ensure inclusive commissioning.

Signing the *Charter for Homeless Health* is the first step towards ensuring a better future for homeless people. Now.

⁷ Hutchinson, S, Alcott, L and Albanese, F (2014) *Needs to know: including single homelessness in joint strategic needs assessments* St Mungo's Broadway and Homeless Link

Conclusion

Homelessness has a huge impact on individual health. Homelessness can make it difficult to get help for health problems, which can lead to worse health in the longer term. This has a knock on effect on the NHS, as failure to improve health at an early stage can lead to avoidable emergency admissions, hospital treatment and reliance on long term care.

There is no single solution, but *Homeless Health Matters: the case for change* shows how health commissioners, local authorities, homelessness services and homeless people themselves can work together to improve homeless health.

**Homeless health matters:
now is the time for change.**



Introduction: homeless health matters

People who are single homeless experience significant health inequalities; they are more likely than the general population to experience multiple physical and mental health problems. Yet they frequently miss out on the healthcare they need. Health problems often go untreated until they become critical, resulting in expensive, and often avoidable, treatment.

The links between housing and health are well known⁸ and local areas are increasingly looking at integrated responses. However, the particular health needs associated with single homelessness are often overlooked or misunderstood.⁹ This report aims to provide the information that relevant commissioners need to understand and address the impact on health of single homelessness. This will help commissioners demonstrate progress towards achieving their statutory duties on improving health and reducing health inequalities.

Single homeless: what do we mean?

This report is concerned with 'single homeless people', generally understood to be those who are homeless but do not meet the priority need criteria¹⁰ to be housed by their local authority. Many may nevertheless have significant support needs. They may live in supported accommodation, e.g. hostels and semi independent housing projects, or sleep rough, sofa surf¹¹ or live in squats. Single homeless people may be in a relationship and/or have children who are not currently living with them.

The extent of single homelessness in England

There are single homeless people living in every local authority. In 2014, Homeless Link estimated there were 38,534 supported accommodation bed spaces in England for single homeless people.¹² The Department for Communities and Local Government (DCLG) publishes annual figures on rough sleeping in England, based on snapshot street counts or estimates from local authorities. These suggest there were 2,414 people sleeping rough on a single night during the autumn of 2013.¹³ Many more people sleep rough over the course of a year: 6,508 people were seen sleeping rough by outreach workers in London alone in the year up to April 2014.¹⁴

This report is part of the **St Mungo's Broadway** campaign **A Future. Now: Homeless Health Matters**. We are calling on local areas to take action to improve the health of homeless people. As a first step, we are asking that Health and Wellbeing Boards sign up to our [Charter for Homeless Health](#).

⁸ Barnes, M, Cullinane, C, Scott, S and Silvester, H (2013) *People living in bad housing – numbers and health impacts 2013*; National Housing Federation (2014) *Connecting Housing and Health series*

⁹ Hutchinson, S, Alcott, L and Albanese, F (2014) *Needs to know: including single homelessness in joint strategic needs assessments* St Mungo's Broadway and Homeless Link

¹⁰ Priority need groups established in the 1996 Housing Act and the Homeless (Priority Need) Order 2002 criteria are intended to protect pregnant women and those with dependent children; those vulnerable as a result of old age, mental illness or disability or other special reason; 16 and 17 year olds and care leavers under 21; victims of domestic violence; people who have been made homeless by a disaster and people who meet certain definitions of vulnerability

¹¹ People who habitually stay with friends, family or acquaintances rather than in accommodation that they themselves own or rent

¹² Homeless Link (2014) *Support for single homeless people in England*

¹³ Department for Communities and Local Government (2014) *Rough sleeping statistics England Autumn 2013 Official Statistics*

¹⁴ St Mungo's Broadway (2014) *CHAIN Annual Report 2013/14: Street to Home*

The St Mungo's Broadway Charter for Homeless Health

People who are homeless face some of the worst health inequalities in society. They are at much greater risk of mental and physical health problems than the general population and their experiences of homelessness often make it more difficult to access the healthcare they need.

The *[Insert Local Authority name]*

Health and Wellbeing Board is committed to changing this.

We therefore commit to:

Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

Commission for inclusion: We will work with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

Homeless Health Matters: outline

This report aims to assist Health and Wellbeing Boards and their constituent members in delivering the commitments of the *Charter for Homeless Health*.

Section One sets out the case for action, including: the impact of homelessness on health; the barriers to healthcare commonly experienced by people who are homeless; the economic case; and the legal duties which should encourage action.

Section Two makes recommendations to Health and Wellbeing Boards and their constituent members for action. The *Charter for Homeless Health* commitments are explored in order. A number of recommendations are made for each, and examples of existing services that aim to improve homeless health are described.

**Homeless Health Matters:
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Inclusion Health

Single homeless people are one of the four groups focused on by the Inclusion Health programme run by the Department of Health. This recognises that homeless people (not only those who are single homeless), Gypsies and Travellers, people involved in prostitution and vulnerable migrants are among those facing the worst health outcomes in society.

While the focus in this report is on the particular health needs of single homeless people, we recognise that there is an urgent need to ensure the needs of each of these groups is understood and met by the health sector. Many single homeless people may also fall into one or more of the other Inclusion Health groups, and may therefore face additional barriers that must be understood to be overcome. Approaches to improve the health of people who are homeless may be integrated into wider efforts to tackle health inequalities across all these groups.

Section One: the case for change



Section One sets out the case for urgent change in how the health needs of homeless people are addressed. Facing poor health and struggling to get the care that most people take for granted, people who are homeless often find it difficult to take control of their health. This prevents people recovering from homelessness, places significant financial burdens on the health system, and disrupts efforts to reduce health inequalities.

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I. What's the impact?

Homelessness and ill health

Homelessness is a significant social determinant of health and is associated with premature mortality. **People who are or have been single homeless experience multiple and chronic health problems at a rate that is significantly higher than the general population.**

The 2014 Homeless Link Health Needs Audit found that 73% of homeless people reported a physical health problem. In total, 41% of those surveyed reported a long term problem, compared with 28% of the general population who report a long term physical health condition.¹⁵

Multiple and co-occurring physical and mental health problems alongside substance use are common. Many single homeless people experience long term and chronic conditions.¹⁶ Infectious diseases such as Tuberculosis, Hepatitis C and HIV disproportionately affect people who are homeless,¹⁷ and at St Mungo's Broadway our experience is that these conditions can be difficult for people living in hostels or on the street to manage.

