Integrating health and social care for people experiencing homelessness

A step-by-step resource for implementing the joint guideline

November 2022

Centre for Homelessness Impact

NICE National Institute for Health and Care Excellence
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NICE balances the best care with value for money across the NHS and social care, to deliver for both individuals and society as a whole.

We do this by:

• Providing rigorous, independent assessment of complex evidence to produce guidance and advice for health and social care practitioners.
• Developing recommendations that drive innovation into the hands of health and care professionals.
• Encouraging the uptake of best practice to improve outcomes for everyone.

About the Centre for Homelessness Impact

The Centre for Homelessness Impact champions the creation and use of better evidence for a world without homelessness. Our mission is to improve the lives of those experiencing homelessness by ensuring that policy, practice and funding decisions are underpinned by reliable evidence.

About the author

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By Liz Cairncross
People experiencing homelessness have far worse health and social care outcomes than the general population. The average age of death for the population with experience of homelessness is around 30 years lower than for the general population.

People experiencing homelessness use acute hospital services and emergency care more than the general population. When admitted to a hospital, the length of hospital stay is often much longer because multiple unmet needs are identified. Barriers to access and engagement with preventive, primary care and social care services can mean that problems remain untreated until they become very severe and complex. These barriers include stigma and discrimination; lack of trusted contacts; fragmented, siloed and rigid services; strict eligibility criteria; and lack of information sharing and appropriate communication between different service providers.

The NICE guideline on integrated health and social care for people experiencing homelessness was developed with the Centre for Homelessness Impact. It makes recommendations about models of provision for services that are specific to people experiencing homelessness, as well as improving access and engagement with mainstream services. It aims to integrate services as much as possible in order to improve outcomes for people experiencing homelessness and contribute to ending homelessness.

The purpose of this resource is to raise awareness of the recommendations, summarise the evidence base and give advice on implementation using case studies and examples of good practice. Some of the guideline’s recommendations are not illustrated with examples in this resource because of limited information available.

A guideline only has an impact if it is implemented well, and we hope this resource will support practitioners and commissioners to put the recommendations into practice as they deliver and plan care.

Dr Sam Roberts is CEO of NICE
Dr Ligia Teixeira is CEO of the Centre for Homelessness Impact
Delivery of services

The NICE guideline covers:

- General principles
- Planning and commissioning
- Models of multidisciplinary service provision
- The role of peers
- Improving access to and engagement with health and social care
- Assessing individual needs
- Intermediate care
- Transitions between different settings
- Housing with health and social care support
- Safeguarding
- Long-term support
- Staff support and development

The following sections provide real world examples, links to tools and other resources that may be useful to commissioners and practitioners wishing to develop or improve their services for people experiencing homelessness.
Recommendations

1.1 General principles

1.1.1 Recognise that more effort and targeted approaches are often needed to ensure that health and social care for people experiencing homelessness is available, accessible, and provided to the same standards and quality as for the general population.

Evidence suggests that in order to address the stark inequalities in service engagement, needs and outcomes, a more targeted approach to service delivery is required for people experiencing homelessness. People using services want flexible and tailored services where they can receive good quality care. Examples of service access barriers include rigid appointment systems, out-of-pocket expenses for services, and lack of affordable transport to appointments.

If you are a commissioner, you can lower barriers to access and engagement in healthcare by, for example, commissioning drop-in and in-reach services so that people do not have to travel to appointments.

If you are a GP practice, follow NHS guidance that gives people the right to register, and make sure you don’t require an address or ID, or reject them on the grounds of their migration status.1

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Co-design and co-delivery of services

1.1.2 Recognise the value of co-designing and co-delivering services with people with lived experience of homelessness, to improve the quality of health and social care (see Section 1.4 on the role of peers).

A growing body of evidence suggests that involving people with lived experience of homelessness in co-designing and co-delivering health and social care helps to build trust in services and service providers.2

If you are a commissioner, you can involve people with experience of homelessness through interviews about their care or in carrying out peer-led research and evaluation.

For example:
- Groundswell produced information on Covid-19 testing and vaccines and what works for people facing homelessness aimed at commissioners and service providers, informed by peer researchers.
- Six peer researchers from Crisis Skylight worked with Groundswell in 2020 to carry out research in Birmingham to identify barriers to people experiencing homelessness to accessing care and treatment at a local level. Action plans were developed to eradicate those barriers.

If you are a service provider, you can work with experts by experience to support improvement in services, and in particular those that are specific to the local area and local context.

For example:
- Pathway have produced an Experts by Experience involvement handbook which is informed by their approach.

Supporting engagement with services.

1.1.3 Promote engagement by providing services that:
- are person-centred, empathetic, non-judgemental
- aim to address health inequalities
- are inclusive and pay attention to the diverse experiences of people using the service.

1.1.4 Consider using psychologically informed environments and trauma-informed care. Recognise that people’s behaviour and engagement with services is influenced by their traumatic experiences, socioeconomic circumstances and previous experiences of services.

If you provide a service to people experiencing homelessness, be aware of the impact previous traumas and negative experiences can have on behaviour and engagement with services. There is evidence that one strategy to develop engagement is through approaches that are friendly, non-judgemental, culturally sensitive and use trauma-informed care or psychologically informed environments. Services provided in this way take into account individuals’ psychological and emotional needs, and their experiences of trauma.3

Reflective practice is an integral part of a psychologically informed environment. Reflective practice gives opportunities for staff to:
- reflect on previous practice
- talk about why they made the decisions they made, and why they acted or behaved in particular ways
- talk about their emotional responses to their actions and the actions of others
- engage in continuous learning.

Reflective practice may also provide insight into personal values and beliefs, and help practitioners understand how these may influence their actions and decision-making.

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For example:
- Pathway have produced an Experts by Experience involvement handbook which is informed by their approach.

2 See for example, Astra Zeneca, Depaul UK (2012) Making it better: improving the health of young homeless people: 61p

Sustaining engagement with services

1.1.5 Recognise the importance of longer contact times in developing and sustaining trusting relationships between frontline health and social care staff and people experiencing homelessness.

A relationship of trust and civility, and a strength-based approach encourages the use of services. It is easier to form trusting relationships with professionals who pay attention and have more time available, and who take a sincere interest in the individual. Research indicates that positive interactions include: being treated with dignity, remembering, acknowledging, listening, talking, giving advice, being available, creating a safe and welcoming environment, showing concern, joking, giving tangible aid, and reaching out.¹

For example:
The CQC’s GP Mythbuster 29: Looking after homeless patients in General Practice sets out expected standards of care as well as examples:

- introducing double appointments
- keeping prescriptions as short a duration as possible
- ensuring clear boundaries for consultations are in place
- giving fast access to a named GP
- waiving any charges for housing letters or medical reports.

The Psychology in Hostels project is a partnership between Thames Reach homeless accommodation provider, South London and Maudsley NHS Foundation Trust and London Borough of Lambeth Integrated Care Commissioning Cluster. It offers integrated mental health and accommodation-support services, using the psychologically informed environment approach. This enables high engagement with people who may have severe mental health problems, histories of complex trauma and comorbid drug and alcohol use across three Thames Reach hostels. It is a flexible place-based service with no exclusion criteria based on diagnoses or presenting needs. Using an in-reach model, an NHS embedded clinical team of psychologists offers individual assertive psychology engagement, specialist assessments, onward referrals, individual and group therapy, art therapy, staff reflective practice, support, training, consultation and incident debriefs, working in partnership with hostel staff. The approach has resulted in high engagement and attendance at appointments, as well as reduced returns to rough sleeping, A&E attendance, and criminal justice contact.

1.1.6 Promote shared decision making, building self-reliance and using strengths-based approaches to care (also known as assets-based approaches). See also NICE’s guideline on shared decision making.

Evidence suggests that shared decision-making, or care that integrates patient and provider perspectives and preferences is valued by people experiencing homelessness and providers/staff. Considering their perspective when making decisions demonstrates to people experiencing homelessness that their experiences and perspectives are valued. People experiencing homelessness also want to better understand the information they receive about their own health and healthcare processes.⁵

If you are a practitioner, understand the value of hearing, recognising, and valuing a patient’s perspective, the necessity of respecting boundaries of the patient’s own authority and honouring patients as their own experts, while extending efforts toward patient education and information sharing. NICE’s shared decision making learning package may also be useful.

