



Developing the long term plan for the NHS: Joint response from Homeless Link and St Mungo's

This joint consultation response from Homeless Link and St Mungo's focuses on improving the health and wellbeing of homeless people and reducing the health inequalities faced by this group.

Homeless Link is the national membership body for the homelessness and supported housing sector in England. **St Mungo's** is a homelessness charity and housing association, providing a bed and support to more than 2,700 people a night who are either homeless or at risk of homelessness.

Our top priority is for NHS England to effectively deliver on the expectations outlined in the Government's Rough Sleeping Strategy, which was published in August 2018. The strategy calls for the NHS 'to spend up to £30 million on health services for people who sleep rough, over the next five years'. We expect this to be new funding for the commissioning of specialist health services for homeless people, to reduce demand on overstretched core health services.

Beyond this, over the next five and ten years we want the NHS to focus on:

- addressing the barriers that exist to accessing core health services
- expanding effective specialist services that directly improve health outcomes for those most in need
- investing in wider holistic and integrated programmes of support that improve health and wellbeing
- tackling the social risks and determinants of health to prevent poor health outcomes.

We are ready to work closely with the NHS to explore how to achieve this in practice and we can help bring forward the voices of those with lived experience of homelessness to help. However, a commitment to delivering the changes above must be clearly articulated in the Long Term Plan.

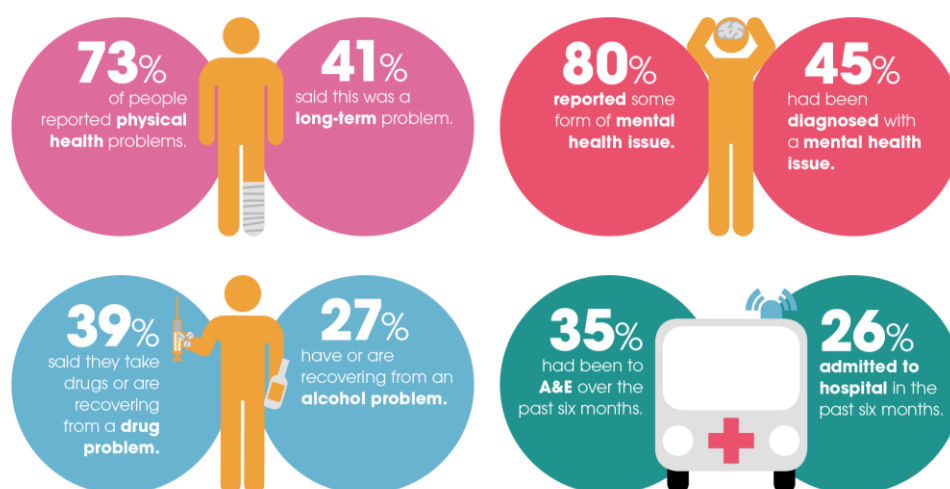
This consultation response is based on the questions asked by NHS England, which have been adapted to allow us to respond more effectively with respect to the needs of people who are homeless. This response has been informed by consultation with our members, services, and clients.

1. What do you think are the barriers to improving care and health outcomes for homeless people?

1.1 High and complex needs which are mutually reinforcing

Homeless people experience some of the poorest health outcomes in England with high levels of morbidity and early mortality. The average age of death of a person who dies while homeless is just 47, 30 years lower than the general population. The evidence below

gathered from the 2014 Health Audit¹ provides a stark picture of the health outcomes experienced and self-reported by homeless people.



As the above figures show, homelessness, mental health problems, physical health problems, and substance addiction often co-exist, exacerbated by experiences of complex trauma, poverty and social exclusion. These are mutually reinforcing – for example many are stuck in a vicious cycle where their poor mental health is an obstacle to engaging with services that can help them move off the street, while at the same time their homelessness acts as a barrier to getting the mental health support which is desperately needed.