Among St Mungo's Broadway clients:

- 70%** report a physical health need
- 47%** have a significant medical condition
- 65%** report a mental health problem
- 27%** report simultaneous physical and mental health problems and substance use issues
- 73%** smoke cigarettes/tobacco
- 52%** use alcohol and/or drugs problematically
- 35%** say that drug use was a factor contributing to their homelessness and 33% cited alcohol use¹⁸

Mental health problems are far more common among homeless people than in the general population.

Homeless Link's Health Needs Audit found that 80% of those surveyed had some sort of mental health problem, with 45% having a mental health diagnosis compared to 25% among the general population.¹⁹ Research published by the **Salvation Army** found that 53% of homeless women, and 34% of homeless men had attempted suicide at least once.²⁰

For many people who are homeless, particularly women, mental health issues are rooted in experiences of neglect and abuse in childhood. These are often compounded throughout adult life and by the experience of homelessness itself.²¹

¹⁵ Homeless Link (2014) *The unhealthy state of homelessness: health audit results 2014*

¹⁶ Deloitte (2013) *Healthcare for the Homeless*; Bines, W (1994) *The health of single homeless people* (Centre for Housing Policy Discussion Paper 9); Homeless Link (2010) *The health and wellbeing of people who are homeless: evidence from a national audit*; Homeless Link (2013) *Survey of Needs and Provision (SNAP)*; MacGuire, N, Johnson, R, Vostanis, P, Keats, H, (2009) *Homelessness and Complex Trauma: A Review of the Literature*

¹⁷ Beijer U et al (2012) 'Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis' *The Lancet Infectious Diseases*; 12: 11, 859–870

¹⁸ Figures above taken from St Mungo's Broadway 2014 survey of clients

¹⁹ Homeless Link (2014) *The unhealthy state of homelessness: health audit results*

²⁰ Bonner, A and Luscombe, C (2009) *The Seeds of Exclusion 2009* The Salvation Army, University of Cardiff and University of Kent

²¹ Hutchinson, S, Page, A and Sample, E (2014) *Rebuilding Shattered Lives: the final report St Mungo's*

Drug and alcohol use often develop as a means to cope with the difficulties of homeless life and past trauma; the effects of drug and alcohol use also have a strong and destructive effect on the physical health of homeless people. Homeless people with alcohol dependency are 28 times more likely to have an emergency admission to hospital than the general public.²²

Ultimately, homelessness can kill. Homelessness is an independent risk factor for premature death.²³ Between 2009 and 2014, 307 deaths were recorded among people who had slept rough in London. The average age of death for men was only 47, for women, only 43.²⁴ This reflects findings from research based on a much larger sample size, which also found the average age of death of someone who died while homeless (including those in homeless hostels or night shelters) was 47, and for women, 43.²⁵

Analysis of data on deaths within our hostels between 2001 and 2012 suggests people living in homeless hostels are 3.5 times more likely than the general population to die at any age between 15 and 64. Women under 45 are 8.5 times more likely to die than their housed counterparts.²⁶

Many of these deaths may have been avoided with improved access to healthcare. The Faculty for Homeless and Inclusion Health notes, “when homeless people die they do not commonly die as a result of exposure or other direct effects of homelessness, they die of treatable medical problems, HIV, liver and other gastro-intestinal disease,

respiratory disease, acute and chronic consequences of drug and alcohol dependence”.²⁷



²² Data from Central London CCG 2011

²³ Morrison, DS (2009) 'Homelessness as an independent risk factor for mortality: results from a retrospective cohort study' *International Journal of Epidemiology* v.38 pp. 877-883; The Faculty for Homeless and Inclusion Health (2013) *Standards for commissioners and service providers: Version 2.0* (Mean) based on analysis of CHAIN data.

²⁴ Thomas, B (2011) *Homelessness: a silent killer* Crisis

²⁵ Thomas, B (2011) *Homelessness: a silent killer* Crisis

²⁶ Based on analysis of data from hostels run by St Mungo's prior to the merger with Broadway.

²⁷ The Faculty for Homeless and Inclusion Health (2013) *Standards for commissioners and service providers: Version 2.0*

2. The barriers to accessing healthcare

The chronic poor health of many single homeless people is compounded by extensive barriers to accessing healthcare. Understanding how these barriers operate is vital if inequalities in service access are to be addressed.

GPs are the primary point of access to health services. Despite improvements in recent years, many homeless people still **struggle to register with a GP**, often due to being unable to provide a permanent address or the documentation required to register. More work is needed to ensure every homeless person can register with a GP.

Health services are conventionally designed to **treat one condition at a time**. The multiple health problems frequently experienced by homeless people often means support must be accessed from different parts of the health system. This can be difficult to navigate, particularly when people are leading chaotic lifestyles and managing issues relating to mental health and substance use.

Untreated mental health problems can act as a barrier to seeking help. Those with conditions such as depression can find it hard to be proactive about improving their health. **People with complex needs, and, in particular, complex trauma,²⁸ often find it difficult to manage their emotions in the face of perceived adversity, and can exhibit challenging behaviours and poor compliance with appointments and treatment.** Missed appointments can then lead to people being excluded from services. Negative interactions with, and exclusion from, support services can themselves act as traumatic experiences,²⁹ meaning engagement can be distressing.

Despite investment in the Improving Access to Psychological Therapies (IAPT) programme, **people who are homeless consistently miss out on mental health care** as services available are often not suitable for those with complex needs. There is a particular **lack of support for people with a dual diagnosis of mental health and substance use.**³⁰ Many mental health services exclude those who are currently using drugs or alcohol. However, our experience working with clients with dual diagnosis shows they often need to deal with their mental health problems in order to tackle their drug or alcohol use, which can be rooted in the same trauma.