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1.1.7 Recognise that people experiencing homelessness, especially those with experience of rough sleeping, need services that provide a long-term commitment to care to promote recovery, stability and lasting positive outcomes. People experiencing homelessness prefer service providers who are patient and consistent in offering treatment and support over a long period of time. Care and support exist on a continuum, where at one end accessing a service once every six months is sufficient to meet the needs of a person experiencing homelessness, and at the other end, much more intensive support is required.

Supporting re-engagement with services

1.1.8 Be aware that some people experiencing homelessness may find it difficult to look after themselves because of their circumstances and may find services difficult to engage with. For people who disengage from or refuse health and social care services:

- actively support re-engagement
- enable people to re-engage with services at the same point as they left, if appropriate.

People experiencing homelessness often have very low self-esteem or feelings of low self-worth, which affect the likelihood that they will seek help. They may feel that they are not worth it, or that no one will listen to them. People experiencing homelessness may often use a service, but then ‘disappear’ until they reappear, reflecting the non-linear journey that many people experiencing homelessness can take.

If you are a commissioner or service provider, you may find many people experiencing homelessness need intense long-term support. This is especially the case for those with experience of rough sleeping who may need a long-term commitment to care to achieve positive outcomes.

If you are a service commissioner or provider, actively support engagement by providing flexible approaches for re-engagement to people experiencing homelessness, rather than forcing care and support onto them.  

Communication and information

1.1.9 Follow the recommendations on communication and information in NICE’s guidelines on:

- patient experience in adult NHS services
- people’s experience in adult social care services
- service user experience in adult mental health
- babies, children and young people’s experience of healthcare.

Much existing NICE guidance on communication and information is equally relevant and applicable to people experiencing homelessness.

If you are providing health and social care to people experiencing homelessness, clear communication will bring a significant benefit to their care experience and simple language and explanations, instead of jargon, create a sense of comfort.

For example:

- Groundswell have developed a series of vaccine guides (see section 1.3.5)
- Working with the East End Health Network, Diabetes UK have produced a set of dietary guides for people with type 2 diabetes who are experiencing homelessness or living in temporary accommodation.


7 See for example: Groundswell (2016) More than a statistic: How we did it. London: Groundswell


9 See for example: Groundswell (2016) More than a statistic: How we did it. London: Groundswell

1.1.11 Take into account each person’s communication and information needs and preferences, and their circumstances. For example:

- provide translation and interpretation services if needed
- ensure that written information is available in different formats and languages, including Easy Read
- provide extra support for people with low literacy levels or with speech, language and communication difficulties
- consider the person’s access to phone or internet.

The evidence indicates that receiving appointment information by letters is ineffective and that people without access to the internet or the skills to use it, and those without a phone are at a disadvantage, as they cannot easily communicate via emails and text messages.9

1.1.12 Consider involving an advocate to support communication even when this is not a statutory requirement. This may be someone nominated by the person or an independent advocate who can, for example:

- support people to overcome stigma and previous negative and traumatic experiences
- help people with low literacy levels to access information and services
- reinforce information about available services and appointments.

Evidence suggests that people experiencing homelessness find that additional support such as an advocate or a peer advocate helps them gain confidence, built on trust between people with common experiences.10 The person acting as an advocate can be nominated or appointed. NICE have recently published a guideline on advocacy services for adults with health and social care needs.

If you are arranging a health or social care appointment for a person experiencing homelessness, ask them how they would like to be communicated with, and what language they speak and read.

- An example of providing accessible information for frontline workers and people experiencing homelessness in a range of formats, including translations to Polish, Romanian, Turkish, Amharic, Arabic and Tigrinya is provided by Groundswell’s Covid-19 resources: https://groundswell.org.uk/all-resources/coronavirus/.

If you want to know more about peer advocates, examples of this approach include:

- The Groundswell Homeless Health Peer Advocacy (HHPA) service supports people experiencing homelessness to address physical and mental health issues. The volunteer Peer Advocates delivering the service have all experienced homelessness themselves; in some areas Groundswell also have specialist Care Navigators or Case Workers – the majority began as volunteers. Everyone goes through a rigorous selection procedure (including DBS checks), attends a comprehensive training programme, and receives ongoing support and supervision to enable them to carry out the role safely.

- Bevan Healthcare have produced a video about their SHIPS peer advocacy project to enable people experiencing digital exclusion in Bradford and Leeds to access the health and welfare services they need to be able to self-care.

- Pathway’s Experts by Experience involvement handbook covers the recruitment and selection of experts by experience, ways of working and practical issues such as travel expenses, overnight stays and meals etc. Experts by experience are people who have recent personal experience of homelessness and using or caring for someone who uses health, mental health and/or social care services.

- Miler et al11 provide guidelines for embedding peers in services covering role description, compensation, support, development, value and accommodation.

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1.1.13 Give people experiencing homelessness information about:

- their rights to health and social care services, including for those with no or limited recourse to public funds
- how to access health and social care services, including:
  - primary care services and how to register with a GP without a permanent address
  - specialist health services that can be accessed directly, such as maternity, blood-borne virus, drug and alcohol recovery, mental health, sexual health, and family planning services
- outreach services
- local authority services, including housing services and social care
- voluntary and charity sector services.

Many people experiencing homelessness, and especially those from other countries, are not aware of what services are available to them and what their entitlements to health and social care are.

If you are providing primary care, or specialist health services that people can directly access without a referral, local outreach services, services provided by local authorities and by voluntary and charity sector, provide information about the rights of people experiencing homelessness to access these services and information and support.

For example:

- Recognising the difficulty of registering with a GP for many people experiencing homelessness, Groundswell and the Healthy London partnership have developed free My Right to Healthcare cards, supported by NHS England and Improvement, which can be ordered or downloaded from Groundswell.
- St Ann’s Hospice has a downloadable poster for people who support someone experiencing homelessness whose health is getting worse, publicising the range of services available.

1.2 Planning and commissioning

These recommendations are for commissioners of health and social care and housing services.

Planning integrated multidisciplinary health and social care services

1.2.1 Commissioners of health, social care and housing services should work together to plan and fund integrated multidisciplinary health and social care services for people experiencing homelessness and involve commissioners from other sectors, such as criminal justice and domestic abuse, as needed. These services should contribute to the government’s aim of ending rough sleeping and preventing homelessness.

Research indicates the benefits of service collaboration, such as improving communication, reducing duplication of effort, and improving working relationships. Joint planning and commissioning and a more coordinated approach across health, social care and housing services could increase the efficiency of care provision and awareness of what other services provide, reduce duplication and delay in care, and close gaps in service delivery.


Some examples of different practical and technical approaches include:

- The Norfolk Strategic Housing Partnership has been formed and includes all local authorities, health, police, probation, housing associations in Norfolk, and an independent chair. The multi-agency partnership is taking a collaborative approach to end homelessness in Norfolk. Partners have produced a strategy together (No Homelessness in Norfolk) and have contributed funding to the partnership and appointed a co-ordinator to support the development of new initiatives, increase collaboration, reduce duplication, improve efficiency and pilot innovative practice. The partnership has set up a forum including frontline service providers from the statutory and voluntary sector and includes people with experience of homelessness. The partnership plans to introduce co-production of new approaches with people with lived experience of homelessness.

- The MEAM approach aims to help local areas design and deliver better coordinated services for people experiencing multiple disadvantage. Areas using the approach consider seven principles, which they adapt to local needs and circumstances.

- The Healthy London Partnership published updated commissioning guidance in 2019 for commissioners of health services for people who are affected by homelessness in London. It outlines 10 commitments for improving health outcomes for people affected by homelessness. The commitments were developed in consultation with a wide group of stakeholders including the views of people with lived experience of homelessness. Each commitment includes practical suggestions on how to commission high quality, timely and co-ordinated healthcare for people who are experiencing homelessness.

- Ten prompts for local leaders designed to support local systems to improve the health and care outcomes of people sleeping rough are included as an appendix to the King’s Fund’s Delivering health and care for people who sleep rough: Going above and beyond. Although the focus is on people who sleep rough, it provides a useful set of prompts and examples of approaches that local areas have valued which are relevant to the wider group of people experiencing homelessness.

1.2.2 Recognise that people experiencing homelessness often need additional resources and a more targeted service delivery to: ensure that resources are allocated according to need and disadvantage; take into account the social determinants of health; improve long-term outcomes and address health inequalities.

In order to address the stark inequalities in service engagement, needs and outcomes for people experiencing homelessness, the guideline calls for a more targeted approach to service delivery for people experiencing homelessness.