Together these experiences create deep-seated barriers to improving health outcomes for homeless people and impact how an individual engages and accesses services, and how they respond to support. Many are labelled as ‘difficult’ or hard to treat, and this results in referrals being refused or stigma leading to complex needs being misdiagnosed or misunderstood.

Without a conscious, proactive effort by the NHS and wider social services these barriers, and the resulting poor and costly health outcomes, will continue to persist, in turn costing core and acute services more in the process.

1.2 Difficulty accessing primary health services

A significant number of homeless people are not accessing primary health care services when they need it.

The reasons for this include discrimination and stigma from staff resulting in adverse experiences and disengagement. GP practices which do not have the right processes and personnel in place can unwittingly exclude people. Many services refuse to register individuals who do not have an address. Restrictive appointment times, which are hard to make and keep for people sleeping on the street, can also create barriers to accessing

¹ Homeless Link (2014) *The unhealthy state of homelessness: Health audit results 2014*. Accessed from <https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf>

mainstream health services. This is exacerbated by the fact that outreach teams and social workers are rarely able to refer someone to secondary services, so rough sleepers are reliant on these failing referral systems in General Practice.

This is all compounded by the frequency of misdiagnosis, complex trauma, mental health, and substance use problems make this particularly challenging. The prevalence of these support needs also often leads to physical health problems going ignored.

Because of these difficulties homeless people are heavy users of acute NHS services. The number of A&E visits and hospital admissions per homeless person is four times higher than for the general public. This is estimated to cost a minimum of £85m per year, meaning costs of more than £2,100 compared to £525 per person among the general population.²

1.3 Secondary services are not equipped to deal with the high and complex needs of homeless people

Even when an individual successfully gets referred to secondary services, the treatment offered is often inappropriate or too structured to meet needs. Treatment rarely comes to the client, with interventions on the street or in homeless services rare.

A recent survey of street outreach services carried out by St Mungo's for the report entitled [*Dying on the streets: the case for moving quickly to end rough sleeping*](#), showed that secondary services are getting increasingly difficult to access. 70% of respondents said that access to mental health support for people sleeping rough has got harder in their area during the last five years, and 42% said the same for alcohol and drugs services³. In the survey only a minority of respondents said important mental health services were in practice available to people sleeping rough in their area.

One of the major reasons for this is the prevalence of 'dual diagnosis' as a comorbidity, where individuals present with a combination of mental health and substance use problems. Frequently mental health teams will not work with individuals until their substance use problem is addressed, but in many cases this substance use is itself a product of unmet mental health needs. But even if a referral is made and treatment is started, many struggle to engage in structured mental health treatment or group sessions that are favoured in community recovery services before detoxification. The result is that these individuals do not get the support they need, and their conditions worsen before reaching crisis. This is partly a product of the separate funding arrangements for mental health and substance use services, and the lack of partnership between CCGs and local authorities over providing services which address both.

1.4 Wider issues causing poor health outcomes are not adequately addressed

Living on the streets or without a stable home can make you vulnerable to ill health and drug and alcohol problems. Many people become homeless because of existing health needs. The longer people remain without a stable and safe place to live, the more these problems multiply and the harder they are to overcome.

² Department of Communities, Housing and Local Government (2012), *Evidence review of the costs of homelessness*. Accessed from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

³ St Mungo's (2018), *Dying on the Streets: the case for moving quickly to end rough sleeping* <https://www.mungos.org/wp-content/uploads/2018/06/Dying-on-the-Streets-Report.pdf>.

Preventing the situations that lead to poor health is needed. Access to wider social services, the availability and affordability of housing, food, safety and community cohesion all impact on the health and wellbeing of individuals. Without housing and financial support, improving health outcomes will continue to be difficult. The cycle of these factors, such as unemployment, debt, poverty and homelessness work to compound over time and make it difficult to improve health outcomes in isolation.

There is also only so much medical treatment can offer in isolation. Many health problems are the product of social exclusion, which requires a greater focus on prevention and wellbeing and increased involvement with public health and local authorities.