“[I’ve been trying to get help for my mental health problems] but they won’t, because I drink... I said well, I drink because of my issues, she said which way are we doing this? I went through detox, after detox, after detox, then I was thrown back out on the street. Well, what’s the first thing I’m going to do? I’m back out on the street having another drink” – St Mungo’s Broadway client

Identification of homelessness is key to improving the healthcare that homeless people receive. However, there is evidence that **health staff often remain unaware that a patient is homeless** because the patient has not been asked, or fears admitting their homelessness.³¹

²⁸ Herman, J (1997) *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror* New York: Basic Books

²⁹ Scanlon, C. and Adlam, J (2008) 'Homelessness and disorder: the challenge of the antisocial and the societal response', 27-38, in C. Kaye and M. Howlett (eds) *Mental Health Services Today and Tomorrow: Part 1 Experiences of Providing and Receiving Care* Oxford: Radcliffe; Department of Health (2003) *Personality disorder: no longer a diagnosis of exclusion - policy implementation guidance for the development of services for people with personality disorder*; Anderson, S (2011) *Complex Responses: Understanding poor frontline responses to adults with multiple needs. A review of the literature and analysis of contributing factors* Revolving Doors Agency

³⁰ Brodie, C, Carter, S and Perera, G (2013) *Rough sleepers and health care: a review of the health needs and healthcare costs of rough sleepers in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea, and Westminster* Broadway; St Mungo's (2009) *Happiness Matters: homeless people's views about breaking the link between homelessness and mental health*

³¹ Homeless Link and St Mungo's (March 2012) *Improving hospital admission and discharge for people who are homeless*

A **lack of understanding** on the part of health staff is often a crucial barrier to care. **Many homeless people report experiencing discrimination, which makes them unwilling to seek medical help, or can even result in their being refused treatment.**³² Staff may lack the skills to work with people who have complex needs, or who exhibit challenging behaviour.

Homeless people may feel they have **more immediate problems** to deal with than their health, and put off seeking treatment until they require urgent care.³³ They may also struggle to engage with their own health needs, and some may find it difficult to comply with advice.

People who are single homeless may also be **more transient** than other populations. This can make it more difficult to maintain engagement with health services, particularly where there are low levels of trust of medical staff.

Low levels of literacy can also deter people from seeking help and can make understanding written advice, such as prescription instructions, challenging. Research by St Mungo's Broadway found that 51% of people who are homeless lack the basic English skills needed for everyday life.³⁴

Single homeless people, and especially those with multiple and complex needs, can find it difficult to access health services. Health services are under a duty not only to reduce inequalities in health outcomes, but also in access to health. Commissioners should aim for inclusive commissioning that overcomes these barriers and creates responsive and accessible health services. Approaches to achieve this are set out in Section Two.



³² Homeless Link and St Mungo's (March, 2012) *Improving hospital admission and discharge for people who are homeless*; Brodie, C, Carter, S and Perera, G (2013) *Rough sleepers and health care: A review of the health needs and healthcare costs of rough sleepers in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea, and Westminster Broadway*

³³ McCormick, B, (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health

³⁴ Dumoulin, D and Jones, K (2014) *Reading Counts: Why English and maths skills matter in tackling homelessness* St Mungo's Broadway and the Work Foundation

3. The financial cost of homeless ill health

The undeniable moral case for improving the health of homeless people is backed up by a significant financial rationale.

The barriers to health services outlined in the last chapter mean people who are homeless often find it difficult to access primary care and preventative support, only seeking help when their condition has deteriorated to the point at which they need emergency hospital treatment. This results in a tendency to use more expensive emergency services, longer stays in hospital and multiple readmissions.³⁵ Among St Mungo's Broadway clients, 22% had an ambulance called out for them at least once in the past year and 36% attended A&E at least once.³⁶ Homeless Link found that homeless people report an average of 1.66 A&E visits a year, compared to 0.38 among the general population.³⁷

This has clear cost implications for the NHS and wider services. The Department of Health estimated that the cost of hospital treatment alone for homeless people is at least £85m a year, meaning costs of more than £2,100 compared to £525 per person among the general population.³⁸

An increasing body of evidence shows that health interventions targeted at people who are homeless can bring significant financial savings.

- Evaluation of the St Mungo's and Lambeth PCT Intermediate Care pilot, which provided health services within a homelessness hostel, found that during the time the project ran, **A&E visits dropped by half, from 8.4 per month to four per month between 2008 and 2009**. Inpatient admissions fell from 10 a month to 2.33 a month. This suggests savings of about £8,000 for the NHS, while improving mortality and morbidity as a result of improved health.³⁹
- Evaluation of the London Pathway, which provides clinical support to homeless people as they prepare for discharge from hospital, estimated the service would lead to net savings of £300,000 a year (based on annual staff costs of £100,000). The programme **reduced the average length of stay by 3.2 days**.⁴⁰
- Research on Tuberculosis screening (provided predominantly but not exclusively to people who are homeless) found that the cost of screening per person was £96.36 in a hospital, £13.17 in a hostel and £1.26 in a GP practice, suggesting that providing this service outside of secondary care can bring considerable cost efficiencies.⁴¹

³⁵ Brighter Futures (2012) *Better Treatment for Rough Sleepers, reducing A&E attendances*; Homeless Link and St Mungo's (2012) *Improving Hospital Admission and Discharge for people who are homeless*

³⁶ St Mungo's Broadway 2014 client needs survey

³⁷ Homeless Link (2014) *The unhealthy state of homelessness: health audit results 2014*

³⁸ McCormick, B. (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health. This is based on analysis of service use by patients classed as 'No Fixed Abode' (NFA). However, the limitations of NFA data have been raised, e.g. Aspinall, P. J. (2014) *Hidden Needs - Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers Inclusion Health*

³⁹ Hendry, C. (2009) *Economic Evaluation of the Homeless Intermediate Care Pilot Project*

⁴⁰ Hewitt, N. (2010) *Evaluation of the London Pathway for Homeless Patients* University College London Hospitals

⁴¹ G. H. Bothamley, J. P. Rowan, C. J. Griffiths, M. Beeks, M. McDonald, E. Beasley, C. van den Bosch, G. Feder (2002) 'Screening for tuberculosis: the port of arrival scheme compared with screening in general practice and the homeless' in *Thorax* v57 pp.45-49

The case for intervening early to address developing health needs is supported by new analysis of data collected for a review of the health needs and health costs of rough sleepers in north west London.⁴² This demonstrates the high costs incurred by a small group of homeless people with particularly high health needs. The use of acute hospital services, outpatient and inpatient hospital admissions by 561 people seen sleeping rough in London between January 2010 and December 2011 was examined.