For example:

- Pathway developed Homeless and Inclusion Health standards for commissioners and service providers with the support of the National Inclusion Health Board. These provide a set of clinical standards for inclusion healthcare, along with specific standards for particular groups and settings. Inclusion health aims to redress extreme health and social inequities among the most vulnerable and marginalised in a community, including people experiencing homelessness.

- Safe Surgeries have produced a toolkit for commissioners which explains why commissioners should help to build Safe Surgeries locally and outlines steps they can take to support primary care provision for everyone, including seven steps for safe and accessible patient registration.
Local homelessness health and social care needs assessment

1.2.3 Conduct and maintain an up-to-date local homelessness health and social care needs assessment and use this to design, plan and deliver services according to need. Include thorough engagement with service providers (including voluntary and charity sector service providers) and experts by experience.

1.2.4 Local homelessness health and social care needs assessments should:
- quantify and characterise the population experiencing homelessness or at risk of homelessness, including health inequalities, diversity and inclusion issues and specific needs and identify trends
- assess the quality and capacity of existing mainstream and specialist service provision to inform the need for service development and investment
- assess access to and engagement with current services by people experiencing homelessness
- identify opportunities for more integrated service delivery
- take into consideration relevant findings from Safeguarding Adults Reviews.

If you are a commissioner, you can consider a range of examples of approaches to needs assessments:
- A homeless health needs audit. Homeless Link developed a step-by-step guide on running a local health needs audit with support from Public Health England. It aims to: increase the evidence available about the health needs of people who experience homelessness and the wider determinants of their health; bring statutory and voluntary services together to develop responses to local priorities and address gaps in services; give people experiencing homelessness a stronger voice in local commissioning processes; and help commissioners understand the effectiveness of their services. The guide includes a sample topic guide for focus groups, information for interviewers and links to resources. To accompany the guide, there is an interactive tool to explore the data collected from 27 health needs audits across England.

Recording housing status

1.2.5 Work with health and social care providers to improve recording of housing status so that the information can be used by services to:
- best meet people’s needs and plan, audit and improve services.

Evidence indicates that people experiencing homelessness often have gaps in or no recorded medical history, where missing or incomplete documentation is often a major problem.\(^14\) If you are a service provider, make sure that data are recorded accurately as it will help you to understand how people experiencing homelessness use your service, and inform resource allocation and service planning.

Developing services

1.2.7 Consider providing services and support aimed at the needs of particular groups of people experiencing homelessness, as appropriate, such as:
- women (also see the NICE guideline on pregnancy and complex social factors)
- young people
- older people
- disabled people
- people with no or limited recourse to public funds because of their immigration status
- LGBTQ+ people
- people from different minority ethnic or religious backgrounds.

The guidelines recommend considering providing services and support aimed at the needs of particular groups. Specialist services for people who need palliative care are one example of support to a particular group of people experiencing homelessness.

For example:

• St Mungo’s Palliative Care Service comprises two members of staff: a palliative care coordinator and a bereavement care coordinator. The palliative care coordinator provides support to multiple services ranging from first stage hostels, semi-independent accommodation, Housing First and outreach services for clients to make informed choices about their future needs and wishes and ensures access to supportive services including specialist palliative care. In addition, the role involves providing training both internally and externally, reviewing and updating policies and procedures, staff support for St Mungo’s staff, and work with hospices. The bereavement care coordinator manages and oversees bereavement support for the organisation, providing emotional support to staff and clients who have experienced a recent or historical loss, creating and delivering bespoke bereavement training both internally and externally.

• St Ann’s Hospice in Manchester has a hospice-based palliative care coordinator. The Homeless Palliative Care Service at St Ann’s Hospice offers support to clients, key workers and health and social care staff when someone’s health is getting worse. The service aims to reach people earlier on in their illness and improve the quality of care for those with advanced ill health. This support for people experiencing homelessness, staff and teams is augmented by a homelessness and loss counselling service. Support for clients includes giving information to aid informed decisions, case management, advocacy and social support, helping people to reconnect with loved-ones and the provision of specialist end of life care. The free use of iPads encourages engagement with health services. The hospice also offers free counselling to people who are affected by homelessness themselves, or for staff working in the homelessness sector who have experienced a loss of any kind. With an emphasis on access, the hospice’s counsellor can go to the client and there are flexible appointment times, drop-in clinics and one-off sessions. Access to interpreting services offers support for people whose first language is not English. The hospice also offers training tailored to the needs of a particular team and topics might include: how to identify clients of concern; an understanding of palliative and end of life care and how it can help; care planning in temporary accommodation, along with bereavement support, self-care and resilience.

• A third example is to twin palliative care teams with hostels providing in-reach support. Trained palliative care nurses and a social worker come in to support staff and residents as part of their work, including bereavement support, training and referrals. This can also simplify the consent process.

1.2.9 Ensure that there are processes to:
- support people experiencing homelessness to register with a GP
- document and address any problems with GP registrations for people experiencing homelessness.

Evidence indicates that people experiencing homelessness face challenges when registering for GP services. Many local GP practices refuse to register people without proof of address or proof of identity. Hurdles or entry restrictions when registering for services are widespread.15

If you are working in primary care, look at ways to support people experiencing homelessness to register with a GP and address any problems they may be experiencing.

An example of a tool to address this includes:

The Safe Surgeries Toolkit is a resource for general practices that want to provide a welcoming environment for everyone in their community and an equitable service for all of their patients. It has been developed by Doctors of the World (DoTW) UK with the aim of addressing the particular barriers to primary care faced by migrants in vulnerable circumstances, including refugees and survivors of trafficking. All of the advice given complies with NHS England guidance.

1.2.10 Consider reducing caseloads and lengthening contact time for health and social care practitioners working with people experiencing homelessness to enable them to use approaches that sustain engagement with services.

There is some evidence that short appointments are a barrier to service access, as people experiencing homelessness report feeling rushed with insufficient time to discuss their needs.16

If you are a health or social care provider, look at ways to reduce practitioners’ caseloads and provide longer appointments.

15 Broadbridge, Ang and Blatchford, Sheila (2018) Views and experiences of local mental health services for people with experience of homelessness or insecure housing. 15


Please, Nicholas and Bretherton, Joanne (2020) Health and care services for people sleeping rough: the views of people with lived experience. 23
1.3 Models of multidisciplinary service provision

Homelessness multidisciplinary teams

1.3.2 Homelessness multidisciplinary teams should act as expert teams, providing and coordinating care across outreach, primary, secondary and emergency care, social care and housing services. Homelessness multidisciplinary teams may include:

- experts by experience
- healthcare professionals with relevant specialist expertise (for example, drug and alcohol treatment, mental health, primary care, emergency care, palliative care)
- social workers
- housing options officers or homelessness prevention officers
- outreach and homelessness practitioners
- voluntary and charity sector professionals
- staff with practical expertise in accessing benefits and entitlements for people experiencing homelessness.

1.3.5 Homelessness multidisciplinary teams should:

- offer person-centred case management by a designated practitioner within the multidisciplinary team and ensure continuity of care for as long as it is needed by the person
- offer wraparound health and social care support that encompasses the person’s needs, including:
  - physical health
  - mental health and psychological support (such as psychological therapies)
  - physical rehabilitation (such as occupational therapy and physiotherapy)
  - drug and alcohol treatment
  - social care
  - palliative care
  - communication support
  - practical needs, such as help with benefits, housing and referral for legal advice.

The evidence suggests that all too often health and care systems are fragmented and care is provided in “silos”, with minimal coordination between agencies and providers. Research suggests that people experiencing homelessness want more individualised care and support and that service providers need to adopt a more holistic approach to health and social care.

If you are a service leader, consider setting up a specialist multidisciplinary team (MDT), consisting of practitioners and professionals from health, social care and allied disciplines and sectors, to work together to provide holistic, person-centred and coordinated care and support.

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18 Groundswell (2016) More than a statistic

St Mungo’s, (2009) Happiness Matters: Homeless people’s views about breaking the link between homelessness and mental ill health.

There are a number of examples of MDT approaches to providing accessible healthcare to people experiencing homelessness, ranging from services for people with mental health needs, to identifying and managing diabetes, and vaccine roll-out:

- The START Homeless Outreach Teams are five multidisciplinary, integrated statutory community teams for people sleeping rough and hostel residents in Lambeth, Southwark and Croydon. They are funded by the local Clinical Commissioning Groups, NHS England and Office for Health Improvement and Disparities, and are composed of community psychiatric nurses, occupational therapists, social workers, with peer support from Groundswell, as well as three psychiatrists, two psychologists, a GP trainee and a nurse prescriber delivering opiate substitute therapy.