2. What should be the top priorities for addressing inequalities in health over the next five and ten years?

The Government's Rough Sleeping Strategy, published in August 2018, stated that the NHS Long Term Plan will include new objectives for reducing health inequalities, including for rough sleeping. The Strategy calls on the NHS 'to spend up to £30 million on health services for people who sleep rough, over the next five years'.

Our overarching priority is for the NHS to spend at least this amount of new money on dedicated interventions for people who sleep rough. Conservative estimates suggest NHS spending on homeless people amounts to at least £85 million a year. Investment in healthcare provision for people who sleep rough is needed to take the pressure off inappropriate A&E visits and hospital admissions which are responsible for much of this cost.

Over the next five and ten years, we also want the NHS to focus on:

- addressing the barriers that exist to accessing core health services
- expanding effective specialist services that directly improve health outcomes for those most in need
- investing in wider holistic and integrated programmes of support that improve health and wellbeing
- tackling the social risks and determinants of health to prevent poor health outcomes.

2.1 Addressing the barriers that exist to accessing core health services

Core health services, both primary and secondary, are often too exclusionary or inflexible for homeless people with complex needs. Services should be made more accessible – for example by expanding walk-in primary care clinics or offering longer appointment times to deal with multiple needs.

Alongside these positive changes there should be greater efforts to end punitive practices. There should be a commitment to no individual being turned away from General Practice due to a lack of address, or presenting with dual diagnosis. Both these practices contravene established guidance – the former in regards to the Primary Medical Care Policy and Guidance Manual, and the latter in reference to NICE guidelines.⁴ NHS England should immediately prioritise actions to end both practices

⁴ Primary Medical Care and Guidance Policy Manual (2017) <https://www.england.nhs.uk/publication/primarymedical-care-policy-and-guidance-manual-pgm/> and NICE,

Beyond this, training of frontline staff is essential to creating the cultural change necessary and reducing stigma and barriers facing homeless people when accessing health services. These training packages should be co-produced with experts by experience, and support staff to understand the issue of homelessness, turning them from gate-keepers to 'gate-openers'.

2.2 Expanding effective specialist services that directly improve health outcomes for those most in need

Specialist services offer a tried and tested model of improving outcomes, particularly for rough sleepers, and expanding these should be a priority for the NHS.

Specialist services can include dedicated teams for rough sleepers who take referrals from street outreach teams, or are integrated within them, and can carry out health assessments and treatment on the street. These can be highly effective, particularly in areas with high levels of rough sleeping.

Other examples include dedicated health professionals providing 'in-reach' to homeless services such as hostels or day centres, which allows the flexibility necessary to assess and treat complex health problems. Research by the Kings College London HEARTH study found that of 900 homelessness projects (702 hostels, 198 day centres), 43.4% were linked to a specialist primary health care service, and 40.2% not linked⁵. In practice it is likely that over half of homelessness projects are not linked into specialist primary care. All projects should be linked in with primary health services, which will in the process reduce reliance on acute care.

2.3 Investing in wider holistic and integrated programmes of support that improve health and wellbeing

As established, the support needs of rough sleepers can be complex and mutually reinforcing. The overall goal of health policy should be towards holistic support for people's mental and physical health, including safeguarding, substance use and any other support needs. To ensure this, CCGs should require services to adopt an 'every contact counts' principle, advocated by the Healthy London Partnership among others, which includes a holistic assessment of need, covering physical health, mental health, substance use and safeguarding needs. This can be done through NHS screening services reaching all homeless people and annual primary care reviews.

Ensuring services are trauma-informed - given the prevalence of these experiences among homeless people – is an important part of any holistic response. Developing trauma-informed systems for single homeless people can have wider societal implications; use of high cost services, such as mental health care, hospital admissions and custodial sentences are likely to reduce as people stabilise and begin addressing their complex needs. In addition, services which support young people and families in a trauma-informed way can reduce the intergenerational impact of trauma.