It was found that the **average cost of healthcare for each of the 5% of people seen sleeping rough who needed the most healthcare was £27,000 over two years, compared to under £300 for the 10% who needed the least.**

The existence of such a group of high need patients strengthens the case for improving homeless people's health through access to healthcare at an earlier stage, and for helping people to manage both their health and housing problems to avoid problems worsening.

There are clear costs to both individuals and to the health service of failing to recognise homelessness as a social determinant of health or to get healthcare right for single homeless people. This chapter has illustrated the costs of homeless health, but also shown that where the health needs of homeless people are specifically addressed, significant savings are possible.



⁴² St Mungo's Broadway and Resolving Chaos (2014) *An analysis of the cost of acute health service use by rough sleepers in London*

4. The health inequalities agenda: the responsibilities of statutory agencies

The *Health and Social Care Act 2012* and the *NHS Mandate*⁴³ further strengthen the case for local action to tackle the significant health inequalities faced by homeless people outlined previously.

The Act introduced duties to improve health and reduce health inequalities. The Secretary of State has clearly stated that “further progress is needed... to tackle inequalities in access and outcomes. Across the system in 2014-15 we now need to build on this early progress, broadening our knowledge and understanding, and supporting effective action across all communities”.⁴⁴

Improvement of health

The Act gives responsibility for public health to local authorities, requiring that they take appropriate steps to **improve the health of people in the area**, and provide assistance to individuals to help them **“minimise any risks to health arising from their accommodation or environment”**.⁴⁵ As such, the local authority has a duty to improve the health of all, including single homeless people, and to provide assistance to help minimise health risks arising from accommodation.

Local authorities are also required to produce an **assessment of local health needs**, which should identify the needs of all people in the local area. These Joint Strategic Needs Assessments (JSNAs) should identify the health needs of homeless people, including single homeless people, and the gaps in current services. This is underlined in Department of Health Guidance on compiling Joint Strategic Needs Assessments that states

“health and wellbeing boards will need to consider...how needs may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services; and those with complex and multiple needs such as...homeless people”.⁴⁶

Health inequalities

The Act places duties on the Secretary of State for Health, NHS England and clinical commissioning groups (CCGs) to **“have regard to the need to reduce health inequalities”**. Local health commissioners (CCGs and NHS England area teams) are, therefore, required to reduce inequalities in both outcomes from health services and access to health services. As shown in earlier sections, single homeless people are disadvantaged in both outcomes and access.

Progress towards reducing health inequalities is measured using a range of indicators set out within NHS, Public Health and Social Care **Outcomes Frameworks**. A number of these indicators are particularly relevant to the health of homeless people. Addressing homeless health will therefore help commissioners to demonstrate that they are improving outcomes against these indicators while reducing fundamental health inequalities.

⁴³ Department of Health (2013) *The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 - March 2015*

⁴⁴ Hunt, J (2014) *Department of Health Annual Assessment of the NHS Commissioning Board (known as NHS England) 2013-14* Department of Health

⁴⁵ *Health and Social Care Act 2012*, Section 2B, London: The Stationary Office

⁴⁶ Department of Health (2011) *Joint Strategic Needs Assessment and joint health and wellbeing strategies explained*

Outcomes Frameworks: key indicators

NHS Outcomes Framework	Public Health Outcomes Framework	Social Care Outcomes Framework
<ul style="list-style-type: none"> • Emergency readmissions within 30 days of discharge from hospital • Patient experience of hospital care and A&E services • Excess under 75 mortality rate in adults with serious mental illness • Cardiovascular disease, respiratory disease and liver disease 	<ul style="list-style-type: none"> • Numbers of households who are statutory homeless • The number of households in temporary accommodation • Levels of domestic abuse • Alcohol related admissions to hospital • Treatment for TB to completion • Smoking prevalence – adults (over 18s) • Successful completion of drug treatment • Suicide rate 	<ul style="list-style-type: none"> • Social care related quality of life • Proportion of adults in contact with secondary mental health services in paid employment • Proportion of adults in contact with secondary mental health services living independently, with or without support • Delayed transfers of care from hospital, and those which are attributable to adult social care

The NHS Outcomes Framework is used to measure progress towards meeting the goals in the NHS Mandate, which sets out the Secretary of State's expectations of NHS England. The Mandate highlights the link between ill health and homelessness, and establishes **“helping people experiencing ill health, whether mental or physical, to remain in or return to work, and avoid homelessness”** as a priority for the organisation.⁴⁷

The importance of addressing the complex needs of single homeless people was underpinned by the Secretary of State's Ministerial Statement in his annual assessment of NHS England. He stated the Government's wish to “see the NHS make further progress in transforming primary care to improve services for...those with the most complex need”.⁴⁸

Integration

The Act gives Health and Wellbeing Boards and CCGs responsibility to **promote integration between local services, including health, social care or health related services**. Given the complexity of need many homeless people experience, this duty to increase integration is particularly important.

Section One of this report has set out our case that homelessness is a social determinant of health, and that action should be taken to improve homeless health. Efforts to address health inequalities will benefit from recognition of the particular inequalities faced by homeless people. Section Two provides examples of how this can be achieved in practice.

⁴⁷ Department of Health (2013) *The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 - March 2015*

⁴⁸ Written Ministerial Statement by the Secretary of State for Health Jeremy Hunt, on 'Annual Assessment of NHS England Annual, NHS Mandate and Outcomes Framework' Tuesday 22 July 2014

Section Two: taking action



What can be done to better address the health needs of homeless people? **Section Two** seeks to answer this question. It sets out our recommendations for local commissioners and provides examples of good practice. Each chapter addresses one of the *Charter for Homeless Health* commitments to: improve understanding; provide leadership; and ensure inclusive commissioning.

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I. Improve understanding



From the *Charter for Homeless Health*

Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

This chapter sets out the central role of Health and Wellbeing Boards in ensuring data is collected on the health needs of homeless people and highlights opportunities to involve other local organisations in this.

Joint Strategic Needs Assessments (JSNAs) underpin every local area's strategy for meeting the health and wellbeing needs of their population. However, despite the health inequalities outlined above, a recent audit⁴⁹ of 50 JSNAs carried out by St Mungo's Broadway and Homeless Link found:

- Only 36% of JSNAs referred to single homelessness or rough sleeping
- Only a quarter of JSNAs provided detailed analysis of the needs of single homeless people
- 50% referred only to statutory homelessness, or to non specific 'homelessness' without considering the different health impacts of statutory and single homelessness
- No correlation between the level of homelessness in an area and whether the JSNA included single homelessness.