START is based in South London and the Maudsley NHS Foundation Trust and integrated with Adult Social Care in two of the boroughs where it operates which enables the team to carry out Mental Health Act, Mental Capacity Act and Care Act assessments, and to lead on safeguarding procedures.

The teams work in a trauma-informed, relational way to engage and assess people experiencing homelessness through pre-treatment, assertive outreach work, and then deliver formal treatment for mental ill health, substance misuse and any other presenting needs. Three of the teams work with people sleeping rough with primary mental illness including schizophrenia, affective disorders and personality disorders. The other two teams work with clients with dual diagnosis and who may benefit from higher levels of support. All clients are hard to engage and unable to use mainstream care services. The team can support clients through transitions in care such as prison, hospital and accommodation moves, and work closely with third sector partners such as day centres, outreach and hostels. This long term, relational approach and the MDT arrangement has led to recovery from mental illness and addiction, resettlement from the streets and reduced contact with criminal justice, bed days and emergency care. Similar models exist in Manchester, Westminster, and through Enabling Assessment Services London (EASL).

- A quality improvement project to improve the identification and management of diabetes in people experiencing homelessness in Bolton provides an example of the multidisciplinary approach to planning and delivering care improvements. Following the formation of a MDT advisory group, including diabetes specialists, a podiatrist, retinal screening lead, community leads, Bolton out-of-hours staff, the local Council for Voluntary Service, hostel staff and members of the homeless and vulnerable adults team, the initiative has led to: routine diabetes screening in hostels, outreach diabetes screening at a regular soup kitchen, hostel training on diabetes and monthly awareness events led by diabetes community champions, drop-in retinal screening, drop-in podiatry, additional nutritional support, a point-of-care testing system, and weekly review of admissions to A&E of people with no fixed abode.

- Vaccine roll-out in North West London – The North West London Homeless Health Partnership worked with Groundswell in a partnership to deliver vaccinations to more than 70% of people experiencing homelessness across eight local authorities. Key principles for achieving this success were: a coordinated response; using inclusion health principles; a pragmatic and targeted model; upscale using specialist knowledge and expertise. The initiative used a mixed model approach to ensure vaccinators were going where people were: in-reach at accommodation settings, community action days for people who were sleeping rough and pop-up hubs in community venues. Peer support was offered by charity Groundswell. Groundswell have also produced a short film and a guide on what works when rolling out the Covid-19 vaccine.

- Leicester’s NHS run Homeless Mental Health Service (HMHS) offers individualised mental health assessment and support, as well as access to mainstream NHS mental health services locally provided within Leicestershire Partnership NHS Trust. The service is staffed by two psychologists, a psychiatrist, three mental health practitioners, two dual qualified mental health nurses, a support worker and a dedicated clinical admin worker. An essential element is the mental health drop-in aspect of the service, and the accessibility and flexibility that provides. Pre-Covid-19, the service was based at the Dawn Centre, a council-run one-stop shop where anyone experiencing homelessness can walk in to access immediate support with benefits, housing advice and access to emergency accommodation, practical help, shower, change of clothes, access to a mental health assessment and GP appointment. The Dawn Centre hosts a YMCA day centre, a large council-run hostel, a specialist GP service, council staff specialising in housing and homelessness, outreach teams, and floating support. HMHS staff are part of the Multi-Agency Care Collaborative (MACC) which meets weekly to discuss and attempt to resolve difficulties which may be preventing service users with complex problems accessing services and support. MACC membership is multi-agency, and includes mental and physical health practitioners, staff working on housing, drugs and alcohol, sex workers, day centres and other voluntary sector staff.

- In North Devon, the NHS Better Care Fund is funding a North Devon Homeless and Inclusion Health Nurse based at The Freedom Centre in Barnstaple where many different agencies are co-located to provide support and intervention for those experiencing homelessness or who are vulnerably housed. The multidisciplinary team comprises of a mental health nurse, environmental health officer, freedom centre charity support workers, rough sleeping housing officer, together drug and alcohol worker, North Devon council lead for rough sleepers, GPs, and representatives from the police, probation services, and the Department for Work and Pensions.
1.4 The role of peers

1.4.1 Involve peers (experts by experience) in delivering and designing services, for example by:
- directly delivering health and social care interventions, for example, as part of outreach
- providing a user perspective to influence the design and development of services
- providing training for health and social care staff
- carrying out participatory research and data collection, for example, to support service audits, needs assessments and quality improvement.

1.4.2 Offer peer support to people experiencing homelessness, for example to help with:
- understanding how others with similar experiences have changed their lives (role modelling)
- developing self-efficacy
- navigating services
- supporting attendance at appointments
- providing peer advocacy at appointments or in A&E
- forming trusting relationships with practitioners and improving communication.

Research indicates that some people experiencing homelessness do not trust service providers or the healthcare system. Peer supporters can help build trusting relationships with service providers and improve the overall communication. There is evidence that people experiencing homelessness value care and support from those with a shared, common experience. People with lived experience are able to communicate in a way that people experiencing homelessness can understand. Peer supporters feel that acting as role models may inspire people experiencing homelessness to do better, or to feel that their goals are achievable, and that there is hope.

Evidence suggests that peer supporters can help navigate the system or the care management of people experiencing homelessness, such as by helping them attend appointments, acting as their advocates, and delivering interventions, such as outreach care.

Further examples of peer support for people experiencing homelessness:
- The University College London Hospitals NHS Foundation Trust runs a Find & Treat service, which includes former tuberculosis (TB) and hepatitis C patients who work as peer advocates along with a wider multidisciplinary team that includes nurse specialists, social care and outreach workers, radiographers and expert technicians. In partnership with Groundswell, the service recruits, trains and supports former TB and hepatitis C patients who have experienced homelessness to work as peer advocates in the multidisciplinary team. The peers are an authentic voice to other service users and professionals and can increase screening uptake, support people to get cured, improve awareness and tackle stigma. Peers are now clinically trained and supervised to provide a range of tests and Covid-19 vaccination. Peer-led engagement and treatment has been able to complete in 90 minutes care that would previously have involved four hospital appointments. This is a specialist outreach team that works alongside other NHS and third sector frontline services to tackle communicable diseases among people affected by homelessness, drug or alcohol users, vulnerable migrants and people who have been in prison - all groups with a high risk of onward transmission.
- In Brighton and Hove, the Common Ambition project aims to improve health services for homeless and vulnerably-housed people. People with lived experience of homelessness are working with frontline providers and commissioners to develop a new approach to co-production within homeless health services, in order to improve health services and outcomes for people experiencing homelessness in Brighton and Hove. The project involves conducting a health needs audit and a review of current services for homeless people, feeding the findings into service improvements that better meet patient needs.

Groundswell (2016) More than a statistic
1.5 Improving access to and engagement with health and social care

Supporting access to and engagement with services

1.5.1 Design and deliver services in a way that reduces barriers to access and engagement with health and social care, for example, by providing:

- outreach services (see the section on outreach services)
- low-threshold services
- flexible opening and appointment times
- self-referral
- drop-in services
- ‘one-stop shops’ for multiple services
- incentives and help to access care, such as transport support, vouchers or digital connectivity
- advocates (see recommendation 1.1.12 in the section on communication and information)
- peer support (see the section on the role of peers)
- care navigation
- psychologically informed environments and trauma-informed care.

1.5.9 Primary care service providers should ensure that people without an address can register with a GP practice, in line with the NHS Primary medical care policy and guidance manual.

Evidence indicates that service access barriers include rigid appointment systems and limited opening hours, out-of-pocket expenses for services, and transport. Low-threshold, flexible services would allow more people experiencing homelessness to access and engage with services, and appointment systems should be more flexible and responsive to their needs.

For example

If you are a service provider, establish whether people experiencing homelessness in your area are excluded from accessing healthcare in one of these four key ways:

- An address is often required, for example, for registration with a GP or for the NHS Low Income Scheme (which allows for free prescriptions)
- Some services have incompatible access criteria. For example, some substance use services require accommodation, but accommodation may only be available to those who are sober
- Local authority rehousing services require a ‘local connection’, for example a certain time spent living in the area
- Social care and substance use services may only be provided for recognised local residents and specified at-risk groups, including those at risk of gender-based/domestic violence. Councils may refer a person without a local connection back to their ‘home’ area, unless they would be at risk of violence there.