Coexisting severe mental illness and substance misuse: community health and social care services (2016) <https://www.nice.org.uk/guidance/ng58/chapter/Recommendations#first-contact-with-services>

⁵ Kings College London (2018), *Mapping of specialist primary health care services in England for people who are homeless*, <https://www.kcl.ac.uk/sspp/policy-institute/scwru/res/hrp/hrp-studies/HEARTH/HEARTH-study-Mapping-FullReport-2018.pdf>

The NHS must also stop people falling through the cracks between different kinds of services. For example, inpatient services and housing / homelessness services are not sufficiently joined up, and too many people are forced to sleep rough after being discharged from hospital.⁶ Addressing this requires better links between hospital staff, the local authority and community-based agencies to promote involvement of appropriate agencies in the discharge process.

2.4 Tackling the social risks and determinants of health to prevent poor health outcomes

There are clear social determinants for rough sleeping and complex needs which require preventative action. There is a role for interventions by the NHS and others at a much earlier stage to prevent and reduce the poor health outcomes.

Disadvantages in income, education, employment and housing contributes to health inequalities. Needs can multiply over the life course, indicating that a life-course approach could be effective.⁷ The cycle of these factors, such as unemployment, poverty and homelessness work to compound overtime and make it difficult to improve health in isolation. Coordination and integration of health services alongside housing and welfare is needed.

We agree with the VCSE Health and Wellbeing Alliance that the NHS needs to prioritise the allocation of funding to include work directly addressing social risks and determinants of health such as poor housing, low income, debt and other contributory factors to poverty, which are key indicators of health inequality. Longer term, preventative work will reduce future demand on the NHS. Effective welfare, employment, housing, criminal justice and education policies that improve the life chances of those most disadvantaged and at risk of poor health will have the biggest impact.

3. What examples of good services or ways of working that are taking place locally should be spread across the country?

3.1 Examples of addressing the barriers that exist in accessing core health services

Advocacy and effective communications have been used to help rough sleepers unlock mainstream services. The Healthy London Partnership have worked on an initiative to reduce the number of rough sleepers being unable to register with a GP due to lack of address. They have produced plastic cards which remind GP receptionists and other practice staff of the national patient registration guidance from NHS England, which states that people do not need a fixed address or identification to register or access treatment at GP practices. The plastic cards are designed to be carried by adults who are homeless across London, including people who sleep rough. Since December 2016, 60,000 cards have been delivered to shelters, day centres, food banks, drop in centres and other organisations across London. NHS England could be delivering this kind of internal communication themselves.

Advocacy services can also 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

⁶ St Mungo's (2016), *Stop the Scandal: An investigation into mental health and rough sleeping*
<https://www.mungos.org/publication/stop-scandal-investigation-mental-health-rough-sleeping/>

⁷ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)31959-1/fulltext?code=lancet-site](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31959-1/fulltext?code=lancet-site)

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.

The Groundswell Homeless Health Peer Advocacy Service (HHPA) supports people experiencing homelessness to address both physical and mental health issues. The service is a good example of how to increase access to healthcare, particularly where specialist services are limited or non-existent. Their Peer Advocates have all experienced homelessness themselves, and work in a variety of London boroughs. Crucially, they accept referrals from anyone working in a homelessness or health service, as well as self-referrals.⁸ This kind of service can and should be more widely commissioned by CCGs.

3.2 Examples of effective specialist services that directly improve health outcomes for those most in need

There are a wide variety of specialist services, which employ proactive efforts to reach excluded groups, including rough sleepers.

One such example is a specialist team with a focus on a specific intervention for an individual client group. This is the model used by specialist mental health teams such as START and Focus, provided by the South London and Maudsley NHS Foundation Trust (SLaM). START takes referrals from a wide range of sources, including voluntary sector street outreach teams. The team is comprised of doctors, nurses, social workers, psychologists and a psychotherapist – and has delivered effective outcomes. However, the service has been subject to substantial cutbacks in recent years. In 2012, financial pressures meant that staffing was reduced by 50% and the team could only offer support to 130 clients in 3 boroughs rather than 200. In 2016, further pressures led to them being disinvested in one of the three boroughs so they can now only offer a service to 2 local authorities. This has led to vulnerable rough sleepers with mental illness not receiving a service.