We are calling on all Health and Wellbeing Boards to use their JSNA to identify the health needs of homeless people in their community, including those of people who are single homeless.

Recommendation 1: Health and Wellbeing Boards should ensure that the health needs of single homeless people are included in their JSNA. See St Mungo's Broadway and Homeless Link's briefing for further information.⁵⁰

The challenge of gathering data on the health needs of people who are homeless and other excluded groups has been evidenced in recent research by the National Inclusion Health Board for the Department of Health.⁵¹ However, these challenges in data collection should not be a reason to omit the health needs of single homeless people from local needs assessments. There is much that can be achieved in local areas alongside the pursuit of an improved national approach over the longer term.

⁴⁹ Hutchinson, S, Alcott, L and Albanese, F (2014) *Needs to know: including single homeless people in JSNAs* St Mungo's Broadway and Homeless Link. Based on keyword searches of a purposive sample of 50 Health and Wellbeing Boards, including a mix of areas with high, medium and low levels of single homelessness.

⁵⁰ St Mungo's Broadway and Homeless Link (2014) *Improving the health of the poorest, fastest: including single homeless people in your JSNA*

⁵¹ Aspinall, P J (2014) *Hidden Needs – Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers* Inclusion Health

Homelessness agencies are a key source of information about local need. Local authorities already contract homelessness agencies to provide support, and should use this relationship to gather intelligence on local needs and barriers to services. This should include information on those unable to access services, for example, due to waiting lists or exclusions. Homelessness agencies should ensure they are recording information on the health needs of their clients and using this to contribute to local needs assessments and strategies. Cooperation between CCGs and homelessness services will be crucial to ensure this information is comprehensive.

Recommendation 2: Health and Wellbeing Boards should work with local homelessness agencies to collect information on homeless health needs, including access to local services. Local authorities will already be commissioning services such as homelessness hostels and outreach services and will have strong links with local agencies.

Homeless people themselves are also a vital source of information about health needs, and especially about gaps in or obstacles to accessing services. As the consumer champion for health and social care, Healthwatch branches have a key role in representing people who are homeless. An example from Islington shows how this can work in practice.

Healthwatch Islington is working closely with **Islington CCG** to help them better understand why vulnerable groups, including homeless people, were struggling to access GP care. Islington CCG with Healthwatch brought local services working with excluded groups together to identify and better understand issues. The CCG also undertakes regular focus groups and workshops with the local community. This work has led to the introduction of training for GP receptionists. Healthwatch Islington will be organising 'mystery shopping' checks to assess whether improvements are made as a result.

Recommendation 3: Health and Wellbeing Boards should work with client involvement groups to ensure needs assessments, strategies and commissioning decisions are informed by the experience of people who are homeless.

This client involvement may be delivered through local Healthwatch organisations, who should work with client involvement groups or consider ways of facilitating this where there are no existing groups.

Inclusion Healthcare

A specialist GP practice for homeless people in Leicester; Inclusion Healthcare, demonstrates that identification of need is a critical step in commissioning inclusive services.

The service was first commissioned (by the then Primary Care Trust) after a local GP undertook research that revealed a significant need for homeless healthcare. A pilot was funded that showed there was sufficient need for a full specialist GP practice.

The GP practice is now run as a social enterprise, funded by NHS England through a five year Alternative Provider Medical Services (APMS) contract. Other services, for example a full time alcohol specialist nurse, have been added to the contract as areas of unmet need are identified. The social enterprise has expanded and secured additional DAAT (Drug and Alcohol Action Team) and CCG contracts for substance use services in the community and at HMP Leicester. These further improve patient pathways and allow services to be delivered more efficiently as central costs are shared across business units.

Inclusion Healthcare offers primary care, including GP appointments, specialist consultant nurse care, outreach nurses visiting hospitals and hostels and physiotherapy. In addition, it provides access to visiting optician, podiatry and specialist alcohol and substance use services. It works closely with a range of local partners including Probation and the Leicester Partnership Trust with whom they have established a shared care drug treatment service. Now an established training practice, Inclusion Healthcare contributes to GP, undergraduate medical and nursing training.

Inclusion Healthcare also runs a Patient Participation group, offering patients the chance to give their views and feedback on services.

More information: http://inclusion-healthcare.co.uk/patient_care



2: Provide leadership to improve homeless health



From the *Charter for Homeless Health*

Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

The complex health conditions and range of other support needs presented by people who are homeless require coordination across multiple services. While the provisions of the *Health and Social Care Act 2012* include a welcome increased focus on health inequalities and integration, the split in commissioning between NHS England area teams (which have a direct commissioning function for primary care), CCGs (that commission secondary care) and upper tier local authorities (that commission public health, and social care⁵²) presents a real risk of a lack of coordination. This has the potential to be **dangerous** for vulnerable individuals who fall between these services. Strong leadership is needed to ensure consistent efforts are made to address the health inequalities faced by homeless people.

With their role in tackling health inequalities, **Directors of Public Health** should provide this leadership in local areas. All Directors of Public Health should:

- Ensure single homelessness is included in the JSNA
- Ensure Health and Wellbeing Boards receive regular reports on levels of single homelessness, health needs identified and progress in addressing them
- Promote integrated responses to homeless health needs
- Identify and coordinate opportunities for cross boundary or cross borough working on homeless health services.

Considering their broad remit, Directors of Public Health may wish to delegate the above roles to a senior official to act as the **accountable officer for homeless health**. This role may also include a consideration of other socially excluded groups.

Health and Wellbeing Boards as a whole also have a key role to play in holding their Director of Public Health to account for the above.

Recommendation 4: Health and Wellbeing Boards should provide leadership on addressing homeless health. **Directors of Public Health** have a key leadership role to play in tackling health inequalities and should lead in promoting integrated responses and identifying opportunities for cross boundary working.

Recommendation 5: Health and Wellbeing Boards should provide leadership on homeless health by ensuring they are regularly considering homeless health. **Local Healthwatch organisations** should scrutinise JSNAs to ensure they include the health needs of homeless people, including those who are single homeless.