Most of these thresholds, or barriers to service access such as restrictive eligibility criteria, are not set in law and there are usually allowances for individual circumstances such as a need to access local specialist healthcare.

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22 Kerman, Nick, Gran-Ruaz, Sophia, Laurence, Madalynne et al. (2019) Perceptions of Service Use Among Currently and Formerly Homeless Adults with Mental Health Problems. Community Mental Health Journal 55(5): 777-783

23 Mills, Emma; Burton, Christopher; Matheson, Catriona (2015) Engaging the citizenship of the homeless: a qualitative study of specialist primary care providers. Family Practice 32(4): 462-5 467

Astra Zeneca, Depaul UK (2012) Making it better: improving the health of young homeless people. 61p

Some examples include:

- Inclusion Health have developed an online tool to help Primary Care Networks to assess their engagement with Inclusion Health groups. These are the groups identified as experiencing the worst health inequalities in the UK, including people experiencing homelessness. The tool consists of five sections and takes around 10 minutes to complete. Once the self-assessment is completed, Primary Care Networks are provided with a unique and tailored guide which will help them to embed action on tackling health inequalities into its everyday activities.

- Groundswell have created a film (Clarissa) and accompanying resource pack which aims to improve understanding of the experiences of people affected by homelessness and why access to healthcare may be difficult. It includes discussion topics on: GP access; person-centred care; changes in policy and practice; supporting staff; trauma-informed practice; and the value of peer support.

- Arch Health Care runs the Morley Street GP surgery and the homeless health engagement service for Brighton and Hove. The practice registers people sleeping rough, people in temporary supported accommodation, sofa surfers, gypsies, Roma and travellers. A full range of services are provided and the practice aims to meet QOF targets including COPD, asthma, and diabetes reviews. Accessibility is seen as very important, so efforts are made to make it as easy as possible for people to register with help to fill in forms, offering same day appointments and medication where possible, training for reception staff on mental health and substance misuse. In addition to the specialist GP service, the practice provides: in-reach to hospitals through Pathway teams and Pathway Plus; outreach to day centres through a nursing team which provides weekly clinics; and city-wide leadership and integration through an annual conference, fortnightly complex case reviews involving social workers, housing staff and the voluntary sector.

- Bevan Health Care provides responsive NHS GP services designed to meet the needs of people who are impacted by homelessness or in unstable accommodation in Bradford and Leeds, as well as refugees and people seeking asylum. Bevan also provides outreach services, a wellbeing centre, a ‘Help through Crisis’ initiative, and the York Street Health Practice in Leeds. Staff include GPs and practice nurses, a mental health nurse, psychologist, psychiatrist, occupational therapists, and substance misuse expertise. Complex patient clinics provide extra time for appointments.

- The Pathway model trains NHS staff to help patients access the accommodation, care and support they need to recover and get life onto a better pathway after their stay in hospital. Pathway teams are led by specialist GPs who bring their experience caring for people experiencing homelessness in the community, as well as expertise in methadone prescribing, personality disorder, and chronic disease management. Nursing staff manage the team caseload and bring clinical experience in homelessness, addictions and/or mental health. Housing staff manage the team caseload and bring clinical experience in homelessness, addictions and/or mental health. Housing specialists bring their expertise to the service and help build links with voluntary sector services in the community. Some Pathway teams also include Care Navigators who have personal experience of homelessness, and larger teams also include occupational therapists, social workers and mental health practitioners. Pathway teams work with patients to create bespoke care plans for their support, including referrals to addiction services, ongoing treatment for health issues such as hepatitis C and tuberculosis, and community services offering social care. Coordinating input from housing departments, mental health and addictions services, social services, community and charity sector partners, teams provide empathetic, patient-centred, recovery-focused care.

Based in the hospital, Pathway teams:

- Provide expert advice and clinical advocacy around homeless and inclusion health issues (such as substance misuse and substitute prescribing) for inpatients, improving care and treatment outcomes

- Ensure patients with high support needs are able to engage with health and other services through holistic inpatient support and care, thereby reducing rates of early self-discharge

- Help patients affected by homelessness find somewhere safe and appropriate to stay on discharge, taking into account their needs around health, care and general support

- Support patients with financial issues, welfare entitlement and to access specialist legal help where possible

- Help to replace lost ID documents

- Ensure patients are registered with a GP for ongoing care

- Refer and signpost to specialist community services to help with a variety of social, mental and physical health, and addictions issues

- Reconnect patients to family and social support networks on discharge.
1.5.13 Take health and social care services to people experiencing homelessness by providing multidisciplinary outreach care in non-traditional settings, such as on the street, hostels or day centres.

Outreach services

1.5.15 Use outreach to identify health problems earlier, promote health and support engagement with care, for example by:

- supporting access to national screening programmes
- assessing people for long-term conditions, infectious diseases, and mental health needs
- providing preventive health opportunities, such as vaccination, drug and alcohol treatment services, harm minimisation, smoking cessation and nutrition advice.

Evidence indicates the positive effects of outreach services, which bring flexibility that is not possible in traditional healthcare services. Bringing services to people can help to build trust and a strong connection with the service provider and practitioners. Outreach services provide an opportunity to introduce harm reduction strategies, and an opportunity for screening and immunisation.

Examples of outreach approaches include:

- A team of engagement workers in Bristol Mental Health’s Assertive Contact and Engagement (ACE) service (provided by St Mungo’s) reach out to people who have barriers to using services. Referrals can be made by anyone. Services include outreach, one-to-one support, drop-ins, groups and therapy. Taking a holistic approach, ACE encourages participation and carries out joint work with mental health recovery teams. ACE also provides training for community groups and services, on how to work with individuals with mental health issues.

- University College London Hospital’s Find & Treat service is described earlier in terms of the role of peers. It is a specialist outreach team that works alongside other NHS and third sector frontline services to tackle a range of long-term conditions among people experiencing homelessness, drug or alcohol users, migrants facing hardship and people who have been in prison. These groups can have problems accessing hospital-based diagnostic services and completing a minimum of six months daily drug treatment. The service spans from detection to diagnosis and onward care. Using a mobile digital X-ray unit, the service is able to screen almost 10,000 people at higher risk every year. Directly Observed Treatment (DOT) is delivered in the community, and DOT options are tailored to individual patient needs and include Video Observed Treatment using web-based solutions. The service is working with the Office for Health Improvement and Disparities, the Inclusion Health Board and the Faculty of Homeless and Inclusion Health to design a better outreach service around the needs of the people it serves, which will include expanding its work outside London, incorporating screening for other important infections using point-of-care tests and ensuring that people are vaccinated and protected.

- The Connection at St Martins have a street engagement team which provides daytime outreach with health partners. This includes a weekly outreach prescribing clinic, as well as some on-street prescribing.

- Bevan Health Care provide a range of outreach services including a Street Medicine Team. The Street Medicine Team Service operates a weekly programme using a mobile medical unit visiting different locations in Bradford and Leeds. The team promotes immediate treatments to those in need, leading on to regular engagement with primary care services and GP registration. Equipped to deal with a wide range of medical conditions, the outreach staff provide health promotion, practice registration, assessment and treatment, health screening and advice. This is enabled by full access to medical records, updating these for any future care. Collaborations with other care providers and support organisations enable this service to remain a useful and up-to-date frontline service.

If you are a health or social care service provider or practitioner, look at whether you can provide services in non-traditional settings such as the street, hostels, or day centres. Outreach services may help to prevent people falling through the safety net of health and social care, and can be more accessible for those who have a history of marginalisation, such as people who have concerns about eligibility to access services (for example, migrants). Street outreach services often involve embedding health staff within local authority or third sector outreach teams, who know where people are likely to be found and might have pre-established relationships with them – for example, placing mental health nurses in street outreach or drug and alcohol teams.

If you are a service provider or practitioner, consider skillling up generic outreach workers, for example through mental health training and psychologically informed techniques to build trust and provide support.

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Croft White, Clare and Parry Crooke, Georgia (2004) Hidden homelessness: lost voices - the invisibility of homeless people with multiple needs.