Outreach by peer workers^{9,10} and community nurses¹¹ has also been shown to improve the health outcomes of excluded groups. Thames Reach used a Homelessness Transition Fund grant to embed a specialist mental health outreach worker in street outreach teams mainly working in outer London. This was combined with spot purchasing of support from a specialist homelessness mental health team, Enabling Assessment Service (EASL), for the most challenging cases.

Specialist general practice is another effective model, and is often targeted at a wider range of marginalised groups. Inclusion Healthcare in Leicester City offers permanent registration to homeless people and other marginalised groups, and works in partnership with two hostels in the city to support and provide treatment to its residents, as well as male and female street workers. The team is made up of experienced doctors and nurses, a liaison nurse who works between the practice and local hospitals to improve patient journeys, an

⁸ <http://groundswell.org.uk/wp-content/uploads/2017/10/Saving-Lives-Saving-Money-Full-Report-Web.pdf>

⁹ Coldwell CM, Bender WS. *The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis.* Am J Psychiatry 2007; 164: 393–99.

¹⁰ Simoni JM, Nelson KM, Franks JC, Yard SS, Lehavot K. *Are peer interventions for HIV efficacious? A systematic review.* AIDS Behav 2011; 15: 1589–95.

¹¹ Speirs V, Johnson M, Jirojwong S, et al. *A systematic review of interventions for homeless women.* J Clin Nurs 2013; 22: 1080–93.

alcohol worker, a health visitor, a specialist midwife, and direct links into drug and mental health services.¹²

City Reach in Norfolk is an example of tailored healthcare services for marginalised groups. The service helps people who find it difficult to visit mainstream GPs, such as homeless people, people with a substance use problem, and asylum seekers. The service was set up by a group of local healthcare professionals and homelessness service staff to address GP access issues for vulnerable clients, which was a particular issue after the closure of a GP service that worked with the local homelessness hostel. City Reach mainly provides homeless people and other vulnerable people access to a GP and nurse at its main office. Homeless people typically access these services through a referral from a homelessness service, such as a day centre. Staff at City Reach also accompany street outreach workers on their shifts, and conduct on-the-spot health assessment.¹³

The kind of specialist service commissioned, and the scale of its operation, will clearly depend on local needs. But there should be a clear ambition for all CCGs to commission specialist services targeted at the most vulnerable.

The specialist services described above exist as a response to the high levels of rough sleeping that exist at present. Over time, these specialist services can be phased out and integrated into mainstream services (which can integrate this 'specialist' approach) or could be developed into multidisciplinary teams to respond to multiple disadvantage / complex needs more widely.

3.3 Examples of wider holistic and integrated programmes of support that improve health and wellbeing

Case management linked to other services has been shown to be an effective approach for homeless people, including those with mental illness and substance abuse, resulting in reduced hospitalisations and decreases in substance use. Coordinated programs for homeless people with complex needs usually result in better health outcomes than usual care.¹⁴ The Making Every Adult Matter (MEAM) work has demonstrated the positive impact a more coordinated approach can have on supporting people with multiple and complex needs.¹⁵ However, there is a fragmentation in services that makes it even more difficult to navigate the adult social care system.¹⁶ This fragmentation and difficulty accessing social care support is evident at a number of key points in a person's contact with the health and social care system, including hospital discharge¹⁷ and palliative care for people who are homeless.¹⁸

Housing First is designed to provide open-ended support to long-term and recurrently homeless people who have high support needs. Unlike many homelessness services, Housing First provides long-term or permanent support to people with on-going needs.