⁵² Lower tier local authorities are responsible for commissioning housing services, which include housing options/homelessness services

3. Commission for inclusion



From the *Charter for Homeless Health*

Commission for inclusion: We will work with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

3.1 Commissioning for inclusion

After the health needs of single homeless people have been identified in the Joint Strategic Needs Assessment (JSNA), there will be a choice about how best to respond. There is no one size fits all solution and the most appropriate action will depend on a number of factors, including the level of homelessness in each area and the availability of existing support. However, there are a number of overarching principles that should guide commissioning decisions. This chapter highlights these principles, exploring and providing examples of the different options available.

The **Faculty for Homeless and Health Inclusion Standards for Commissioners**⁵³ sets out recommendations for commissioners on working with homeless people and other excluded groups. These provide a crucial starting point for any commissioning and should be taken into consideration in all areas. Key principles include:

- Improving collection of data on homelessness and ensuring this is regularly reviewed
- Ensuring staff act as 'gate openers' not 'gatekeepers', so vulnerable people are not turned away due to prejudice or misunderstanding related to their homelessness
- Multi agency working to tackle complex and multiple problems.⁵⁴

3.1.1 Integrate health and housing

The identification of homelessness as a significant social determinant of health makes a clear case for taking an integrated approach to addressing health and housing need. The transfer of public health responsibilities to local authorities and the establishment of Health and Wellbeing Boards has provided clear opportunities to implement this. Arrangements for achieving it range from pooling or aligning budgets to informal agreements between services.

⁵³ The Faculty for Homeless and Inclusion Health (2013) *Standards for commissioners and service providers: Version 2.0*

⁵⁴ For more information see www.pathway.org.uk

Integrated health, housing and social care in Bradford

Partnership working between the City of Bradford, the clinical commissioning group, Bevan Healthcare CIC and Horton Housing Association, as well as innovative commissioning has led to the creation of integrated health, housing and social care support for homeless people. There are two service delivery models. One is hospital based (Pathway), the other is an accommodation based project (Bradford Respite Intermediate Care and Support Service or BRICSS).

Pathway, based at Bradford Royal Infirmary, is a multidisciplinary assessment and referral team hosted by Bevan Healthcare. The team consists of a practice GP, nurse and a specialist housing worker from Horton Housing Association.

BRICSS is a 14 bed accommodation unit run by Horton Housing that, working with Bevan Healthcare, offers short term, temporary accommodation for homeless clients who are discharged from hospital. It brings together clinical, social care and housing/homelessness practitioners to work alongside the Pathway team to identify suitable clients, ensure continuity of clinical care and improve health outcomes. The service is short term and is the stepping stone for

clients to other appropriate services, which can offer longer term support to the individual.

Neither model was commissioned during the normal commissioning cycle. Pathway is funded by a Department of Health 'Innovation, Excellence and Strategy' development fund through a joint bid by Pathway and Bevan Healthcare, complemented by funding from Horton Housing Association. The capital funding for BRICSS comes from the Department of Health and Horton Housing Association; revenue funding is via the Department of Health, the CCG and Bradford's Public Health team.

A presentation on the service⁵⁵ highlights the importance of relationships in providing integrated services – between commissioners and providers, and operational and strategic leaders. Benefits of partnership and integration include improved communications within integrated staff teams; opportunities for joint bidding; higher quality services due to shared knowledge and expertise; reciprocal referrals; and efficiencies resulting from pooled resources.

More information: <http://www.hortonhousing.co.uk/service-detail.asp?Service=76&L=0&S=0&C=0>

⁵⁵ Presentation to the Public Health England National Single Homeless Population Health Forum 22 July 2014 'Integrating health, housing and social care' by Gina Rowlands and Liz Barry available at https://www.phe-events.org.uk/HPA/media/uploaded/EVHPA/event_374/Homeless%20-%20Combined.pdf From slide 60. Accessed 3.10.2014

St Mungo's Broadway London Homeless Hospital Discharge Network

The London Homeless Hospital Discharge Network provides an example of health services working in an integrated and innovative way within hostel services for homeless people.

The London Homeless Hospital Discharge Network currently comprises a number of health supported bed spaces across Hackney, Westminster, Camden and Lewisham. The service focuses on homeless people discharged from acute hospitals. It helps them to recuperate from the stay in hospital, but also to learn to manage long term conditions more effectively.

A comprehensive health assessment is undertaken, followed by help to secure mainstream health and social care services, and to become and stay engaged with services. The service can also help clients who make frequent use of emergency services such as A&E in a preventative role.

The core nursing team is available five days a week. The nurses have support from GP services and a part time clinical psychologist and two part time

psychotherapists, recognising the levels of mental health problems among our clients.

The health team works closely with hostel staff to jointly plan and deliver support to clients. Clients may remain in the service for a few days, or up to 12 weeks, receiving support to move on to appropriate supported accommodation as appropriate.

“[If I hadn't come here] I probably would have end up dead, because I wouldn't have taken my HIV treatment, I probably would have end up being abused, back on the street work, back on the drugs again, back in hospital... When I came here the amount of support that I got here was unbelievable, you know? Every five minutes they pop in to see if I was alright, make sure I take all my medication, support me when I had to take my IVs, HIV treatment... So I get to come here, because if I didn't come here I'd be back on the street... Since I've come here I've realised I'm somebody” – Hospital Discharge Network resident

This service is funded by the Department of Health, Homeless Hospital Discharge Fund and Camden CCG.

More information: <http://homelesshealthcare.org.uk/news/hospital-discharge-network/>

Integrating health and housing does not always need special commissioning. Much can be achieved by simple funding solutions using housing investment to target health inequalities, and/or health investment to support housing outcomes.⁵⁶ Examples include health professionals working out of homelessness services and outreach workers using treatment rooms in GP practices to change dressings or carry out health checks.

GP in reach at The Old Theatre

The Old Theatre is a St Mungo's Broadway residential service providing support for 12 homeless people with complex needs. Charitable funding has been used to provide a quarterly GP drop in service. This gives clients the opportunity to speak to a GP on site. Clients do not have to be registered with the GP to attend the surgery. The service helps clients who would be unwilling or unsure about registering or visiting the GP the opportunity to get advice and build a relationship with a doctor first. It also enables shared knowledge between the GP and the hostel staff.

At the first in reach session, 60% of all available clients met with the GP, rising to 72% at the second session. Where clients have not engaged with the GP it is generally because they are seeing their own GP.