In Bolton, a specialist nursing service for rough sleepers works closely with the Council and local voluntary sector services. It provides support on the streets, as well as into hostels and from its town centre base. The team has eight staff, including an advanced clinical practitioner, a trainee advanced clinical practitioner, two Band 6 nurses, two Band 4 nurses and two Band 2 nurses and a trainee, all dedicated to homeless healthcare. The service receives funding from the Rough Sleepers Initiative and Greater Manchester Health and Social Care Partnership for two of the posts. As well as providing support to rough sleepers, the Homeless and Vulnerable Adults Service also works with asylum seekers who are street homeless or accessing either the guest houses or hostel accommodation. The team provide drop-in clinics three days a week, as well as in-reach to three hostels, charitable organisations, guest houses and the night shelter. Staff work closely with the council’s drug and alcohol service, local charities working with people experiencing homelessness and the local authority’s rough sleeping outreach team. Hospital in-reach is also provided three times a week, which facilitates safe discharge with community follow-up. The team do a lot of joint working and liaison with other services, and are involved in safeguarding on a regular basis. The team see some regular patients and emphasise the importance of continuity in building relationships.

A group of organisations including the Royal College of Nursing, Pathway, and Queen’s Nursing Institute have produced a set of guidelines for health-related street outreach to people experiencing homelessness. These were developed in partnership with a range of organisations. The guidelines aim to assist services to plan new health-related street outreach projects, or to review their existing outreach. These guidelines are designed as a flexible tool for sharing innovative ideas, allowing services to use them as appropriate to their areas.

1.6 Assessing individual needs

1.6.2 Assess the health and social care needs of the person experiencing homelessness. When carrying out the assessment:

- take into account their capacity, rights to autonomy and self-determination, and any safeguarding issues
- avoid unnecessary and potentially distressing repetition of their history if it is already on record
- involve peers or advocates as appropriate (see also the section on the role of peers).

1.6.3 Include in the assessment:

- a comprehensive assessment of the person’s physical and mental health needs (including acute and long-term conditions) and social care needs. This should take into consideration their housing and benefits situation, bearing in mind the need to address health inequalities, and be responsive to diversity, and inclusion needs
- asking if the person has children or dependants and assessing how this affects their needs
- understanding the historical context of their situation, including past psychological trauma and experience of services.
1.6.4 In assessments to inform a health and social care plan for people who might benefit from high levels of support, use a multidisciplinary approach to enable a comprehensive and holistic assessment of their needs, involving:

- the person, and their advocate if one is nominated or appointed
- input from professionals with specialist expertise and practitioners who have detailed knowledge of the person’s health and social care needs, including staff working in homelessness and housing services.

There is no strong evidence on different approaches to improving access to services through needs assessments. However, NICE expert advisors considered that a multidisciplinary approach is needed to ensure the full range of health and social care needs are identified, including consideration of risk and safeguarding issues.

Examples available of tools for assessing needs:

- The Queen’s Nursing Institute developed a Guidance with Health Assessment Tool in 2015 for assessing the health of people who are experiencing homelessness.
- Pathway, in partnership with Lambeth Council, South London and Maudsley NHS Trust, Thames Reach, the Greater London Authority and Enabling Assessment Service London (EASL) developed tools and guidance for mental health service assessments for rough sleepers in 2017. It is intended to be used when all other approaches have failed, been rejected, or where there is an increase in risk due to a change in circumstances. It should help workers to both assess people with mental health conditions who are sleeping rough and to elicit an appropriate response from statutory agencies. The guidance covers:
  - Assessment of the risks run by someone who is sleeping rough
  - Use of the Mental Capacity Act – is the individual really making an informed decision to stay on the street?
  - Use of the Mental Health Act - and developing a hospital admission plan.
  - Raising an adult safeguarding alert.
- It includes: a Mental Capacity Act Screening Tool, a Mental Health Act Screening Tool, and a Hospital Homelessness Mental Health Admission Plan.
- Speech, language and communication needs: Briefing for homelessness services explains about speech, language and communication needs, how they might be recognised and what homelessness services can do to increase engagement, and overcome barriers, for people with these needs.
- NHS England and Improvement, alongside the Office for Health Improvement and Disparities, and representatives from the voluntary sector and the NHS, have developed a pathway and suite of supporting documents to enable emergency departments to support people experiencing (or at risk of) homelessness and rough sleeping; and to realise service improvements relating to re-attendance, admission/re-admission and length of stay in order to improve patient outcomes. The suite of documents developed include:
  - Homeless and rough sleeping ED pathway
  - Homeless and rough sleeping checklist
  - Homeless and rough sleeping toolkit including:
    - Case studies
    - E-learning
    - Top tips at reception and suggested language
    - Streetlink guidance for ambulance services.
- The documents will be published on FutureNHS UEC Homelessness and Rough Sleeping.
1.7 Intermediate care

1.7.1 Provide intermediate care services with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care. These may be for people who are:

✓ discharged from hospital (step-down care)
✓ referred from the community who are at acute risk of deterioration and hospitalisation (step-up care).

See also NICE's guideline on intermediate care including reablement.

There is some evidence that both step-down intermediate care and hostel based step-up care is cost-effective.24

If you are a service provider, there are a number of approaches to consider. A scoping paper25 by Kings Health Partners in 2016 provides examples and options for a range of approaches to respite care for people experiencing homelessness, including step down and step up. Other examples of intermediate care services for people experiencing homelessness include:

• Bradford Respite Intermediate Care Support Service (BRICSS) was established to address the complex medical and social care needs of people affected by homelessness being discharged from hospital and prevent the ‘revolving door’ of admissions. BRICSS developed as a partnership between Horton Housing Association and Bevan Healthcare (BHC). They provide a 14-bed unit for patients impacted by homelessness with continuing healthcare needs on hospital discharge, and aim for a 12-week placement in BRICSS. Patients are referred by a hospital-based Pathway Team. Medical aims and outcomes are set on a detailed management plan which supports timely move on to the correct accommodation. Clinical, social and housing practitioners provide integrated healthcare and social support. The BRICSS health team is composed of a GP, mental health / substance misuse nurse and physical health nurse. An evaluation indicated improved mental and physical health and a reduction in hospital admissions.

• Cornwall Council working in partnership with Harbour Housing and Stay at Home have redesigned their out-of-hospital care services to increase the number of options available to patients affected by homelessness leaving hospital on Discharge to Assess Pathways. For those patients who do not have a home and require more than just a sign-posting service, Harbour Housing provides access to six self-contained units of accessible step-down accommodation. This comes with onsite practical support such as helping people to get to their hospital appointments, as well as holistic ‘enrichment support’ for improved health and wellbeing including counselling and a range of strengths-based activities. Where people have care and support needs including self-neglect and issues linked to drug and alcohol use, a specialist reablement service is provided for up to six weeks. The Stay at Home service provides CQC regulated activities into the step-down accommodation and into the community. Specialist reablement workers are trained in the use of trauma-informed approaches and can, for example, deliver naloxone to prevent drug-related deaths from overdose. Cornwall is one of 17 test sites that are up and running until March 2023 which are part of an evaluation of out-of-hospital care.

• Gloria House provides a model of step-down accommodation for patients being discharged from the Royal London Hospital. The scheme is a partnership between Peabody Housing, the Royal London Hospital Pathway Team and Tower Hamlets CCG. It is a six bedded house. Staffing includes on-site keyworker support but no on-site nursing or clinical input. Residents receive support with: accessing benefits; GP registration and hospital appointments; medication prompting; legal assistance; and help with accessing food banks and hardship funds. Key ingredients are: a successful three-way partnership between housing provider, hospital and CCG; exclusive referral rights by the Pathway team; CCG funded beds with some notable success at reclaiming housing benefit to offset costs; strong package of support to help occupants with all aspects of health, housing and social care; and ability to deal with more complex cases if required.


1.8 Transitions between different settings

1.8.1 Homelessness multidisciplinary teams or leads should support people experiencing homelessness through transitions between settings (such as the street, hostels, Housing First and other supported housing, hospital, mental health services, social care, residential or community drug and alcohol treatment, and custody) and consider providing time-limited intensive support, which includes:

- having a key practitioner coordinating care
- building a relationship of trust
- providing links to services in the community
- gradually lowering of intensity of support, as appropriate.

1.8.2 Practitioners in any setting supporting people experiencing homelessness should:

- ensure that all handovers of care responsibilities are planned and coordinated, and relevant information is shared if agreed
- offer pre-emptive, structured support before, during and after transitions
- recognise that people may be vulnerable during periods of transition, but also that there may be opportunities for intervention.