¹² <https://inclusionhealthcare.co.uk/>

¹³ <http://www.norfolkcommunityhealthandcare.nhs.uk/The-care-we-offer/Service-search/city-reach.htm>

¹⁴ <https://www.sciencedirect.com/science/article/pii/S0749379705002953>

¹⁵ Barclay, J (April 2016) *Changing systems, changing lives*

¹⁶ Mason et al. (2017) *Multiple Exclusion Homelessness and adult social care in England: Exploring the challenges through a researcher-practitioner partnership*

¹⁷ Healthwatch England (2015) *Safely Home?*

¹⁸ Care Quality Commission (2017) *A Second Class Ending*

Through the provision of intensive, flexible and person-centred support, 70-90% of Housing First residents are able to remain housed. Having a place to call home also leads to improvements in health and wellbeing, and reduces ineffective contact with costly public services. There is evidence of improvements in mental and physical health among Housing First service users.¹⁹ The NHS could work more closely with these interventions, through joint commissioning or care planning.

In 2013-14 the Department of Health invested £10 million in 52 homeless hospital discharge programmes, and some of this funding was used to support people who were discharged from mental health hospitals. St Mungo's Hospital Discharge Network was a part of this, and helped homeless people in London who required some ongoing care after leaving hospital. However, most of these services were unable to secure continuation funding. Only 17 out of 41 homeless hospital discharge projects that responded to the survey reported receiving funding to continue delivering services after the central government grant ended.

The Equinox hostel link team in Brighton uses an assertive outreach model which targets the most complex clients – 88% are former rough sleepers and 76% have a history of eviction and/or abandonment from hostels - and challenges and supports them to address the obstacles they have to secure permanent accommodation. While initially set up to tackle alcohol and substance misuse it has evolved into a more holistic service to address other health and wellbeing needs, for example psychological assessments and rebuilding relationships. Of 34 clients supported between January and June 2014, 65% reduced their alcohol/substance intake, 78% reduced the unplanned departure from hostels and 83% reduced their attendance at A&E.²⁰

Centrepoint's Health and Wellbeing team offers a range of in-house services to young people aged 16-25 living in Centrepoint services. This support includes comprehensive health assessments, counselling and psychotherapy, advice and support on sexual health, nutrition and diet, healthy living, and drugs and alcohol. The team works in collaboration with external health services to deliver support in a holistic and person-centred way. Outcomes collected between April 2013 and March 2014 were impressive – ; 90% of young people increased their physical activity; and of the young people receiving a dual diagnosis intervention, 90% reduced their usage.

It makes clear financial sense for the health system to help reverse many of the cuts that many of these services have experienced, and many should be scaled up and rolled-out more widely. The NHS should occupy a greater role through joint commissioning for these kinds of services, and through closer collaboration with local authorities, public health, and the third sector.

3.4 Examples of tackling the social risks and determinants of health to prevent poor health outcomes

As already established, tackling health problems requires tackling housing problems given the strong links between the two. Accommodation and support can play a vital role in

¹⁹ https://hfe.homeless.org.uk/sites/default/files/attachments/Evaluation%20of%20nine%20services%20in%20England_0.pdf

²⁰ For more information see <http://www.equinoxcare.org.uk/services/equinox-brighton-hostel-link-team/>

providing a stable base from which somebody can engage in treatment or receive help to address health needs.

Safe and suitable housing also aids recovery from periods of ill-health, and enables people to better manage their health and care needs. Provision of housing for homeless people with substance use issues or concurrent disorders is associated with decreased substance use.²¹

Support and services available to people living in their own home can help them live independently and successfully maintain accommodation. Programmes are usually targeted at those who are at risk of losing their homes and known 'at risk' groups vulnerable to repeat homelessness, including those with mental health problems and in treatment programmes. Existing evaluations are largely positive about the benefits; including reduced A&E use; gaining employment and improved mental health. Evidence exists of clear cost savings from programmes such as the Family Intervention programme (FIP) and Supporting People programme.

If you would like more information on this response, please contact Rory Weal, Senior Policy and Public Affairs Officer for At Mungo's, on rory.weal@mungos.org.

²¹ <https://bmcpublihealth.biomedcentral.com/articles/10.1186/1471-2458-11-638>