“Since I started running the three monthly clinics at the hostel I have had an increasingly better communication with allied medical services including the HIV community nurse, the Hepatitis C community team and alcohol services. This allows us to provide a more effective way of working with these clients who are difficult to reach.” – Dr Sharon Kaye, a GP providing an in reach service at The Old Theatre

Recommendation 6: Health and housing commissioners should proactively identify opportunities to jointly support services that tackle homeless health. These services should aim to limit the barriers to care, and should be responsive to local need.

3.1.2 Provide training on health and homelessness

People who are homeless tell us that they regularly face a lack of understanding about their complex health needs when trying to access healthcare. Training programmes for non-specialist health staff could help to address this, equipping them to better understand homelessness and how this affects both health and access to healthcare.

Faculty of Homeless and Inclusion Health ‘Inclusion Health CPD day’

Pathway has developed a one day Continuing Professional Development (CPD) training course, introducing the concept of inclusion health. The course includes sessions on *Excellence in primary care for excluded groups*, *Reflective Practice and Latest Developments in Hepatitis C*. The Faculty has applied for Royal College of Physicians CPD approval, and the course is provided in partnership with Brighton and Sussex medical school.

More information: <http://www.pathway.org.uk/wp-content/uploads/2014/04/Flyer-20-June-2014-FINAL.pdf>

Increasing understanding among staff in homelessness agencies of health conditions and services available locally can help improve the advice and support offered by homelessness services, giving staff the skills to identify health needs at an earlier stage and a better understanding of the health services on offer to their clients.

⁵⁶ National Housing Federation (2014) *Connecting housing and health briefing: tackling health inequality through housing*

Hammersmith and Fulham Health and Homelessness Project

Commissioned by Hammersmith and Fulham's Supporting People team and run by St Mungo's Broadway, this project aims help individuals navigate primary and secondary health services, build capacity among hostel staff to help clients to access health services, and focus on early intervention to prevent health problems becoming critical. The service targets the 440 service users and all staff working in Supporting People funded accommodation in the borough.

The service facilitates capacity building training to clients and staff in partnership with health organisations and coordinates complex case conferences. It designs and delivers two health and wellbeing events each year and produces a monthly newsletter. Staff have designed and rolled out a common health assessment tool (CHAT) and collate quarterly submission data to develop analysis of need and engagement in the borough. Bi monthly health action group meetings are held with the health and housing professionals. Three health screening events, the Health MOT, are held each year. The project has also led to the design of a GP appointment card, which clients can use to help them access primary care.

In 2012-13, the project screened 76 clients, trained 118 members of staff across Hammersmith and Fulham, and had 144 people attend a Wellbeing Fair. In total, 133 people attended the health action group.

More information: http://www.mungosbroadway.org.uk/services/recovery_from_homelessness/our_health_specialists

Recommendation 7: Local authority commissioners should support homeless health coordinators to train homelessness agency staff to recognise and understand common health conditions, and to train NHS staff to understand the needs of homeless people.

Recommendation 8: Health services should support the **training** of front of house staff to work with vulnerable patients, including those who are homeless. As outlined on page 19, Islington CCG is training receptionists to work with particularly vulnerable groups of patients, including those who are homeless.

Advocacy services can play a vital role in ensuring homeless people can access the health related services they need. Allocating a member of staff or peer volunteer to help people who are homeless remember and attend appointments, to go along with them, talk to the doctor on their behalf, and help them to understand advice, can help people overcome the fear of seeking help.

“Any hostel, hospital appointment, any doctor’s appointment, [the staff] knock on my door and say ‘are you ready? Alright, let’s go’. They’ve never sent me anywhere on my own, doesn’t matter does it, I can knock that up in stone, they always got time to spare for me... Yeah, I panic, I can’t go out on my own, plus this arm, as you see, I got no grip or anything [so it’s hard to go to appointments alone]” – Hospital Discharge Network resident.

Groundswell's Homeless Health Peer Advocacy programme demonstrates how effective this personal support can be in improving access to healthcare, and the effectiveness of peer support (see over page).

Groundswell Homeless Health Peer Advocacy

Groundswell is a London based charity that enables homeless and vulnerable people to take more control over their lives, have a greater influence on services and play a more complete role in their community.

Their main work is homeless health peer advocacy. The charity trains people with experience of homelessness – current or past – to volunteer as peer advocates. People needing support are referred by support workers to the charity when they have a health appointment (they can also self refer). They are allocated a peer advocate who ensures they attend the appointment, goes with them, and who can speak to the doctor on their behalf.

Using people with experience of homelessness as advocates is vital to the success of the project. People who have previously found it difficult to engage with support and healthcare staff recognise peer advocates really understand their situations, the daily challenges they face and their fears about going to the doctor.

An evaluation showed a substantial fall in NHS resource usage by participants after leaving the service. Costs to the NHS were reduced by 42% after the intervention was completed.

More information: <http://www.groundswell.org.uk/homeless-health-peer-advocacy.html>

Recommendation 9: CCGs and local authorities should commission advocacy services, which support homeless people to access health services.

3.2 Commission cross boundary services

In areas where there is a higher density of homelessness over more than one CCG or local authority boundary, joint commissioning of a central specialist GP practice, or a hospital discharge team may be the most effective way to ensure appropriate healthcare is available to all who need it.

The case for such cross boundary services in London is clear. The numbers may be relatively small within some boroughs and the population highly transient, however the overall number of people sleeping rough is significant: 6,508 people were seen sleeping rough in London in 2013/14. This rationale may also apply in other major conurbations.

In areas where the population is less dense, a small number of homeless people who cannot access healthcare can have a substantial impact. Commissioners should explore options for taking a regional approach.

Recommendation 10: Directors of Public Health and clinical commissioning groups should explore opportunities for cross boundary/ borough commissioning of specialist health services.

Find & Treat service

Find & Treat is a pan London outreach team working with the health sector and with the third sector to tackle Tuberculosis (TB) among homeless people as well as other groups who are at increased risk of TB.

The Find & Treat team is multi disciplinary and includes former TB patients who work as peer advocates, TB nurse specialists, social and outreach workers, radiographers and expert technicians.

The service aims to 'Find' cases by raising awareness among service users and frontline professionals and by screening almost 10,000 high risk people every year using a mobile digital x-ray unit. TB clinics and frontline third sector partners across London, and nationally, refer about 300 complex and socially vulnerable patients each year to the outreach team.