1.8.3 Clinical teams, working with hospital discharge teams and specialist homelessness multidisciplinary teams, where available, should have procedures to:

- minimise self-discharge and
- prevent discharge to the street.

If self-discharge or discharge to the street happens, review the circumstances and implement learning.

Evidence indicates that people affected by homelessness experience inadequate or rushed care with early discharge and no follow-up. There are several issues with hospital discharge procedures, such as being discharged to the streets. Individuals describe being in a vicious cycle, repeatedly going in and out of hospital because they are continually not being given the care and support they need to recover in the long term.26

If you are responsible for hospital discharge, you can look at examples of approaches to transition between hospital and other settings for people experiencing homelessness, such as:

- Specialist homeless hospital discharge nurses. Pathway provide a range of resources for those wishing to develop this kind of provision, including a summary of current recommended practice and local service innovations, analysis of challenges, key performance indicators, a suggested quality framework, a directory of existing freely available continuing professional development resources, and draft standards for education and practice for inclusion health nurses. The key nursing activities include:
  - effective engagement of the patient in all relevant services and support
  - maximising the health and social care benefits for the patient when they attend or are admitted to hospital
  - linking the patient into all necessary health and social care or support pending their discharge
  - advocating for the patient to receive assessment, treatment or services when required
  - ensuring patients are effectively safeguarded
  - ensuring a safe and effective discharge to accommodation (where this is possible)
  - reducing or stopping the revolving door for patients being frequently readmitted to hospital.

- The Bradford Bevan Pathway team is based within the Bradford Royal Infirmary and runs in partnership with Bradford teaching hospitals. The team works with patients who are affected by homelessness or unsuitability housed with higher support needs who have recently been admitted to an acute hospital setting or have attended A&E. The team carries out a holistic assessment of each patient’s needs and a support plan is put in place in preparation for discharge. Support plans often include addressing issues such as housing, mental health, benefits, substance misuse, alcohol issues, benefit problems and other overlapping social issues.

The aims of the team are to:

- transform patient’s experience of both hospitalisation and discharge
- assist in challenging healthcare attitudes, behaviour and practice when dealing with this patient group
- establish empathetic relationships
- ensure patients are valued as individuals
- provide care and support with compassion, commitment and quality
- provide a holistic individual approach linking secondary care with both primary care and the voluntary sector, to enable patients to receive the care and support that they need and deserve
- support in reducing hospital admissions and A&E attendances by providing patients with the appropriate support with both their physical health and social complexities.

They have achieved significant reductions in A&E attendances, hospital admissions and bed days.

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Canavan, R., Barry, M. M., Matanov, A. et al. (2012) Service provision and program planning 68: 7-12
Davis-Berman J (2016) Serious Illness and End-of-Life Care in the European capital cities. BMC health services research 12: 222
Canavan, R., Barry, M. M., Matanov, A. et al. (2012) Service provision and program planning 68: 7-12
Centres for Homelessness Impact August 2022 | A Step-by-Step Resource for Implementing the Joint Guideline

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CENTRE FOR HOMELESSNESS IMPACT
AUGUST 2022 | A STEP-BY-STEP RESOURCE FOR IMPLEMENTING THE JOINT GUIDELINE
At Gloucestershire Hospitals Foundation Trust, a quality improvement project in A&E has led to the appointment of a homeless specialist nurse, as well as a moderate to minor injuries (P3) A&E in-reach navigator who can assess homeless people in A&E, organise transport to accommodation, complete drug and alcohol referrals, and register with a GP. This role then provides a period of wraparound support. By working closely with community services and local authorities, it has been possible to create simple and easy to use referral pathways. This involved considering information governance, data collection, staff workload and challenging unconscious stigmas regarding homelessness. The staff have worked with IT to ensure patients affected by homelessness are identified on admission and developed a homeless patient checklist and department guidelines for use in A&E. The work has led to identification of hidden homelessness, issues around GP registration, and a much-reduced risk of re-attending. Patients are able to go into appropriate accommodation much sooner, leading to improved health and wellbeing in this group.

The Healthy London Partnership has developed guidance on safe and effective discharge of people experiencing homelessness and a checklist for staff. Transforming out-of-hospital care for people who are homeless is a support tool with briefing notes, which complements the High Impact Change Model for transfers between hospital and home, published by the NIHR Policy Research Unit in Health and Social Care Workforce at King’s College, London. It sets out four steps to transform homeless hospital discharge, as well as case studies of unplanned discharges. The authors recommend:

- Strengthen existing ‘Homeless Hospital Discharge (HHD) Protocols’ to ask housing authorities to work to similar timescales as adult social care e.g. complete housing assessments within 72 hours to facilitate early discharge planning and improved monitoring of system flow (including ID of housing related ‘pinch points’).
- Integrated hospital-based specialist homeless healthcare teams (for example, Pathway teams) alongside existing multidisciplinary discharge coordination services. Out-of-hospital care must be integrated so people can move seamlessly between different services, depending on changing needs.
- Provide alternative ‘housing-led’ (step-down) pathways out-of-hospital for people who need time for recovery and reattachment but who cannot go home (they have no home) but whose needs would be over-catered for in a care home.
- Use trusted assessment and boundary spanning to bring the specialist clinical expertise of the homeless healthcare team into ‘housing-led’ intermediate care.

1.9 Housing with health and social care support

1.9.2 Provide wrap-around health and social care support that is flexible to the person’s changing needs and circumstances and helps them maintain suitable accommodation.

Research indicates positive outcomes from health and social care support ‘wrapped around’ housing services, such as through Housing First.27

- Housing First is a housing and support approach which gives people who have experienced homelessness and chronic health and social care needs a stable home from which to rebuild their lives. It provides intensive, person-centred, holistic support that is open-ended, and places no conditions on individuals; however, they should desire to have a tenancy. Housing First England have developed principles and guidance for commissioners and service providers. An early example of a Housing First scheme was developed in Manchester:

- Greater Manchester Housing First launched a pilot Housing First scheme in 2019 with Riverside Housing Association, among others. The housing association has a ‘rough sleeper pathway’, which is 70 units of accommodation. This is made up of rooms with a bathroom in a supported housing scheme, or flats within the community. There is also a focus on the diversity of provision, with LGBTQ+ accommodation, men and women’s accommodation, accommodation for those with addictions and accommodation for people who have been subjected to domestic violence.

Beyond the Housing First approach, there is a lack of a good range of relevant examples available. However, there are some relevant ones in these previous sections: assessing people’s needs, intermediate care, and transitions between different settings.

27 Brown, MM; Jason, LA; Malone, DK; Dvorkin, D; Spika, L. Housing first as an effective model for community stabilization among vulnerable individuals with chronic and nonchronic homelessness histories. Journal of Community Psychology. 2016; vol. 44 (no. 3); 384-390
1.10 Safeguarding

Also see the NICE guideline on domestic violence and abuse.

1.10.1 Designate a person to lead on safeguarding the welfare of people experiencing homelessness, including engagement and face-to-face practical safeguarding support.

1.10.2 Where a social worker is embedded in the homelessness multidisciplinary team, local authorities should consider appointing them to lead on safeguarding enquiries about people experiencing homelessness.

1.10.3 Local authorities should consider having a lead for people experiencing homelessness on the Safeguarding Adults Board.

The NICE guidelines highlight the importance of safeguarding as a key part of supporting people who are experiencing homelessness, but there is a lack of evidence.

If you are a commissioner or service provider, consider designating a social worker within a homelessness multidisciplinary team as a safeguarding lead. They have professional expertise on the assessment and related legal duties and powers under the Care Act 2014.

There are a number of examples of guidance and briefings on safeguarding:

- The Local Government Association and Association of Directors of Adult Social Services have published a couple of briefings on adult safeguarding and homelessness. Adult safeguarding and homelessness: a briefing on positive practice aims to assist senior leaders, such as members of Safeguarding Adults Boards (SABs), as well as commissioners, practitioners and operational managers who are working across relevant sectors and agencies in this field, to support people who are affected by homelessness and at risk of or experiencing abuse or neglect. Adult safeguarding and homelessness: experience informed practice provides examples of positive learning and practice from the different sectors involved, especially housing, health and social care, both statutory and third sector.

- Voices of Independence, Change and Empowerment in Stoke-on-Trent (VOICES) working Keele University, King's College London and CASCAIDr have developed a prototype safeguarding toolkit for practitioners which aims to improve multi-agency support for individuals who have an appearance of need for care and support and are experiencing multiple exclusion homelessness.

- Homeless Link’s publication Adult Safeguarding and Homelessness: Learning from Safeguarding Adult Reviews aims to share the learning from Safeguarding Adults Reviews that has enabled an evidence-base for positive practice to be developed.

- Keeping us safer: An approach for supporting homeless women experiencing multiple disadvantage is guidance that aims to be a practical and holistic approach to supporting women experiencing homelessness and multiple disadvantage, which includes tailored guidance around risk assessment and safety planning, for women living in and accessing homelessness services and those who are sleeping rough.

- Adult Safeguarding and Homelessness: Understanding Good Practice - Knowledge in Practice edited by Adi Cooper and Michael Preston-Shoot highlights evidence-informed practice and serves as a resource for providers and practitioners working with people experiencing multiple exclusion homelessness and adult safeguarding.

- A multidisciplinary team of researchers have produced a capacity guide for clinicians and social care professionals on the assessment of capacity for those working with people experiencing homelessness. Although the guidance does not have any official status, it aims to reflect the requirements of the law in England and Wales, clinical practice and relevant ethical considerations. It provides prompts for clinicians and social care professionals assessing capacity on questions to ask and relevant considerations to take into account, and tools to help think through some of the more common situations of difficulty encountered in practice.
1.11 Long-term support

1.11.1 For people who struggle to engage with services, plan long-term engagement to help meet the person’s needs at their own pace.

1.11.2 Give priority to building a relationship of trust, for example by:

- taking time with the person, particularly at the beginning of the relationship
- being prepared to meet in an informal setting, such as a park or café (with appropriate lone worker policies in place)
- having regular contact
- ensuring consistency of practitioner, so that they meet with 1 person or a small team
- aiming to meet immediate expressed needs to encourage long-term engagement.

1.11.3 Recognise that people experiencing homelessness do not always follow a linear recovery journey and that apparent progress may hide risks.

Research indicates a lack of consistency and care continuity in service delivery. Many people experiencing homelessness report having multiple GPs, counsellors, and social workers, which means it is difficult to form a trusting relationship if they have to keep repeating their story and start from the beginning with a new provider or practitioner every time. Maintaining the same service provider or the same team of practitioners is an important way to build a trusting relationship.

If you are a service provider or practitioner, try to make frequent attempts to engage, but without placing pressure on people to engage; and offer flexible approaches for re-engagement as many people experiencing homelessness can have a non-linear journey.

Specialist nursing and mental health services and specialist GP services, described in previous sections, provide examples of this. Their focus is on long-term engagement, continuity and relationship building, combined with drop-in and self-referral opportunities. Housing-based services such as Housing First also provide a potential foundation for long-term support for people experiencing homelessness.

If you are a service provider or practitioner, try to make frequent attempts to engage, but without placing pressure on people to engage; and offer flexible approaches for re-engagement as many people experiencing homelessness can have a non-linear journey.

1.12 Staff support and development

1.12.1 Consider providing training for all health and social care practitioners, at a level suitable for their professional role, covering:

- understanding the health and social care needs of people experiencing homelessness, and their rights to access services
- homelessness as part of equality and diversity training, including being responsive to health inequalities, diversity issues and inclusion needs and understanding the impact of discrimination and stigma, and how intersectional, overlapping identities can affect people experiencing homelessness
- psychologically informed environments and trauma-informed care
- legal duties and powers
- legal entitlements for migrants.

There is evidence that training has the potential both to raise awareness and to improve provider and practitioner knowledge in the needs of people experiencing homelessness, as well as improving sensitivity and understanding for this population, so that care practitioners can overcome preconceived ideas and judgemental behaviour towards people experiencing homelessness.

If you are a service provider or employer, provide training for staff as appropriate about rights to healthcare, trauma-informed care, issues surrounding homelessness and health, and stigma and discrimination. Regular and ongoing support, professional supervision and reflective practice for staff working with people experiencing homelessness is also recommended.

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There are a wide range of available resources for staff training and development. For example:

- Public Health England developed ‘All Our Health’ as a resource to help health professionals prevent ill health and promote wellbeing as part of their everyday practice. The section on homelessness provides information and e-learning resources to help frontline health and care staff use their trusted relationships with patients, families and communities to take action on homelessness.

- Health Education England’s e-learning for health website offers two e-learning sessions to support the health and care workforce to understand the health impacts of homelessness, identify different forms of homelessness, gain practical steps to making a referral and highlights ways that an organisation can implement the duty effectively.

- The Healthy London Partnership provides a wide range of materials on homeless health and resources for staff working with people experiencing homelessness, including podcasts and a homelessness and health resource pack which aims to bring together information on homelessness services to make it easier for frontline NHS staff and others to find the right support for people who are homeless.

- QNI provide a wide range of reports and guides as part of their homeless and inclusion health programme, including street outreach, nursing, oral and foot health.

- The UK Faculty for Homeless and Inclusion Health has a Homeless and Inclusion Health Digital Library which includes more than 300 videos of presentations and discussions by experts on inclusion health, many of which could be used as part of training on homelessness and inclusion health.

- Fairhealth provide free brief introductions to inclusion health, and health-related street outreach.

- Pathway have produced a series of short films with people with lived experience and clinicians discussing a range of homeless healthcare issues: from how becoming homeless affects individuals, to recognising and dealing with complex trauma, to engaging with patients, and improving practice. In addition, Pathway carried out an Inclusion Health Education Mapping and Review project. The report on the project presents a review of current free and low-cost inclusion health education that is available online, and ranks this in terms of usefulness. This will be useful to both new and experienced practitioners.

- The clinical networks operating in this area are:
  - The QNI Homeless Health Programme,
  - The Faculty of Homeless and Inclusion Health
  - The London Network of Nurses and Midwives Homelessness Group
  - The NHS Future Platform network on homelessness health is also available to people working in the NHS.

Some available resources are for staff working in particular clinical areas. For example:

- The Healthy London Partnership worked with Pathway to develop a training package for GP receptionists and practice managers to help improve healthcare for people who are experiencing homelessness. The Hull Pathway Team worked with the hospital security staff on culture change.

- The London Network of Nurses and Midwives Homelessness Group have an e-learning package for people new to street outreach, and people looking to develop their practice or service.

- The Smile4Life Training pack aims to provide training to enable health and social care staff and support workers to provide evidence based tailored oral health messages to meet the specific and exceptional needs of people impacted by homelessness in Scotland. The content of the training guide reflects the learning requirements and information needs of the wide variety of professionals that are involved in the care and support of people experiencing homelessness.

- Pathway have produced three online training modules on homeless health for emergency medicine staff and ward teams – hospital staff that see a high number of homeless patients. These include: three bite-size videos, with associated questions and slides that cover:
  - Homelessness and health – an introduction
  - Duty to Refer and housing law (with Covid context)
  - The difference you can make – practical things you can do to make a difference to someone who is currently homeless, when they arrive in hospital.

- St Ann’s Hospice in Manchester commissioned a film about palliative care and homelessness, which shares the experiences of professionals across the sectors and people affected by homelessness.

- The homelessness and palliative care toolkit produced by Marie Curie and St Mungo’s is a free online resource with tools and activity worksheets to help in planning and providing care for people experiencing homelessness and those who have been bereaved. Each section contains resources, tools and activity worksheets to help in planning and providing person-centred, multi-agency care for homeless people. The resources can be found throughout the toolkit and also in the resources section. Further on-line training materials have been produced aimed at professionals including social care, mental health and others.

- Enabling Assessment Service London and Homeless Link published homelessness guidance for mental health professionals in 2018. It aims to provide an overview of how homelessness services operate, and some of the ways in which mental health professionals’ input can support better outcomes for people with case studies on homelessness applications; trauma-informed response in a hostel setting; and rough sleeping. It includes key principles for initial assessments and screening, as well as advice on supporting and increasing the capacity of housing staff.
Meeting the psychological and emotional needs of homeless people is non-statutory guidance on dealing with complex psychological and emotional needs from the National Mental Health Development Unit and the Department for Communities and Local Government which was published in 2010. It includes case studies, definitions, guidance on improving practice.

Resources for Autism, Westminster City Council, St Mungo’s, National Autistic Society and Homeless Link created a toolkit and accompanying webinar in 2019 to help staff in homelessness services understand:
- some of the signs that a person might be autistic
- how autism might change the way that people engage with services and support
- how staff can tailor their responses to better meet the needs of autistic people.