This service is funded by NHS London.

Both the National Institute for Health and Clinical Excellence and the Health Protection Agency have independently evaluated the Find & Treat service and demonstrated that it is cost effective and potentially cost saving.

More information: <https://www.uclh.nhs.uk/OURSERVICES/SERVICEA-Z/HTD/Pages/MXU.aspx>

3.3 Implement parity of esteem between mental and physical health

“One of the things that would make the biggest difference in tackling homelessness poor health would be a better relationship with mental health services. In the same way, offer a drop in service for the clients, regular contact and the building of a relationship between mental health and both staff and clients would be a huge benefit working with these complex patients.” – Dr Sharon Kaye, GP providing an in reach service to a homelessness hostel

The recommendations above all apply to mental health as well as physical health. However, the particular challenge of mental health for people who are homeless necessitates separate attention. As outlined in Section One, people who are homeless not only struggle to get help with their mental health (particularly if they also have problems with drug or alcohol use), but also find it more difficult to get help with their physical conditions because of the impact of mental health problems on their lives and wellbeing.

The situation must be addressed with urgency. The Health and Social Care Act 2012 legislated for parity of esteem between physical and mental health. This should mean everyone has the same access to assessment and treatment of mental health conditions as for physical health problems. However, this goal remains far from realised. While the Improving Access to Psychological Therapies (IAPT) programme has expanded access to NHS counselling and Cognitive Behavioural Therapies, there remains a gap in support for people with more severe and/or complex mental health needs, who often need more than a few weeks of talking therapies. This is a particular problem for single homeless people, who often have more complex and severe mental health problems, as set out in Section One.

Recommendation 11: Clinical commissioning groups should commission for choice, providing a wide range of therapies to meet the needs of their local communities, including people who are homeless and those with complex needs. This should include adequate provision of dual diagnosis services.

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS)

This innovative service offers support from the Tavistock and Portman NHS Foundation Trust to GPs across the London Boroughs of City and Hackney. It manages patients with complex mental health and other needs that tend to result in high levels of use of health services, but where their needs are difficult to manage through the primary care system. While PCPCS is not directed specifically at people who are homeless, it is available to them and offers intensive support for the types of complex needs experienced by homeless patients.

“This service was commissioned from a direct primary care request. GPs were aware that there were many patients who needed a mental health service, but who either did not fit the criteria for existing services or were reluctant to engage with services. We felt that we needed a service to sit within primary care, to be flexible and holistic in its approach and to be able to work with complex patients, including those with medically unexplained symptoms. Conventional mental health services, using mainly diagnostic assessments, did not offer this complexity focused approach. We wanted very close working with primary care as we recognised that ongoing continuity of care was essential for this group of patients.” – Rhiannon England, GP Clinical Lead, City and Hackney CCG

The PCPCS supports GPs in the management of these patients through case discussions and training, and by providing a direct clinical service **within GP practices** to referred patients through assessments and a range of brief psychological interventions.

This service is funded by City and Hackney CCG.

An evaluation of the service found that about 75% of all patients show improvements in their mental health, wellbeing and functioning as a result of treatment. About 55% are shown as having “recovered”, meaning an improvement in mental health after treatment.

Compared with the year before referral, the average number of GP attendances per patient seen by the PCPCS fell by 25% in the year after treatment. A typical course of treatment by the PCPCS lasts for 12 or 13 sessions, at an estimated average cost of £1,348 per patient. The subsequent savings from reduced health service use are equivalent to about a third of this cost: a significant offset.

More information: <http://mentalhealthpartnerships.com/project/city-and-hackney-primary-care-psychotherapy-consultation-service/>

Conclusion

Homelessness has a huge impact on individual health. Homelessness can make it difficult to get help for health problems, which can lead to worse health in the longer term. This has a knock on effect on the NHS, as failure to improve health at an early stage can lead to avoidable emergency admissions, hospital treatment and reliance on long term care.

There is no single solution, but *Homeless Health Matters: the case for change* shows how health commissioners, local authorities, homelessness services and homeless people themselves can work together to improve homeless health.

Signing the *Charter for Homeless Health* is the first step to ensure a better future for homeless people. Now.



**Homeless Health Matters:
now is the time for change.**

Useful resources

St Mungo's Broadway and Homeless Link (2014) *Improving the health of the poorest, fastest: including single homeless people in your JSNA* http://www.mungosbroadway.org.uk/homelessness/publications/latest_publications_and_research/2036_needs-to-know-including-single-homelessness-in-joint-strategic-needs-assessments

Aspinall, PJ (2014) *Hidden Needs: Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers* Inclusion Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287805/vulnerable_groups_data_collections.pdf

Gill, P, Macleod, U, Lester, H and Hegenbarth, A (2013) *Improving access to healthcare for Gypsies and Travellers, homeless people and sex workers* Royal College of General Practitioners <http://www.rcgp.org.uk/common-elements/rss/~media/Files/Policy/A-Z-policy/RCGP-Social-Inclusion-Commissioning-Guide.ashx>

HM Government (2010) *Inclusion health: improving the way we meet the primary healthcare needs of socially excluded people* <http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf>

Inclusion Health (2013) *Commissioning Inclusive Services: Practical steps towards inclusive JSNAs, JHWSs and commissioning for Gypsies, Travellers and Roma, homeless people, sex workers and vulnerable migrants* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287787/JSNA_and_JHWS_guide_-_FINAL.pdf

NHS England (2014) *Avoiding Unplanned Admissions Enhanced Service: Proactive Case Finding and Care Review for Vulnerable People* <http://www.nhsemployers.org/~media/Employers/Documents/Primary%20care%20contracts/Enhanced%20Services/201415/Unplanned%20admissions/Avoiding%20Unplanned%20Admissions%20-%20Guidance%20and%20audit%20requirements%20for%202014-15.pdf>

The Faculty for Homeless Health (2011) *Standards for commissioners and service providers* http://www.londonpathway.org.uk/uploads/homeless_health_standards.pdf

The Pavement (2014) *The Pavement* <http://www.thepavement.org.uk/> (Accessed on 10/09/2014)

The Queen's Nursing Institute (2010) *Improving Healthcare for Homeless People – A learning resource* <http://www.qni.org.uk/docs/Section%20B%20Module%205.pdf>



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